South Carolina

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

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 09/25/2023 3.40.09 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

NOT FINAL

State Information

State Information

Plan Year

Start Year 2024

End Year 2025

State Unique Entity Identification

Unique Entity ID KX6SLMCEZL93

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

Agency Name S.C. Department of Alcohol and Other Drug Abuse Services

Organizational Unit S.C. Department of Alcohol and Other Drug Abuse Services

Mailing Address PO 8268

City Columbia

Zip Code 29202

II. Contact Person for the Grantee of the Block Grant

First Name Sara

Last Name Goldsby

Agency Name S. C. Department of Alcohol and Other Drug Abuse Services

Mailing Address P.O. Box 8268

City Columbia

Zip Code 29202

Telephone (803) 896-8371

Fax (803) 896-5557

Email Address sgoldsby@daodas.sc.gov

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name Jan

Last Name Nerud

Telephone 8038961143

Fax (803) 896-5557

Email Address jnerud@daodas.sc.gov

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Footnotes:

NOT FINAL

State Information

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

Fiscal Year 2024

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

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

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: ______________________________

Name of Chief Executive Officer (CEO) or Designee: Sara Goldsby

Signature of CEO or Designee[1]: ______________________________

Title: Director

Date Signed: ______________________________
mm/dd/yyyy

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

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

Footnotes:

HENRY MCMASTER
GOVERNOR

September 22, 2023

Miriam E. Delphin-Rittmon, Ph. D.
Assistant Secretary for Mental Health and Substance Use
Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, Maryland 20857

Dear Dr. Delphin-Rittmon:

As the Governor of the State of South Carolina, for the duration of my tenure, I delegate authority to the Director of the S.C. Department of Alcohol and Other Drug Abuse Services (DAODAS), or anyone officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration Substance Use Prevention Treatment and Recovery Services Block Grant.

The mailing address for DAODAS is:

South Carolina Department of Alcohol and Other Drug Abuse Services
Post Office Box 8268
Columbia, South Carolina 29202

If I may be of further assistance on this issue, please contact Mark Plowden in my office at 803.734.0522 or mplowden@governor.sc.gov.

Yours very truly,

Henry McMaster

HM/mp

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

State Information

Disclosure of Lobbying Activities

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

Name

Sara Goldsby

Title

Director

Organization

South Carolina Department of Alcohol and Other Drug Abuse Services

---

Signature: Date:

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

Footnotes:

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

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

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Footnotes:

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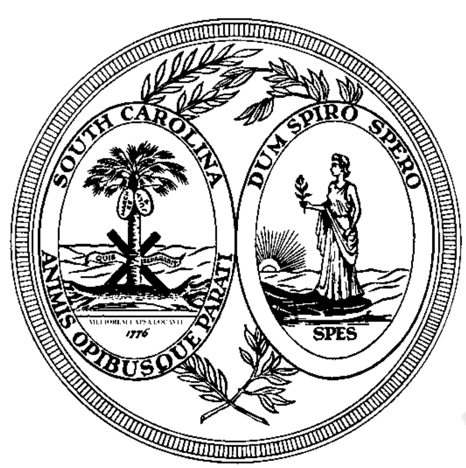

South Carolina Department of Alcohol and Other Drug Abuse Services

Treatment Programs Manual FY2024

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Statewide Base Treatment Services

Subgrantee shall provide the following statewide base treatment services:

1) *Traditional Outpatient, Adolescent, Group, Individual, Family Counseling, Outpatient Services (Outpatient-Tx) (Level I) / Class Code 3001-30xx*
   a) *Definition*: Organized non-residential services, which may be delivered in a wide variety of settings. Addiction treatment personnel or addiction credentialed clinicians provide professionally directed evaluation, treatment, and recovery services to persons with substance use disorders or persons "at risk" for developing substance use disorders. Services should be designed to treat the individual's level of illness severity and to achieve permanent changes in an individual's alcohol- or other drug-using behavior.
   b) *Special Conditions*: Subgrantee shall adhere to the following conditions:
      i) Subgrantee shall comply with DAODAS reporting requirements to ensure that all pregnant/parenting women are identified at intake/admission and that all subsequent services delivered are appropriately documented.
      ii) In addition to the direct service codes applicable to any person receiving services through the Traditional Outpatient component, Subgrantee shall also provide pregnant/parenting women, as appropriate, additional services, to include appropriate referral and assistance in accessing prenatal care and child care.
      iii) *Services to Adolescents* – Adolescents who use alcohol and other drugs differ from adults in significant ways. Adolescence affords a unique opportunity to modify risk factors that are still active and not yet complete in their influence on development. Adolescents must be approached differently from adults because of differences in their stages of emotional, cognitive, physical, social, and moral development. At every level of care, program services for adolescents should be designed to meet their developmental and other special needs. Strategies to engage adolescents, channel their energy, and hold their attention are especially critical. Treatment must address the nuances of adolescent experience, including cognitive, emotional, physical, social, and moral development, in addition to involvement with alcohol and other drugs. To this end, Subgrantee shall:
         (1) Provide family-centered substance use disorder and co-occurring services.
         (2) Use ASAM adolescent admission, continued stay, and discharge criteria. All patient cases should be staffed on a regular basis to determine patients' status in services. The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) or latest implemented edition will be used for diagnosing patients.
         (3) Services should be individualized and culturally competent to meet the needs of diverse populations.
         (4) Treatment services should be evidence based and proven effective with adolescents. To ensure the highest quality services for adolescents, it is highly recommended that staff working with this population pursue the Adolescent Workforce Development trainings offered by DAODAS. It is also recommended that each agency designate at least one staff person as the adolescent counselor for the agency.

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(5) Clinical supervision should be provided to adolescent treatment staff per the agency's policies and procedures. DAODAS contracts with a private provider to meet this need, and providers may seek that consultation as needed.
(6) Subgrantee will use the common screening tool as identified by DAODAS for adolescent services.
(7) DAODAS will conduct periodic reviews to ensure quality of care is being provided appropriately to adolescents.
(8) Collaborate across agencies to meet the needs of the whole patient and their family.
(9) Ongoing recovery support services should be provided as needed.

2) *Alcohol and Drug Safety Action Program (INT-ADSAP) / Class Code 4001*

a) *Definition*: The South Carolina ADSAP provides assessment, education, intervention, and treatment services as mandated pursuant to § 56-5-2990 of the Code of Laws of South Carolina. In addition, certified ADSAP providers will adhere to the revised DUI laws specific to ADSAP that are defined in state law and require mandated treatment for all DUI offenders.

b) All ADSAP client enrollment and termination information will be submitted to DAODAS. All completions of ADSAP clients determined to be financially able to bear the cost of services will be submitted to DAODAS once services are completed and fees are paid as agreed to by the client and the provider. Financial assessment is an ongoing process, and for those individuals who express an inability to pay at any time during the process, the provider shall adhere to the financial assessment guidelines and offer community services to eligible clients in lieu of payment. Therefore, DAODAS directs that community service options shall be made available for individuals found unable to pay. As the statute does not require the completion of community services for the completion of ADSAP, DAODAS recommends that providers use discretion and consider completion with any reasonable effort of an individual to engage in community service.

c) All ADSAPs must be certified by DAODAS and re-certified every two years thereafter.

d) *Special Conditions*: Subgrantee shall adhere to the following conditions:

i) Ensure compliance with all operational standards outlined in the ADSAP Standards Manual (incorporated by reference).

ii) Use only the ADSAP curriculum designated by DAODAS, which will be delivered in accordance with accompanying training and instructions. In addition, each program shall comply with the following requirements:

(1) Course delivery, content, and sequence shall be in accordance with the ADSAP designated group leader's manual with no deletions or additions of outside materials.
(2) No portion of the material contained in the curriculum shall be copied without written permission of Prevention Research Institute.
(3) Each participant shall be issued a student handbook at the beginning of the group.
(4) Group size shall not exceed 25 participants.

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(5) All participants shall be required to attend group sessions for the entire 16-hour duration of the program.
(6) Only certified group leaders shall deliver the curriculum.
(7) Ensure that all certified group leaders comply with ADSAP curriculum delivery requirements.

iii) All programs will use only the common objective assessment instrument designated by DAODAS, which will be delivered in accordance with accompanying training and instructions.

iv) Subgrantee will adhere to General Terms and Conditions paragraph 106. (Fees/Financial Assessment).

v) Per 56-5-2990 (C) of the South Carolina Code of Laws, 1976, as amended, all certified ADSAPs will maintain a record of the number of community service hours performed and the amount of fee offset. This information will be submitted in writing to DAODAS at the end of each year (see deliverables list for specific date). All ADSAPs shall comply with state law and shall provide clients who, pursuant to a financial assessment were deemed unable to pay for services, an option for substituting payment with community service. All ADSAPs shall maintain an updated list of qualified community service organizations in their jurisdiction. ADSAP providers found to be out of compliance with this state law will be immediately notified of noncompliance and required to submit an action-plan. Further failure to comply with this state law may result in decertification of the ADSAP.

vi) Subgrantee shall ensure the attendance of an ADSAP representative or designee at a minimum of three (3) scheduled statewide ADSAP meetings.

vii) Subgrantee shall ensure timely handling of consumer complaints at the local level.

3) *Interstate ADSAP Management –* ***Dorchester Alcohol and Drug Commission ONLY /*** *Class Code 4002*

a) *Definition*: The South Carolina Interstate Alcohol and Drug Safety Action Program (IADSAP) Office provides administrative processing of out-of-state DUI offenders who wish to clear their driver record in South Carolina by meeting the ADSAP requirements.

b) *Service Activity*: Subgrantee shall adhere to the following conditions:

i) Provide and manage sufficient appropriate staff to provide administrative case management services for out-of-state DUI offenders who wish to clear their driver record in South Carolina by meeting the ADSAP requirement. Access to IADSAP staff via telephone must be available to clients during the operating hours of Subgrantee.

ii) Provide and manage all telephone, postage, office, and clerical services necessary to support the provision of administrative case management services to out-of-state DUI offenders.

iii) Collect the sum of no more than one hundred and fifty dollars ($150) from each out-of-state DUI client using the code number “47” in the “County Enrolled” block on the form promulgated by DAODAS, client service center of “I-AD-IN-OP-N-N-A” and activity code number “198.”

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iv) On due date specified on the Contract Deliverable list and using report shell, submit to DAODAS an annual report of relevant financial transactions and client flow data, as well as a narrative discussion of program progress, problems, and plans.

c) *Special Conditions*: Subgrantee shall adhere to the following conditions:
   i) Inform all collaborating entities, both in-state and out-of-state, of the Dorchester Alcohol and Drug Commission (DADC)'s address and telephone number for managing out-of-state clients. Maintain a South Carolina IADSAP website.
   ii) Provide telephone and in-person technical assistance to the DADC for case management of out-of-state DUI offenders.
   iii) Collect and analyze client flow and program management data to determine program effectiveness and efficiency.
   iv) Working with the State ADSAP Coordinator and ADSAP Information Coordinator at DAODAS, coordinate revisions to interstate procedures and policies, resolution of issues, and development of problem solutions.
   v) Participation by the IADSAP coordinator and other appropriate staff in state, regional, and national educational conferences on DUI, interstate issues, laws, and treatment services.

4) *Youth and Adolescent Services (YAS), Intervention / Class Code 5501*
   a) *Definition*: YAS is defined as a program for providing intervention services to high-risk youth, which may include grades kindergarten through 12 who are identified through the school system, human service providers, parents, or self-referrals and are experiencing a wide range of personal or behavioral problems. Through YAS, students and families are provided with the opportunity to learn new ways of coping with their problems in order to avoid the development of more serious problems in the future.
   b) Subgrantee will comply with all DAODAS standards pertinent to this level of care.

5) *Alcohol Intervention Program (AIP)*
   a) *Definition*: The AIP is required by Act 103, The Prevention of Underage Drinking and Access to Alcohol Act of 2007. This law requires an individual who violates the provision of this section to successfully complete a DAODAS-approved alcohol prevention education or intervention program.
   b) *Services Activity*: Subgrantee shall provide AIP services to individuals, ages 17 to 20, referred to Subgrantee pursuant to state law.
      i) Clients will be screened and placed in services using Motivational Enhancement Therapy – Cognitive Behavioral Therapy-5 (MET-CBT 5) as the intervention.
      ii) Services should be a minimum of eight hours and cost no more than $150.00.
      iii) An exit conference will be conducted with all clients. Parents should be included, with client's permission, if at all possible.

6) *Gambling Services / Class Code 3701*
   a) *Definition*: An approved therapeutic service designed to address the problems related to problem gambling. Services for clients who need additional services concurrently or

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following the gambling-specific therapeutic service will be determined in accordance with the existing fee schedule.

b) *Special Conditions*:
   i) Subgrantee shall provide an approved therapeutic service for identified problem or pathological gamblers and related services for family members. Treatment includes bundled services and additional discrete services as indicated on the individual's treatment plan.
   ii) All persons age 13 or older will be administered the electronic health record screening questions pertinent to gambling. Evidence of compliance with this core service requirement will be monitored during the annual oversight visit. If found to be noncompliant, Subgrantee must submit a corrective action plan to DAODAS for approval. If an individual indicates they have engaged in gambling activities, they will be given a full gambling assessment. The gambling screen will be placed in the clinical file with the assessment. If the assessment indicates the individual meets the criteria for a Pathological Gambling diagnosis, they will be entered into the appropriate level of treatment.

c) *Utilization Review (UR) is required for all gambling services*:
   i) Upon completion of the assessment, Subgrantee shall contact DAODAS' Utilization Review (UR) Case Manager to obtain prior authorization of services to be billed, and a prior authorization number. The prior authorization number must accompany any services billed in the appropriate block of the billing form. Failure to obtain the prior authorization shall result in non-payment for services. The following procedures will be followed for utilization review:
      (1) Clinicians will perform periodic reviews with DAODAS' UR Case Manager, as scheduled, to report progress and receive authorization for continuation of services. Upon completion of services, the clinician will call the UR Case Manager and move the patient into case management status. If the patient requires additional treatment services during the case management period, the UR Case Manager must be contacted to authorize the services.
   ii) Clinicians will call the UR Case Manager to report completion of all services and discharge. Failure to perform all UR activities shall result in non-reimbursement of services.
   iii) Additional gambling assessment is required for all patients receiving gambling services at time of discharge and at 90-days post-discharge.

d) *Physical Treatment Components*: The basic approach to treatment will be to use all available and clinically appropriate services that apply to any given patient. Thus, any person who presents for treatment will be provided with a complete biopsychosocial assessment to ascertain all probable diagnoses, to include Pathological Gambling as defined in the DSM-5. The possible alternatives and corresponding actions at this stage will be:
   i) Patient does not meet the full criteria for Pathological Gambling but may still be experiencing problems.

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(1) Problems are linked to gambling. **Action:** Subgrantee may choose to provide treatment services on a private-pay basis or refer the patient to another provider.
(2) Problems are related to a substance use disorder. **Action:** Subgrantee will provide appropriate substance use disorder (SUD) services in accordance with current Substance Use Prevention, Treatment, and Recovery Services Block Grant, Medicaid, and DAODAS policies and procedures.

ii) Patient meets the full criteria for Pathological Gambling.

(1) Patient is appropriate for bundled services. **Action:** Subgrantee will complete the Individualized Treatment Plan (ITP) and administer the first outcomes survey; provide appropriate crisis- and case-management services during the treatment phase; provide the approved therapeutic service; complete the continuing care plan and administer the outcomes survey again during the patient's exit counseling session; and provide scheduled case management services during the continuing care phase and administer the outcomes survey during the final case management session at 90 days following the treatment phase. Subgrantee may provide individual and/or family counseling sessions as necessitated by patient needs and documented in the ITP.
(2) Patient is appropriate for gambling services, but Subgrantee does not have a sufficient number of patients for group counseling. (The clinically appropriate group size is a minimum of two and a maximum of 16.) **Action:** Subgrantee will complete the ITP and administer the first outcomes survey; provide appropriate crisis- and case-management services during the treatment phase; provide the approved therapeutic service, which may include the family unit as appropriate; complete the continuing-care plan and administer the outcomes survey again during the patient's exit counseling session; and provide scheduled case management services during the continuing-care phase and administer the outcomes survey at the final case-management session at 90 days following the treatment phase. Subgrantee may provide additional individual and/or family counseling sessions as necessitated by patient needs and documented in the ITP.
(3) Patient is not appropriate for gambling services. **Action:** Subgrantee will complete the ITP and administer the first outcomes survey; provide appropriate crisis- and case-management services during the treatment phase; provide individual counseling, which may include the family unit as appropriate; complete the continuing-care plan and administer the outcomes survey again during the patient's exit counseling session; and provide scheduled case-management services during the continuing-care phase and administer the outcomes survey at the final case management session at 90 days following the treatment phase. Subgrantee may provide additional individual and/or family counseling sessions as necessitated by patient needs and documented in the ITP.

iii) For consistent and equitable application, Subgrantee shall use rates as outlined on Form "Gambling Contract Service Rates," the DAODAS Policy on Indigence and Fee Assessment, and the DAODAS Financial Assessment Form.

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e) *Gambling Registry*: Each county alcohol and drug abuse authority must have at least one staff member who is authorized to provide an approved therapeutic service for problem or pathological gambling. The DAODAS Utilization Review Case Manager will implement and maintain a registry of qualified gambling addictions counselors. Qualified counselors from county alcohol and drug abuse authorities will maintain this information locally in their privileging files.

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Extended Treatment Services

Subgrantee shall provide the following extended treatment services:

1) *Medically Monitored Inpatient Withdrawal Management / Level 3.7 WM / Class Code 1001*
   a) *Definition*: An organized service delivered by medical, nursing, and clinical professionals, which provides for 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. This level provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care but not severe enough to warrant placement in an acute general hospital. All patients should be seen by a counselor to assess level-of-care needs and facilitate patient engagement in treatment services. The case manager or counselor should make referrals as needed.
   b) *Special Conditions*:
      i) All new programs must be approved by DAODAS.
      ii) Subgrantee shall comply with all CARF and/or Joint Commission quality assurance standards pertinent to this level of care.
      iii) Existing programs must review and update their internal agency policies and procedures manuals annually and submit any changes to DAODAS for review.
      iv) Services under this program require prior authorization for reimbursement. Request for prior authorization of withdrawal management services will be performed by the Withdrawal Management provider upon admission of the patient by contacting the DAODAS Utilization Review (UR) Case Manager at 1-800-374-1390 (or 803-896-5988 for the Columbia area). Patients must meet ASAM PPC-2 criteria for admission to this level of care. The DAODAS reimbursement rate will reflect the Medicaid reimbursement rate.
      v) Withdrawal Management facilities will continue to perform utilization review of indigent Withdrawal Management Level 3.7 WM services after depletion of funds for the remainder of the fiscal year. Withdrawal Management facilities will continue to provide indigent Withdrawal Management services after depletion of the funds. Indigency is determined using the DAODAS-approved Policy on Indigency and Fee Assessment.
      vi) Reimbursement for Level 3.7 WM services may be denied for patients who have a primary diagnosis of Opioid Use Disorder unless they are offered the choice of receiving stabilizing agonist or partial agonist medications, such as methadone or buprenorphine, during inpatient services.
   c) *Access*: There must be 24-hour access to emergency medical services.

2) *Clinically Managed Residential Withdrawal Management / Level 3.2 WM / Class Code 1101*
   a) *Definition*: An organized service that may be delivered by appropriately trained staff who provide 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal. Clinically managed residential withdrawal management is characterized by its emphasis on peer and social support. This level

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provides care for patients whose intoxication/withdrawal signs and symptoms and/or functional deficits are sufficiently severe to require 24-hour structure and support. However, the full resources of a medically monitored inpatient withdrawal management service are not necessary. Some clinically managed residential inpatient withdrawal management programs are staffed to supervise self-administered medications for the management of withdrawal. All programs at this level shall rely on established clinical protocols to identify patients who are in need of medical services beyond the capacity of the facility and to transfer such patients to more appropriate levels of care.

b) *Special Conditions*:
   i) New programs must be approved by DAODAS.
   ii) Existing programs must review and update their policies and procedures manuals annually and submit any changes to DAODAS for review by the date specified on the Contract Deliverables list.
   iii) Social setting inpatient withdrawal management services (Level 3.2 WM) must receive prior authorization through DAODAS' UR Case Manager for all Medicaid and indigent patients prior to rendering the service. Request for prior authorization of inpatient Withdrawal Management services will be performed by the inpatient provider upon admission of the patient by contacting the DAODAS UR Case Manager at 1-800-374-1390, or 803-896-5988 (for the Columbia area). The DAODAS reimbursement rate for this service will reflect the Medicaid reimbursement rate.
   iv) Withdrawal Management facilities will continue to perform utilization review of indigent Withdrawal Management Level 3.2 WM services after depletion of funds for the remainder of the fiscal year. Indigency is determined using the approved DAODAS Policy on Indigency and Fee Assessment.
   v) Reimbursement for Level 3.2 WM services may be denied for patients who have a primary diagnosis of Opioid Use Disorder unless they are offered the choice of receiving stabilizing agonist or partial agonist medications, such as methadone or buprenorphine, during inpatient services.

c) *Access*: There must be 24-hour access to emergency medical services.

3) <u>*Outpatient Withdrawal Management / Ambulatory Withdrawal Management with Extended On-site Monitoring / Level 2 WM / Class Code 3602*</u>
   a) *Definition*: An organized outpatient service, which may be delivered in an office setting, healthcare or addiction treatment facility, by trained clinicians who provide medically supervised evaluation, withdrawal management, and referral services according to a predetermined schedule. Such services are provided in regularly scheduled sessions. They should be delivered under a defined set of policies and procedures or medical protocols. Outpatient services should be designed to treat the patient's level of clinical severity and to achieve safe and comfortable withdrawal from mood-altering drugs (including alcohol) and to effectively facilitate the patient's transition into ongoing treatment and recovery.

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b) *Special Conditions*:
   i) All new programs must be approved by DAODAS.
   ii) Subgrantee shall comply with all CARF and/or Joint Commission quality assurance standards pertinent to this level of care.
   iii) Existing programs must review and update their internal agency policies and procedures manuals annually and submit any changes to DAODAS for review by the date specified on the Contract Deliverables list.
   iv) Essential to this level of care is the availability of appropriately credentialed and licensed nurses (RN, LPN) for monitoring patients over a period of several hours on each day of service. There must be 24-hour access to emergency medical services. Service providers should be able to provide or assist in accessing transportation services for patients who are unable to drive safely for legal or medical reasons, or who otherwise lack transportation.

4) *<u>Clinically Managed High-Intensity Residential / Level 3.5 / Class Code 1501</u>*
   a) *Definition*: High-intensity residential programs are designed to address significant social and psychological problems. Level 3.5 care is characterized by the intensity of the addiction treatment services and the highly structured program activity rather than by the intensity of medical services provided. Daily scheduled professional addiction treatment services are designed to develop and apply recovery skills, including relapse prevention, interpersonal choices, and development of a social network supportive of recovery. Level 3.5 programs rely on the treatment community as a therapeutic agent that introduces and enforces the appropriate social values and behaviors, and by a focus on reintegration into the greater community. Refer to the ASAM criteria for additional information on this level of care. However, mandatory program requirements are listed below:
      i) Physician monitoring and nursing care and observation are available as needed, based on clinical judgment.
      ii) Professional staff (e.g., professional addictions counselor, registered nurse, physician, physician assistant, certified nurse practitioner, clinical nurse specialist who is authorized by the South Carolina Board of Nursing to function in the extended role with prescriptive authority, childcare specialist who meets the criteria for Therapeutic Child Care lead clinical staff) shall provide forty (40) hours of clinical services per week. These hours consist of six (6) hours per day, Monday through Friday, and five (5) hours per day, Saturday and Sunday. Residential staff provide coverage and services during the rest of each day.
      iii) Priority admission shall be provided for pregnant women.
   b) *Special Conditions*:
      i) All new programs must be approved by DAODAS.
      ii) Existing programs must review and update their policies and procedures manuals annually and submit any changes to DAODAS for review by the date specified on the Contract Deliverables list.

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5) *Medically Monitored Intensive Inpatient Treatment / Level 3.7 / Class Code 1505*
   a) *Definition*: Level 3.7 care is delivered by an interdisciplinary staff to patients whose sub-acute biomedical and emotional/behavioral problems are sufficiently severe to require inpatient treatment. Twenty-four (24)-hour observation, monitoring, and treatment are available. The treatment delivered at Level 3.7 is specific to the substance-related disorder, but the interdisciplinary team and the availability of support services also accommodate withdrawal management and/or intensive inpatient treatment of addiction and/or conjoint treatment of coexisting sub-acute biomedical and/or emotional/behavioral conditions that could jeopardize recovery. Refer to the ASAM criteria for additional information for this level of care. However, mandatory program requirements are listed in the following:
      i) A physician or nurse practitioner, or CSNRA, working with the stipulations of a practice agreement with a physician, will assess the patient face-to-face within 24 hours of admission and provide face-to-face evaluations at least once a week. Patients must be discharged from the 3.7 level of care by the physician or reviewed by the physician before the patient is transferred to a lower level of care within the same treatment system.
      ii) An alcohol/drug-focused nursing assessment must be conducted by a registered nurse at the time of admission; an LPN may assist in the collection of patient health data used for the assessment.
      iii) A registered nurse must be responsible for overseeing the monitoring of the patient's progress and medication administration.
   b) *Special Conditions*:
      i) Subgrantee shall comply with all DAODAS requirements pertinent to this level of care.
      ii) All new programs must be approved by DAODAS.

6) *Women's Residential Medically Monitored/Clinically Managed (WRTC) / Level 3.7 with step-down to Level 3.5 / Class Code 1601*
   a) *Definition*: WRTCs provide a long-term structured regimen of 24-hour evaluation, care, and treatment for chemical-abusing or chemically dependent pregnant and/or parenting women. These programs utilize multidisciplinary staff and clinical practices for patients who require out-of-home care. The programming usually includes, but is not limited to: medical supervision, individual counseling, group counseling, family counseling, family involvement, and multidimensional therapies to teach the appropriate use of leisure time, enhance self-esteem, and provide structured achievement experiences. A minimum of 10 beds is required to meet the statewide need for services.
   b) *Service Activity*: Subgrantee shall adhere to the following conditions:
      i) Provide a residential treatment center for pregnant and postpartum women, infants, and children. Provide Medically Monitored Women's Treatment (MMWT), a comprehensive array of gender-specific services that are designed to increase a woman's likelihood of recovery, decrease the risk of relapse, and facilitate successful

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reentry into the community. MMWT is a 24-hour/seven-day-per-week service. The professional staff (i.e., professional addictions clinician, registered nurse, physician, childcare specialist) shall provide at least six (6) hours of clinical services Monday through Friday and five (5) hours on weekends.

ii) Provide priority admission to pregnant women.
iii) Provide or facilitate access to other services, including vocational training, medical care, literacy and GED classes, relationship and communication skills, homemaking skills, and Medicaid eligibility, based on each resident's assessed needs. HIV/AIDS education and prevention will be provided to every program participant.
iv) Ensure that all pregnant residents receive regular, appropriate prenatal care. Provide transportation to prenatal appointments and coordinate case management with prenatal care providers.
v) Ensure that a best practice trauma curriculum is part of the weekly menu of services provided on this level of care.
vi) Provide childcare and child development services for the children of residents.
vii) Document all services in each patient's electronic health record (EHR).
viii) Review and update the WRTC policies and procedures manual annually and submit any changes to DAODAS for review by the date specified on the Contract Deliverables list.
ix) On due date specified on the Contract Deliverables list and using the indicated report shell, submit to DAODAS semi-annual reports on program development focusing on accomplishments and obstacles. These reports will also contain information on:
    (1) number of women served;
    (2) number of pregnant women served;
    (3) number of children served;
    (4) diagnosis or presenting problem;
    (5) number of assessments/admissions/discharges/re-admissions;
    (6) referral services;
    (7) number of Medicaid-eligible patients;
    (8) payment source (Medicaid, self-pay, other insurance, indigent, etc.);
    (9) reports of the quarterly Advisory Committee meetings;
    (10) number of "no shows" and any follow-up;
    (11) number of child abuse cases reported to the S.C. Department of Social Services (DSS); and
    (12) number of pregnant women reported to DSS for child abuse because of their drug use.
x) Utilize an Advisory Committee, the composition of which is consistent with the patient population to be served (gender and ethnicity). Consumer representatives will participate on the Advisory Committee.
xi) Collect National Outcomes Measurement System (NOMS) data at admission, discharge, and 90 days post-discharge.
xii) Provide recovery support services as needed.

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c) *Special Conditions*:
   i) All new programs must be approved by DAODAS.
   ii) Existing programs must review and update their policies and procedures manuals annually and submit any changes to DAODAS for review by the date specified on the Contract Deliverables list.

7) <u>*Adolescent Residential Medically Monitored/Clinically Managed / Level 3.7 with step-down to Level 3.5 / Class Code 1701*</u>
   a) Subgrantee will provide the following services:
      i) A total of at least nine (9) or more beds shall be maintained at all times. The treatment regimen shall include a comprehensive array of age-specific services that are designed to increase an adolescent's likelihood of recovery, decrease the risk of reoccurrence, and facilitate successful reentry into the home, school, and community. Weekday programming shall contain no less than six (6) hours of therapeutic programming per day; weekend programming shall contain no less than five (5) hours per day.
      ii) At least three (3) beds shall be maintained for medically indigent patients. "Medically indigent" is defined as lacking adequate resources for self-pay and not qualifying for either public or private third-party coverage.
      iii) Residents of any county in the state shall be admitted, subject to availability of beds.
      iv) Access to other services shall be provided or facilitated, including homebound educational instruction, medical care, and relationship and communication skills, based on each patient's assessed needs. HIV/AIDS education and prevention shall be provided to every patient.
      v) On the due date specified on the Contract Deliverables list and using the report shell, semi-annual reports on program development (focusing on accomplishments and obstacles) shall be submitted to DAODAS. These reports shall also contain information on:
         (1) number of adolescents served;
         (2) diagnosis of presenting problem;
         (3) number of assessments/admissions/discharges (indicate successful/unsuccessful) and re-admissions;
         (4) referral services;
         (5) number of Medicaid-eligible, self-pay, other insurance, and indigent patients; and
         (6) average length of stay.
      vi) Admissions shall be accepted 24 hours a day/seven days a week.
      vii) NOMS data shall be collected at admission, discharge, and 90 days post-discharge
   b) *Special Conditions*:
      i) All new programs must be approved by DAODAS.
      ii) Existing programs must review and update their policies and procedures manuals annually and submit any changes to DAODAS for review by the date specified on the Contract Deliverables list.

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8) *Intensive Outpatient Treatment Program (9-19 hours/week) / (IOP – General) Level 2.1 / Class Code 2501*
   a) *Definition*: IOP is a structured treatment program that is provided to individuals who are in need of more than traditional outpatient treatment services or as an alternative to inpatient treatment. Intensive services on an outpatient basis provide comprehensive biopsychosocial assessments and individualized treatment, and allow for a valid assessment of environmental, cognitive, and emotional antecedents to substance use and dependency. In addition, it allows the patient opportunities to test new coping strategies while still within a supportive treatment relationship/environment. These conditions will lead to generalization of what was learned in treatment in the patient's natural environment.
   b) *Service Activity*: Subgrantee shall provide intensive outpatient services to individuals who are in need of more than traditional outpatient care. IOP services consist of the following major treatment components:
      i) group counseling and therapy;
      ii) individual counseling and/or psychotherapy;
      iii) skill development;
      iv) family counseling (focused on the recovery environment) or therapy;
      v) family support;
      vi) peer support services;
      vii) medication management; and
      viii) self-help group orientation.
   c) *Special Conditions*: Subgrantee shall adhere to the following conditions:
      i) *Approval Process for New Programs*: Newly established IOPs shall be approved by DAODAS. In order for any new program to be approved, Subgrantee shall submit the following documents to DAODAS:
         (1) program outline;
         (2) weekly schedule;
         (3) description of program components; and
         (4) admission, continued stay, and discharge criteria.

         Written notice of approval shall be provided by DAODAS within forty-five (45) days of receipt of the required items, or a written notice of reason for non-approval shall be provided.

         Additionally, significant changes in approved programs, particularly changes in the required items listed above, should be announced in writing to DAODAS. Written notice of approval, or a written notice of reason for non-approval, shall likewise be provided within 45 days. Finally, Subgrantee shall give notice in writing to DAODAS of plans to close (or reopen) IOPs.
      ii) *Reapproval Process for Existing Programs*: All providers shall submit their programs for reapproval every other year by the date specified on the Contract Deliverables list. If this deliverable is not on the deliverables list, it is not due for that particular year. Subgrantee shall submit to DAODAS the documents outlined in Special

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Condition c)i) above. Written notice of approval, or a written notice of reason for non-approval, shall be provided by DAODAS within 45 days.

iii) *Standard Regimen*: The standard regimen of an IOP shall be a minimum of nine (9) hours per week. Length of stay and level of attendance per week should be based on an individual patient's needs and progress on treatment goals. Continuing treatment shall be provided, according to the individual patient's needs, following completion of the intensive phase of the program. An IOP consists of a minimum of nine (9) hours per week of clinical services.

iv) *Involuntary Commitment Act of 1986*: Patients referred to Subgrantee under provisions of the Involuntary Commitment Act of 1986 shall be given priority for admission to the IOP.

v) *Consultation with Local Mental Health Center*: Subgrantee shall participate as needed in patient services consultation with the appropriate local mental health center for all patients referred by the S.C. Department of Mental Health.

vi) Recovery support services should be provided as needed.

vii) Semi-annual reports on program development (focusing on accomplishments and obstacles) shall be submitted to DAODAS on the due date specified on the Contract Deliverables list and using the report shell. These reports shall also contain information on:
   - (1) referral services;
   - (2) number of Medicaid-eligible patients; and
   - (3) payment source (Medicaid, self-pay, private insurance, etc.).

9) *Women's Intensive Outpatient Treatment Program (9-19 hours/week) / (IOP-W) Level 2.1 / Class Code 2601*

a) *Definition*: A Women's Intensive Outpatient (WIOP) program is designed to provide intensive outpatient services to women who are in need of more intense services than the traditional outpatient treatment as an alternative to inpatient treatment. This allows for a valid assessment of environmental, cognitive, and emotional antecedents to substance use or dependency. It also allows the patient an opportunity to test new coping strategies while still within a supportive relationship.

b) *Service Activity*: Subgrantee shall adhere to the following conditions:

i) WIOP services consist of the following major treatment components:
   - (1) group counseling or therapy;
   - (2) individual counseling and/or psychotherapy;
   - (3) family counseling (focused on the recovery environment) or therapy;
   - (4) skill development;
   - (5) multi-family therapy;
   - (6) family support;
   - (7) peer support services;
   - (8) self-help group orientation; and
   - (9) best practices trauma curriculum.

NOT FINAL

ii) *Approval Process for New Programs*: Newly established WIOPs shall be approved by DAODAS. In order for any new program to be approved, Subgrantee shall submit the following documents to DAODAS:
   (1) program outline;
   (2) weekly schedule (to include trauma curriculum);
   (3) descriptions for four program components; and
   (4) admission, continued stay, and discharge criteria.

   Written notice of approval shall be provided by DAODAS within forty-five (45) days of receipt of the required items, or a written notice of reason for non-approval shall be provided.

   Additionally, significant changes in approved programs, particularly changes in the required items listed above, should be announced in writing to DAODAS. Written notice of approval, or a written notice of reason for non-approval, shall likewise be provided within forty-five (45) days. Finally, Subgrantee shall give notice in writing to DAODAS of plans to close (or reopen) a WIOP.

iii) *Reapproval Process for Existing Programs*: All programs shall submit their programs for reapproval every other year by the date specified on the Contract Deliverables list. If this deliverable is not on the deliverables list, it is not due for that particular year. Subgrantee shall submit to DAODAS the documents outlined in subsection b)ii) above. Written notice of approval, or a written notice of reason for non-approval, shall be provided by DAODAS within forty-five (45) days.

iv) Subgrantee shall provide a specialized intensive treatment and prevention program for alcohol and other drug (AOD)-dependent women and children. A minimum of fifty (50) women and their children will be served during the contract year.

v) Comprehensive, women-specific AOD treatment services that increase a woman's likelihood of recovery and decrease the risk of relapse shall be provided. Length of stay and level of attendance per week should be based on an individual patient's needs and progress on treatment goals. Continuing treatment shall be provided, according to the individual patient's needs, following completion of the intensive phase of the program. A WIOP must consist of a minimum of nine (9) hours per week.

vi) Access to other services – including vocational training, medical care, literacy/GED assessment and intervention, and Medicaid eligibility – shall be provided or facilitated based on each patient's assessed need.

vii) Continuing care services shall be provided according to the individual patient's need following completion of the intensive phase of the program.

viii) Priority admission to services shall be provided for pregnant women. Subgrantee shall ensure that all pregnant patients receive regular, appropriate prenatal care by facilitating transportation for patients to prenatal appointments and assisting in the scheduling of prenatal visits.

ix) Subgrantee shall provide a specialized children's program that enhances the healthy development and meets the physical, psychological, social, and educational needs of

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each child. This program must include child care and specifically designed services based on the developmental needs of each child, provided by prevention and/or clinical staff that promote resiliency skills in children and parent/child bonding. A minimum of three (3) hours per week of structured intervention with each child enrolled in the program will occur. The children's program curriculum will be evaluated annually, and changes will be sent to DAODAS for approval by the date identified on the Contract Deliverables list. If Subgrantee cannot provide this service onsite, it should work with the patient to locate daycare services.

x) Therapeutic sessions that include interaction between parent and child shall be provided for school-age children on a monthly basis.

xi) Subgrantee shall provide access to medical assessments of each patient enrolled in the program and access to identified medical services. Subgrantee shall ensure that each child in the program has had proper immunizations and has access to medical services when needed.

xii) Subgrantee shall ensure that transportation is provided to the program, childcare site, and other agencies for each patient and child enrolled in the program.

xiii) Subgrantee shall submit to DAODAS semi-annual reports on program development (focusing on accomplishments and obstacles) on the due date specified on the Contract Deliverables list and using the report shell. These reports will also contain information on:

(1) number of pregnant women served;
(2) number of women admitted into services;
(3) number and ages of children served;
(4) referral services;
(5) number of Medicaid-eligible patients;
(6) payment source (Medicaid, self-pay, private insurance, etc.);
(7) reports of the quarterly Advisory Committee meeting (This can be a copy of the minutes of the meeting.);
(8) number of child abuse cases reported to the S.C. Department of Social Services (DSS); and
(9) number of pregnant women reported to DSS for child abuse because of their drug use.

xiv) All services shall be documented in the electronic health record system.

xv) Subgrantee shall participate in an on-site program review conducted by DAODAS staff. Subgrantee shall provide clinical records and other program information, as requested, for review.

xvi) An Advisory Committee shall be developed for the purpose of community networking, referral source, and advocacy for women. Representation on the committee shall include agencies submitting letters of support for the proposal, the solicitor's office, and consumers.

xvii) Subgrantee shall provide outcome evaluation of the program as part of the semi-annual narrative report. The due date is listed on the Contract Deliverables list.

xviii) Subgrantee shall provide recovery support services as needed.

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10) *Adolescent Intensive Outpatient Treatment (6-19 hours/week) / (IOP-A) Level 2.1 / Class Code 2701*
   a) *Definition*: Intensive outpatient services are provided to adolescents who are in need of more than traditional outpatient treatment services or as an alternative to inpatient treatment. Intensive services on an outpatient basis provide comprehensive biopsychosocial assessments and individualized treatment and allow for a valid assessment of environmental, cognitive, and emotional antecedents to substance use or dependency. In addition, it allows the patient opportunities to test new coping strategies while still within a supportive treatment relationship/environment. These conditions will lead to generalization of what was learned in treatment in the patient's natural environment.
   b) *Service Activity*: Subgrantee shall provide adolescent intensive outpatient (AIOP) treatment services to adolescents who are in need of more than traditional outpatient care. AIOP services consist of the following major treatment components:
      i) group counseling (using an evidence-based practice) or therapy;
      ii) individual counseling and/or psychotherapy;
      iii) skill development;
      iv) family counseling (focused on the recovery environment) or therapy; and
      v) self-help group orientation.
   c) *Special Conditions*: Subgrantee shall adhere to the following conditions:
      i) *Approval Process for New Programs*: Newly established AIOPs shall be approved by DAODAS. In order for any new program to be approved, Subgrantee shall submit the following documents to DAODAS:
         (1) program outline;
         (2) weekly schedule;
         (3) description for four (4) program components; and
         (4) admission, continued stay, and discharge criteria.

         Written notice of approval shall be provided by DAODAS within forty-five (45) days of receipt of the required items, or a written notice of reason for non-approval shall be provided.

         Additionally, significant changes in approved programs, particularly changes in the required items listed above, should be announced in writing to DAODAS. Written notice of approval, or a written notice of reason for non-approval, shall likewise be provided within forty-five (45) days. Finally, Subgrantee shall give notice in writing to DAODAS of plans to close (or reopen) an AIOP.
      ii) *Reapproval Process for Existing Programs*: All Subgrantees shall submit their programs for reapproval every other year by the date specified on the Contract Deliverables list. If this deliverable is not on the deliverables list, it is not due for that particular year. Subgrantee shall submit to DAODAS the documents outlined in Special Condition c)i) above. Written notice of approval, or a written notice of reason for non-approval, shall be provided by DAODAS within forty-five (45) days.

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iii) *Standard Regimen*: The standard regimen of the AIOP shall be a minimum of six (6) hours per week. Length of stay and level of attendance per week should be based on the individual patient's needs and progress on treatment goals. Continuing treatment shall be provided, according to the individual patient's needs, following completion of the intensive phase of the program.
iv) *Involuntary Commitment Act of 1986*: Patients referred to Subgrantee under provisions of the Involuntary Commitment Act of 1986 shall be given priority for admission to the AIOP.
v) *Consultation with Local Mental Health Center*: Subgrantee shall participate, as needed, in patient services consultation with the appropriate local mental health center for all patients referred by the S.C. Department of Mental Health.
vi) Subgrantee shall submit to DAODAS semi-annual reports on program development (focusing on accomplishments and obstacles) on the due date specified on the Contract Deliverables list and using the report shell. These reports shall also contain information on:
(1) referral services;
(2) number of Medicaid-eligible patients; and
(3) payment source (Medicaid, self-pay, private insurance, etc.).

11) <u>*Day Treatment/Partial Hospitalization Treatment Program – (20+ hours/week) / Level 2.5 / Class Code 2801*</u>

a) *Definition*: Day Treatment/Partial Hospitalization is a structured treatment program that is provided to individuals who are in need of more than traditional intensive outpatient treatment services or as an alternative to inpatient treatment. Day Treatment/Partial Hospitalization generally provides twenty (20) or more hours of clinically intensive programming per week based on individual treatment plans. Programs shall have ready access to psychiatric, medical, and laboratory services. Intensive services at this level of care provide comprehensive biopsychosocial assessments and individualized treatment, and they allow for a valid assessment of dependency. This level of care also provides for frequent monitoring/management of the patient's medical and emotional concerns in order to avoid hospitalization. In addition, it allows the patient opportunities to test new coping strategies while still within a supportive treatment relationship/environment. These conditions will lead to generalization of what was learned in treatment in the patient's natural environment.
b) *Service Activity*: Subgrantee shall provide Day Treatment/Partial Hospitalization services to individuals who are in need of more than traditional intensive outpatient care. Day Treatment/Partial Hospitalization services consist of the following major treatment components:
i) group counseling or therapy;
ii) individual counseling and/or psychotherapy;
iii) skill development;
iv) family counseling (focused on the recovery environment) or therapy;
v) peer support services;

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vi) family support;
vii) self-help group orientation; and
viii) psychiatric/medical/laboratory support.

c) *Special Conditions*: Subgrantee shall adhere to the same process for approval of new programs and reapproval of existing programs as the intensive outpatient treatment services approval process.
   i) *Involuntary Commitment Act of 1986*: Patients referred to Subgrantee under provisions of the Involuntary Commitment Act of 1986 shall be given priority for admission to the Day Treatment/Partial Hospitalization Treatment Program.
   ii) *Consultation With Local Mental Health Center*: Subgrantee shall participate, as needed, in patient services consultation with the appropriate local mental health center for all patients referred by the S.C. Department of Mental Health.

12) *The Bridge (Adolescent Services) / Class Code 3404*

a) *Definition*: The Bridge is a comprehensive, individualized, family-centered service primarily designed for adolescents who are preparing to leave an alcohol and other drug inpatient program; a juvenile justice facility; or other residential setting. Because the move from an institutional setting represents a difficult time for both the adolescent and the family, The Bridge offers a gradual "step-down" transition into the community by providing a comprehensive array of specialized services, including family-based counseling, intensive case management and continuing care, as well as general attention to primary healthcare needs. In addition, in an attempt to meet the needs of a broader community of adolescents, the program also accepts referrals of young people at risk for incarceration from local juvenile justice offices, schools, and other community organizations. Following an intensive assessment to determine individual strengths and needs, a comprehensive plan is tailored to meet the needs of the adolescent and family.

b) *Special Conditions*:
   i) Subgrantee shall maintain and comply with the project's policies and procedures, including but not limited to:
      (1) provision of case management contact, urine drug screening, and home visits at specified frequencies;
      (2) provision of alcohol and other drug treatment as appropriate to individual patient need; and
      (3) arrangements for and monitoring provision of contractual wrap-around services.
   ii) Subgrantee shall assign a Site Supervisor to the program who will coordinate the program for Subgrantee. Primary responsibilities include staff hiring, training, and supervision (especially weekly clinical supervision); establishing subcontracts or other arrangements with local providers of specialized contractual services; building relationships with key local agencies; and managing patient flow, including treatment team decisions regarding patients' movement from phase to phase in the program.

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iii) Subgrantee shall have at least one credentialed counselor assigned to The Bridge at all times.
iv) Subgrantee shall establish a system for encouraging parental contributions of volunteer time to the program, with documentation of at least twenty (20) hours of volunteer services (per site) provided per quarter.
v) Subgrantee shall meet and maintain the following expected outcomes:
   (1) Ninety percent (90%) of Bridge staff time will be dedicated to The Bridge program.
   (2) Each counselor/case manager is expected to maintain a caseload of no fewer than eighteen (18) patients or eighty percent (80%) of his/her capacity. Optimal caseload is twenty-two (22) patients. Each counselor/case manager will be expected to spend at least sixty percent (60%) of his/her time in direct patient service activities.
   (3) Each counselor/case manager will be expected to initiate the majority of intensive case management and continuum of care contact in community-based settings (not office-based).
   (4) The graduation rate for each counselor/case manager will be at least fifty percent (50%) and should be seventy-five percent (75%) (optimal).
   (5) Overall patient reincarceration rates for each site will not exceed the following:

Minimum	Optimal	
15.0%	10.0%	Six (6) months after discharge
20.0%	15.0%	Twelve (12) months after discharge
25.0%	20.0%	Two (2) years after discharge

   (6) At least seventy-five percent (75%) of each counselor/case manager's graduates will be abstinent at the time of graduation, and ninety percent (90%) (optimal) should be abstinent.
   (7) For patients 16 and younger, at least seventy-five percent (75%) of each counselor/case manager's graduates will have completed high school, obtained a GED, or remained actively involved in education, and ninety percent (90%) (optimal) should have met these goals. For patients 17 years and older, at least fifty percent (50%) will have completed high school, obtained a GED, or remained actively involved in education, and seventy percent (70%) (optimal) should have met these goals.
   (8) At least seventy-five percent (75%) of each counselor/case manager's graduates will be employed (excluding those patients who are too young to work), and ninety percent (90%) (optimal) should be employed.
   (9) At least fifty percent (50%) of the families served by each counselor/case manager will demonstrate improved functioning, as indicated by record review, by the time of their child's graduation, and sixty-five percent (65%) (optimal) should meet this goal.
vi) The Program Director shall monitor individual counselor/case manager performance on a regular basis, normally every eight (8) weeks.

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vii) Subgrantee shall participate in the evaluation design as directed by the DAODAS Program Director and Subgrantee. These activities include but are not limited to patient-specific data collection needs and periodic auditing of patient records by the DAODAS Program Director.
viii) Subgrantee shall document all services in CareLogic.
ix) Subgrantee shall submit to DAODAS semi-annual reports on program development (focusing on accomplishments and obstacles) on the due date specified on the Contract Deliverables list and using a report shell.
x) The DAODAS Program Director, at his/her discretion, may issue a waiver of any of the requirements of these standards upon the good-cause-shown request of a site. Requests must demonstrate that the waiver will not in any substantial or material manner have a deleterious effect on the essential quality of services provided to the patient. Waivers issued by DAODAS will be in writing and will specify the maximum duration of the waiver's effect. In addition, any waiver issued by DAODAS may be rescinded at any time at the discretion of the Program Director and will be rescinded if deleterious effect on the essential quality of patient services is evidenced.
xi) All Bridge staff must pass S.C. Department of Social Services Child Protective Services registry checks and S.C. Law Enforcement Division background checks, and produce three (3)-year driving records. This information must be on file at all times at the host site and available for review as part of the record reviews that are conducted by DAODAS.

13) *Hispanic Services (INT – Hispanic Services) / Class Code 9001*

a) *Definition*: Interpretive and translation services shall be provided to Spanish-speaking consumers who access the county alcohol and drug abuse authority's catchment area for both voluntary and involuntary services during the standard work week. Subgrantee shall provide a toll-free number to ensure regional access for these services. Bilingual interpretive and translation services shall be provided to DAODAS on a limited basis.
b) *Service Activity*:
   i) Update resource list for the region that includes other Limited English Proficiency services that are available to the region's counties.
   ii) Maintain log of all requests by counties in the region that includes type of service needs requested, number of requests, start date of service request (interpretation, translation, etc.), and completion date of service request (interpretation, translation, etc.). In addition, on a quarterly basis, submit log with cover letter containing a brief summary of log entries and the number of patients who entered treatment.
   iii) Provide an orientation, on an as-needed basis, that includes an overview of services available to each county authority.
   iv) Report to the DAODAS Division of Treatment and Recovery Services (in writing within forty-eight [48] hours) all patient complaints regarding interpretive and/or translation and other services.
   v) Submit annual summary report that addresses, at a minimum:

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(1) description and dates of interpretations, translations, and other services provided;
(2) agencies to which services were provided;
(3) total number of patients served;
(4) total number of patients who entered treatment services;
(5) total number of complaints; and
(6) lessons learned, to include: how addiction was perceived by the Hispanic/Latino community; whether services were received in a specified timeframe; whether the alcohol and drug abuse authorities provided adequate follow-up; whether the alcohol and drug abuse authorities provided services in a culturally sensitive manner; and any recommendations for improvement.

vi) *Qualifications*: The staff member or contractual worker hired to provide interpretive and translation services shall be state certified and shall maintain all certifications/qualifications appropriate to provide these services. The staff member or contractual worker should be in process of becoming state certified/qualified if these credentials are not already in place. The privileging folder shall contain documentation that demonstrates that the staff member or contractual worker has the qualifications to perform this job.

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DAODAS MEDICATION-ASSISTED TREATMENT (MAT) MANUAL

Opioid Use Disorder

Opioid use disorder (OUD) is widely recognized as a chronic disease prone to recurrence of symptoms. It is known to be one of the most difficult substance use disorders (SUDs) to overcome. As with other diseases, there is scientifically based evidence that certain treatment modalities are more effective than others. Medication Assisted Treatment (MAT) (FDA-approved medication in combination with evidence-based counseling therapy) is highly effective at treating and managing OUD. *(Detoxification and Substance Abuse Treatment, A Treatment Improvement Protocol, SAMHSA, 2015)*

As recommended by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Governor's Prescription Drug Abuse Prevention Council, and with support of the General Assembly, DAODAS continues to increase the state's capacity to treat individuals and families, so that every person in South Carolina who struggles with opioid use has every option available to them to successfully reach recovery.

Expectations for the Receipt of Funds

Opioid use is associated with increased mortality. The leading causes of death in individuals using opioids for non-medical purposes are overdose and trauma. To reduce the risk of death and health complications – and to ensure that high-quality evidence-based treatment is provided – the following expectations must be met by all agencies that receive any funds for medication or MAT services:

- All staff (treatment and administrative) will receive education on OUD and evidence-based treatment practices for the disease.
- *ASAM National Practice Guidelines for the Use of Medications in the Treatment of Addiction Involving Opioid Use* will be adhered to in the treatment of all patients with addiction involving opioids.
- All treatment options, including all FDA-approved medications (methadone, buprenorphine, and naltrexone) will be made accessible to assist in the comprehensive treatment of OUD for patients diagnosed with the disease.
- Education on the identification of and response to opioid overdose will be provided for caregivers of OUD patients pursuant to information required by South Carolina law.
- All clinical staff should have six (6) hours of training on medications for OUD (MOUD) before working with patients using MAT and should earn six (6) continuing education units (CEUs) on MAT and MOUD every two years. Documentation must be maintained in the clinician's privileging file.
- All agencies must provide DAODAS with copies of their Memoranda of Understanding (MOU), Memoranda of Agreement (MOA), or contracts with physicians and other contracted medical providers, to include all staff working within the MAT program.

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Education Opportunities and Resources

Training of all staff at a provider agency is essential to the successful provision of high-quality MAT services. SAMHSA's Treatment Improvement Protocol 40, *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*, should be reviewed and referenced by all providers. SAMHSA's Knowledge Application Program Keys for Physicians is a helpful accompaniment.

The Providers' Clinical Support System (PCSS) for Medications for Opioid Use Disorder offers free online training on MOUD services and OUD and can build upon the knowledge base and clinical proficiency of prescribers and providers from diverse multi-disciplinary healthcare and administrative backgrounds. PCSS-MAT provides learning modules on a broad range of treatments, including methadone, buprenorphine, and naltrexone. An additional opportunity is the "Medication-Assisted Treatment in Opioid Addiction Training" available from DAODAS through the Relias Learning System. Using various teaching tools, this course can help practitioners formulate a plan of care, goals for recovery, and confidentiality guidelines for individuals seeking treatment in any setting. In addition to these online tools, DAODAS will continue to offer ongoing regional or in-person opportunities for MAT and MOUD trainings.

Funding

For maintaining, capacity building, and expansion of MAT services, funds may be used at agencies for the following medical provider contract cost:

- Other personnel directly related to MAT services (e.g., pharmacists or "MAT care coordinators" who may be care coordinators, clinical counselors, or peer support specialists)

DAODAS expects that agencies will use the formulas provided below as a guideline when calculating the cost for a medical provider and the request for funding for initial support of the provider. Be specific to your organization's needs in your request (e.g., your agency is contracting with a medical provider or your agency is hiring a medical provider as your employee). Agencies are to take into account the sustainability calculation, as DAODAS medical provider support is reduced over a period of nine months with the expectation the agency will pay a medical provider's salary based on a fee-for-service model.

Formula for Number of Hours of Medical Coverage for MOUD/MAT Patients:

# of average enrolled patients per year x 10 hours per year to treat patient = **# of hours of medical coverage needed**

10 hours of treatment time =

3 visits @ 60 minutes

3 visits @ 30 minutes

22 visits @ 15 minutes

TOTAL = 28 visits

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Formula for Salary of Medical Provider:

Hourly rate x # of hours medical provider is needed = **salary**

Formula for Becoming Sustainable Without DAODAS Support:

100% of hourly rate x # of hours per week x 12 weeks = 3 months of salary Quarter 1

66% of hourly rate x # of hours per week x 12 weeks = 3 months of salary Quarter 2

33% of hourly rate x # of hours per week x 12 weeks = 3 months of salary Quarter 3

$0.00 x # of hours per week x 12 weeks = $0.00 Quarter 4

100% for 3 months + 66% for 3 months + 33% for 3 months = Funding Request

Published Average Salaries for Medical Providers in South Carolina:

Advanced Practice Registered Nurse (APRN)	$107,939 = 51.89 per hour
Physician Assistant (PA)	$122,095 = 53.86 per hour
Nurse Practitioner (NP)	$101,852 = 48.97 per hour

For agencies that meet the expectations listed on Page 25, funds may be used for medications and pharmacotherapy-related services for patients who are uninsured and unable to pay for:

- FDA-approved medications (methadone, buprenorphine, naltrexone)
- Other services directly related to pharmacotherapy (e.g., lab work, medical assessments, medical follow-up)

Reimbursement for Medication and Ancillary Medical Services

DAODAS, as a payer of last resort, will reimburse the costs of medications and the directly related ancillary medical services for patients who are **uninsured**, **ineligible for Medicaid**, **or unable to pay for care. Each provider agency delivering MAT services is required to use the DAODAS-approved Financial Screening and Assessment Application. Providers will be audited on the use of this document to ensure compliance.** *(See Appendix A for the DAODAS-approved Financial Screening and Assessment Application.)*

Utilization Review for Reimbursement

For reimbursement for all prescribed medications and related medical services rendered, **clinicians or billing staff will contact Virginia Ervin, the State Opioid Treatment Authority (SOTA) (1-800-374-1390), for each patient.**

In addition, clinicians or billing staff will submit a manual claim in CareLogic for the exact cost of the buprenorphine and naltrexone (Vivitrol) and will create an activity for the ancillary medical services claims.

Remove prior authorization requirements for initiation of medication: DAODAS will allow providers to prescribe medication without prior authorization within ASAM-recommended dosages. This practice allows medication to be initiated rapidly for patients with less complex treatment needs, allowing the SOTA to focus on cases that fall outside typical parameters.

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Removing this requirement can minimize interruptions between episodes of care (e.g., if an individual has a brief lapse in treatment and returns to care). The overall goal is to increase access and ensure medication is continued long enough to lower the risk of overdose death.

Rollback of prior authorization: The American Society of Addiction Medicine (ASAM) National Practice Guidelines recommend that required intake assessments and prior authorizations should not delay or preclude initiating medication for substance use disorders. As of 2021, 21 states and the District of Columbia have removed all prior-authorization requirements for initiation of methadone and buprenorphine.

Fee Matrix Setup – Medical Services

Service/Activity	Rate	Procedure	Type/Claim
Alcohol and Drug Assessment Nursing Services	$38.95	H0001:U2	
Medical Evaluation and Management (New Patient - 30 Minutes)	AF Physician/Psychiatrist $80.29 AM Physician Team Member (PA) or SA Nurse Practitioner (APRN) $55.97	99203	
Alcohol and/or Substance Use Structured Screening and Brief Intervention Services *(if admitted)*	$19.94	99408	
Medical Evaluation and Management (Established Patient - 15 Minutes)	AF Physician/Psychiatrist $58.11 AM Physician Team Member (PA) or SA Nurse Practitioner (APRN) $37.69	99213	
Medication Administration	$12.97	96372	
Medication Management (15-minute unit)	UB Pharmacist $15.82 AH Psychologist, HO Master's Level, HN Bachelor's level, or TD Registered Nurse (RN) $8.26 TE Licensed Practical Nurse (LPN) $5.19	H0034	

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Service/Activity	Rate	Procedure	Type/Claim
Injection - Vivitrol	100%	J2315	Manual
Electrocardiogram (EKG) *(Charleston Center only)*	$70.00	93000	
Metabolic Profile / Liver Function Test	$35.00	80074	
UDA / Other Lab Screening	$20.00	H0003	18 per year See Appendix C (*Request authorization if labs requests exceed 18 screens per patient.*)
Buprenorphine	100%	J3490	Manual
Daily Naltrexone	100%	65432	Manual
Sublocade	100%	Q9991	Manual
Methadone *(Charleston Center & GateWay Counseling Center only)*	$14.00 or $12.00	S0109	

Fee Matrix Setup – Treatment Services

Service/Activity	Rate	Procedure	Type/Claim
Care Coordination (in office) (15-minute unit)	$15.00	CC0000	
Care Coordination (out of office) (15-minute unit)	$20.00	CC0001	
Originating Site Fee (telehealth) encounter	$14.96	Q3014	
Service Plan Development (with patient) encounter	$45.71	H0032HF	
SAC Individual (15-minute unit)	$22.31	H0004	
SAC Group (per encounter, minimum one hour)	$48.48	H0005	
PSS Individual – In Agency	$13.24	H0038	
PSS Individual – Outside of Agency	$18.15	H0038	
PSS Group (hourly unit)	$9.20	H0038 HQ	
IOP (all-inclusive hourly unit)	$37.41	H0015	

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The option to bill in CareLogic is available to those agencies that submit a letter expressing commitment to the expectations above. The new program in the electronic health record, **"Payer Plan,"** will be set up to require prior authorization and will be listed under DAODAS Special Projects as **"MAT – Medication-Assisted Treatment State Funding."** Additional payers under Special Projects for DAODAS include **"SOR Grant for MAT patients."** As of January 1, 2019, the payer became the "SOR" payer. Refer to EHR notifications or DAODAS e-mails for additional information. For the services to bill correctly, the current, effective payer **must be listed as the primary payer**.

Total billed claims will be entered as a Grant Payment at the BHSA level in CareLogic and billed to the current MAT payer source, to be drawn down from the total grant payment after approval at the BHSA level. DAODAS will confirm services were authorized through the UR process, and the payments will be approved. The "Claim Payments by Fiscal Year w unique client totals" report should be submitted no later than the **ninth working day** of each month dating back to the start of the fiscal year. DAODAS will reimburse agencies, with agencies needing to confirm payments for claims and make the necessary corrections for any claims that are denied by DAODAS.

Conditions

Providers will eliminate mandatory counseling or other psychosocial treatment as a condition for receiving medication. To reduce the risk of diversion, any refusal to engage in counseling should be considered as a factor in allowing take-home doses. However, individuals should not be removed from treatment because they continue to misuse substances. Again, removal of these requirements can support the primary goals of preventing relapse and overdose death. Patients should be encouraged to engage in peer support services, but not denied medication when refusing services.

Removal of psychosocial treatment requirement: ASAM recommends that medication should not be discontinued if patients refuse counseling or other psychosocial treatment. A large-scale trial reported no difference in outcomes for patients undergoing standardized buprenorphine-naloxone treatment that included manualized medical management plus opioid drug counseling, compared with those who received medical management alone plus regular case worker involvement to facilitate psychosocial supports in the community. Notably, nearly all the participants in this study relapsed after being tapered off medication at sixteen (16) weeks or less. This underlines the importance of ensuring a longer duration of treatment with medication, which should not be stopped if patients continue to misuse substances and should be resumed immediately after any disruptions in episodes of care (Weiss et al., 2010). Concerns about misuse or diversion of medications can be mitigated by increased frequency of monitoring *(see below)*. However, involvement in longer duration of psychosocial treatment should be strongly encouraged, as it has been shown to have limited effects on treatment retention in doses of less than ninety (90) days. Common modalities, such as cognitive behavioral therapy and contingency management, require

NOT FINAL

twelve (12) to twenty-four (24) weeks of treatment *(Substance Abuse and Mental Health Services Administration, Office of the Surgeon General, 2016)*.

It is understood that each patient has variable personal circumstances and clinical stability. DAODAS expects that patients will receive case management and assistance early in the course of their treatment so that they may become self-sufficient.

DAODAS encourages agencies to explore referral and partnership options for patients needing "safety net" care.

DAODAS expects agencies that coordinate care for patients with a prescriber or medical provider outside the agency to have in place a memorandum of agreement or other legal document that clearly states the following elements:

- responsibilities of each party;
- reimbursement rates; and
- coordination of care.

Agencies must submit a copy of the practice agreement to DAODAS.

DAODAS expects that all agencies will submit the Medical Provider Information Form for all medical providers – both contracted outside the agency or contracted directly with the agency *(see Appendix I)*.

DAODAS also expects that agencies will explore multiple local pharmacies and negotiate for the lowest-priced medications for uninsured patients. For uninsured patients, agencies will work with Besse Medical Supply and Alkermes to receive the lowest rate on injectable naltrexone and will work with MAKO Rx to receive the lowest rate on buprenorphine products.

Besse Medical Supply rate for injectable naltrexone: $1,155

MAKO Rx rates for oral naltrexone and buprenorphine:

Drug Name and Dose	Per Unit Invoice Cost
Buprenorphine/Naloxone 2mg/0.5mg SL tabs	$3.50 per tablet
Buprenorphine/Naloxone 8mg/2mg SL tabs	$3.50 per tablet
Naltrexone 50mg tabs	$3.50 per tablet
Buprenorphine/Naloxone 2/0.5mg SL film	$5.00 per film
Buprenorphine/Naloxone 4/1mg SL film	$5.00 per film
Buprenorphine/Naloxone 8/2mg SL film	$5.00 per film
Buprenorphine/Naloxone 12/3mg SL film	$8.50 per film
Buprenorphine 8mg tabs	$3.50 per tablet

South Carolina Medicaid covers buprenorphine products and injectable naltrexone (i.e., Vivitrol) under both fee-for-service (FFS) and managed care organization (MCO) plans. Although these and other insurance plans may present some limitations on authorization for the medications, DAODAS' MAT funds will not be used to reduce limitations for patients who are insured.

NOT FINAL

By using SAMHSA Block Grant assessment funds, Healthy Outcomes Plan funds, and Block Grant treatment funds in conjunction with State MAT funds, patients should be able to access and receive appropriate rehabilitative care.

Exception for Pregnant and Breastfeeding Women

South Carolina Medicaid covers buprenorphine tablets and film, as well as methadone, under FFS and MCO plans. Some pregnant women may be better treated with methadone for the term of – or at different stages in – their pregnancy. DAODAS will cover the cost of methadone for women who are pregnant or breastfeeding, but only when the women have been recommended for methadone by a physician *and* are receiving inpatient or residential treatment services from a county alcohol and drug abuse authority. Pregnant women in the outpatient setting for whom the physician recommends methadone should be referred to the nearest opioid treatment program.

Deliverables

For Agencies Receiving State Funding for Physicians, Physician Assistants, Nurse Practitioners, Advanced Practice Nurses

1. Provide the following treatment-related information:
    a. Total number of patients treated by the medical provider
    b. Medical services rendered by the medical provider
    c. Medicines prescribed by the medical provider

For Agencies Receiving Funding for Peer Support Specialists or Care Coordinators

1. Provide the number of referrals made and managed among the agency and other agencies.
2. List other agencies that patients were referred to and/or that referred patients to the agency.
3. Provide documentation that your agency's Peer Advisory Council met and list any issues discussed.
4. Provide the amount that the Peer Support Specialist billed at six months and one year.

For ALL Agencies

1. Provide information on other sources of funding (e.g., grants, billing, self-pay) collected for medications and/or support.
2. Provide a narrative describing the plans to sustain the funded positions past the contract. (A draft sustainability plan is due by June 2024.)
3. Provide narrative on some activities and services rendered related to MAT at the agency.
4. Provide documentation that all staff received six (6) hours of training on MOUD/MAT before working with patients on MOUD and earned six (6) continuing education units (CEUs) on MOUD/MAT every two years.

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Telehealth Services

For MAT patients receiving medical services via telemedicine, the patient must be present at the county alcohol and drug abuse authority.

TeleMAT services may be provided by a physician/nurse practitioner who meets guidelines established by their respective licensing boards.

Physicians Licensed by the Board of Medical Examiners (BME):

- First visit must be face to face prior to providing services via a telehealth platform.

(BME Website – https://llr.sc.gov/med/
BME Telemedicine Advisory Opinion – https://llr.sc.gov/med/PDF/Telemedicine%20Advisory%20Opinon.pdf)

Nurse Practitioners (NPs):

- First visit must be face to face prior to providing services via a telehealth platform.
- NP must have an established practice agreement with a physician, to include:
  - Prescribing guidelines with the collaborating physician; and
  - Procedures addressing telehealth within the practice guidelines.
- NP and physician must both be waivered.
- NP must already have prescribing authority and approval through the Board of Nursing.

(Board of Nursing Website – https://llr.sc.gov/nurse/, which includes information related to sample practice agreements, links to the APRN Scope of Practice that outlines guidelines for telehealth for NPs, FAQs, and other information)

Telehealth Resources:

Palmetto Care Connections – http://www.palmettocareconnections.org/

S.C. Department of Health and Human Services Telemedicine for MAT – https://www.scdhhs.gov/press-release/medication-assisted-treatment-services-telemedicine

South Carolina Telemedicine Act – https://www.scstatehouse.gov/sess121_2015-2016/bills/1035.htm)

CARF – Telehealth Standards

NOT FINAL

What to Expect from DAODAS

DAODAS will review letters of commitment, budgets, and additional agency-specific factors outlined herein.

DAODAS will assist agencies in meeting the expectations to receive funds and will work to clarify any questions that arise and troubleshoot any unique needs that must be addressed at the provider level and at the patient level.

It should be noted that DAODAS' expectations for the receipt of funds may change with amendments to or development of national practice guidelines, state policies, or federal policies related to MOUD and MAT. DAODAS expects its administrative processes to continually improve with valuable feedback from provider agencies and with its own internal development practices. The department expects that, over time, its ability to help extend services will grow, and together DAODAS and the county authorities can reach more South Carolinians with MOUD and MAT services.

Any additions, changes, or removal of programs or services for MAT should be detailed in a letter to DAODAS.

If there are any additional questions or requests for assistance, contact the appropriate DAODAS representative listed in Appendix D.

NOTE: DAODAS understands that programming needs to be flexible within its statewide service system. To increase communication, DAODAS asks that agencies submit, in writing, any major planned or proposed changes to the MAT program that an agency is administering before these changes are implemented. While DAODAS will not necessarily be approving the planned/proposed changes, this communication will help both DAODAS and the agencies to ensure the appropriate use of state or federal funds and to keep DAODAS abreast of program implementation. Send any planned/proposed changes to Anita Ray by e-mail (aray@daodas.sc.gov).

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DAODAS TREATMENT FORMS

Adolescent Residential Medically Monitored/Clinically Managed

FY24 Mid-Year Report

Due: January 31, 2024

Subgrantee/Agency Name: ______________________________ Grant No.: _________-BG-24

Prepared by:____ Date: ___________________

Telephone: ____________________ E-mail Address: _________________________________

Approved by: ____ Date: ___________________

Shall submit to DAODAS semi-annual narrative reports by dates specified on the Deliverables List on program development focusing on accomplishments and obstacles. These reports shall also contain information on:

Narrative:

Complete the table below with data from July 1, 2023, through December 31, 2023.

Indicator	Data
Number of Adolescents Served	
Diagnosis of Presenting Problem	
Number of Assessments/Admissions/ Discharges (indicate successful/unsuccessful) and Readmissions	
Referral Services	
Number of Medicaid-Eligible, Self-Pay, Other Insurance and Indigent Patients (Specify insurance type)	
Average Length of Stay	

NOT FINAL

Adolescent Residential Medically Monitored/Clinically Managed

FY24 Year-End Report

Due: July 31, 2024

Subgrantee/Agency Name: ______________________________ Grant No.: _________-BG-24

Prepared by: ____ Date: ___________________

Telephone: ____________________ E-mail Address: _________________________________

Approved by: ____ Date: ___________________

Shall submit to DAODAS semi-annual narrative reports by dates specified on the Deliverables List on program development focusing on accomplishments and obstacles. These reports shall also contain information on:

Narrative:

Complete the table below with data from July 1, 2023, through June 30, 2024.

Indicator	Data
Number of Adolescents Served	
Diagnosis of Presenting Problem	
Number of Assessments/Admissions	
Referral Services	
Number of Medicaid-Eligible, Self-Pay, Other Insurance and Indigent Patients (Specify insurance type)	
Average Length of Stay	

NOT FINAL

Adolescent Intensive Outpatient Treatment Program

FY24 Mid-Year Report

Due: January 31, 2024

Subgrantee/Agency Name: ______________________________ Grant No.: _________-BG-24

Prepared by: ____ Date: ___________________

Telephone: ____________________ E-mail Address: _________________________________

Approved by: ____ Date: ___________________

Shall submit to DAODAS semi-annual reports on program development as specified on the Grant Deliverables list. These reports will provide a narrative on significant accomplishments and obstacles and contain information on:

Narrative:

Complete the table below with data from July 1, 2023, through December 31, 2023.

Indicator	Data
Referral Services	
Number of Medicaid-Eligible Clients	
Payment Source: Medicaid, Self-Pay, Private Insurance, etc. (specify)	

NOT FINAL

Adolescent Intensive Outpatient Treatment Program

FY24 Year-End Report

Due: July 31, 2024

Subgrantee/Agency Name: _______________________________ Grant No.: _________-BG-24

Prepared by: ____ Date: ____________________

Telephone: ____________________ E-mail Address: __________________________________

Approved by: ____ Date: ____________________

Shall submit to DAODAS semi-annual reports on program development as specified on the Grant Deliverables list. These reports will provide a narrative on significant accomplishments and obstacles and contain information on:

Narrative:

Complete the table below with data from July 1, 2023, through June 30, 2024.

Indicator	Data
Referral Services	
Number of Medicaid-Eligible Clients	
Payment Source: Medicaid, Self-Pay, Private Insurance, etc. (specify)	

NOT FINAL

Intensive Outpatient Treatment Program

FY24 Mid-Year Report

Due: January 31, 2024

Subgrantee/Agency Name: ______________________________ Grant No.: _________-BG-24

Prepared by: ____ Date: ___________________

Telephone: ____________________ E-mail Address: _________________________________

Approved by: ____ Date: ___________________

Shall submit to DAODAS semi-annual reports on program development as specified on the Grant Deliverables list. These reports will provide a narrative on significant accomplishments and obstacles and contain information on:

Narrative:

Complete the table below with data from July 1, 2023, through December 31, 2023.

Indicator	Data
Referral Services	
Number of Medicaid-Eligible Clients	
Payment Source: Medicaid, Self-Pay, Private Insurance, etc. (specify)	

NOT FINAL

Intensive Outpatient Treatment Program

FY24 Year-End Report

Due: July 31, 2024

Subgrantee/Agency Name: ______________________________ Grant No.: _________-BG-24

Prepared by: ____ Date: ___________________

Telephone: ____________________ E-mail Address: _________________________________

Approved by: ____ Date: ___________________

Shall submit to DAODAS semi-annual reports on program development as specified on the Grant Deliverables list. These reports will provide a narrative on significant accomplishments and obstacles and contain information on:

Narrative:

Complete the table below with data from July 1, 2023, through June 30, 2024.

Indicator	Data
Referral Services	
Number of Medicaid-Eligible Clients	
Payment Source: Medicaid, Self-Pay, Private Insurance, etc. (specify)	

NOT FINAL

The Bridge Program

FY24 Mid-Year Report

Due: January 31, 2024

Subgrantee/Agency Name: ______________________________ Grant No.: _________-BG-23

Prepared by: ____ Date: ___________________

Telephone: ____________________ E-mail Address: _________________________________

Approved by: ____ Date: ___________________

Reply to the following prompts based on The Bridge program implementation from July 1, 2023, through December 31, 2023:

1. In detail, describe how the agency implemented The Bridge, to include innovations, successes, and corrective action steps taken. Other issues to address are implementation strengths that could be associated with innovations and successes, along with barriers that can be linked to corrective action steps taken.

2. Describe in detail what resources (staff, experience, training, materials, time) were used and their impact on service provision.

3. From the perspective of service implementation, describe in detail any problems related to timeliness of Bridge availability and access.

4. From the perspective of continuous quality improvement and quality assurance, describe in detail what policies and procedures were in place to ensure that these services are implemented with quality.

5. Describe in detail evaluation indicators associated with The Bridge provision being monitored to determine the efficiency and effectiveness of the service. Discuss progress to date making sure to include any: a) process improvements identified; and b) expected/anticipated outcomes.

6. What was the total number of patients referred by the S.C. Department of Juvenile Justice and schools for The Bridge program?

NOT FINAL

Complete the summary data table and address the prompt related to the summary of any existing barriers faced while implementing The Bridge.

Indicator for July 1, 2023 – December 29, 2023	Data
Total number of Bridge patients served	
Total number of patients served using Bridge funding	
Total number of patients who completed The Bridge program/transitioned to a lower level of care	
Total number of individuals who – prior to the six-month reporting period – reduced their recurrent use of alcohol, tobacco, and other drugs	
Total number of patients who reduced juvenile offenses, including truancy and delinquency during the six-month reporting period	

7. From your perspective, summarize any presenting challenges and plans to address them:

NOT FINAL

The Bridge Program

FY24 Year-End Report

Due: July 31, 2024

Subgrantee/Agency Name: ______________________________ Grant No.: _________-BG-23

Prepared by: ____ Date: ___________________

Telephone: ____________________ E-mail Address: _________________________________

Approved by: ____ Date: ___________________

Reply to the following prompts based on The Bridge program implementation from July 1, 2023, through June 30, 2024.

1. In detail, describe how the agency implemented The Bridge, to include innovations, successes, and corrective action steps taken. Other issues to address here are implementation strengths that could be associated with innovations and successes, along with barriers that can be linked to corrective action steps taken.

2. Describe in detail what resources (staff, experience, training, materials, time) were used and their impact on service provision.

3. From the perspective of service implementation, describe in detail any problems related to timeliness of Bridge availability and access.

4. From the perspective of continuous quality improvement and quality assurance, describe in detail what policies and procedures were in place to ensure that these services are implemented with quality.

5. Describe in detail evaluation indicators associated with The Bridge provision being monitored to determine the efficiency and effectiveness of the service. Discuss progress to date, making sure to include any: a) process improvements identified; and b) expected/anticipated outcomes.

6. What was the total number of patients referred by the S.C. Department of Juvenile Justice and schools for The Bridge program?

NOT FINAL

Complete the summary data table and address the prompt related to the summary of any existing barriers faced while implementing The Bridge.

Indicator for July 1, 2023 – June 30, 2024	Data
Total number of Bridge patients served	
Total number of patients served using Bridge funding	
Total number of patients who completed The Bridge program/transitioned to a lower level of care	
Total number of individuals who – prior to the second six months of the reporting period – reduced their recurrent use of alcohol, tobacco, and other drugs	
Total number of patients who reduced juvenile offenses, including truancy and delinquency, during the second six months of the reporting period	

7. From your perspective, summarize any presenting challenges and plans to address them:

NOT FINAL

Women's Intensive Outpatient Treatment Program

FY24 Mid-Year Report

Due: January 31, 2024

Subgrantee/Agency Name: ______________________________ Grant No.: _________-BG-23

Prepared by: ____ Date: ___________________

Telephone: ____________________ E-mail Address: _________________________________

Approved by: ____ Date: ___________________

Shall submit to DAODAS semi-annual reports on program development as specified on the Grant Deliverables list. These reports will provide a narrative on significant accomplishments and obstacles and contain information on:

1. Narrative:

2. Reports of Quarterly Advisory Committee Meetings (This can be a copy of the minutes of the meetings.):

Complete the table below with data from July 1, 2023, through December 31, 2023.

Indicator	Data
Number of Pregnant Women Served	
Number of Pregnant Women Admitted into Services	
Referral Services	
Number of Medicaid-Eligible Clients	
Payment Source: Medicaid, Self-Pay, Private Insurance, etc. (specify)	
Number of Child Abuse Cases Reported to the S.C. Department of Social Services (DSS)	
Number of Pregnant Women Reported to DSS for Child Abuse Because of Their Drug Use	

NOT FINAL

Women's Intensive Outpatient Treatment Program

FY24 Year-End Report

Due: July 31, 2024

Subgrantee/Agency Name: ______________________________ Grant No.: _________-BG-23

Prepared by: ____ Date: ___________________

Telephone: ____________________ E-mail Address: _________________________________

Approved by: ____ Date: ___________________

Shall submit to DAODAS semi-annual reports on program development as specified on the Grant Deliverables list. These reports will provide a narrative on significant accomplishments and obstacles and contain information on:

1. Narrative:

2. Reports of Quarterly Advisory Committee Meetings (This can be a copy of the minutes of the meetings.):

Complete the table below with data from July 1, 2023, through June 30, 2024.

Indicator	Data
Number of Pregnant Women Served	
Number of Pregnant Women Admitted Into Services	
Referral Services	
Number of Medicaid-Eligible Clients	
Payment Source: Medicaid, Self-Pay, Private Insurance, etc. (specify)	
Number of Child Abuse Cases Reported to the S.C. Department of Social Services (DSS)	
Number of Pregnant Women Reported to DSS for Child Abuse Because of Their Drug Use	

NOT FINAL

Women's Residential Medically Monitored/Clinically Managed (WRTC)

FY24 Mid-Year Report

Due: January 31, 2024

Subgrantee/Agency Name: ______________________________ Grant No.: _________-BG-23

Prepared by: ____ Date: ___________________

Telephone: ____________________ E-mail Address: _________________________________

Approved by: ____ Date: ___________________

Shall submit to DAODAS semi-annual narrative as specified on the Grant Deliverables list in program development focusing on accomplishments and obstacles. These reports will also contain information on:

1. Narrative:

2. Reports of the Quarterly Advisory Committee Meetings:

Complete the table below with data from July 1, 2023, through December 31, 2023.

Indicator	Data
Number of Women Served	
Number of Pregnant Women Served	
Number of Children Served	
Diagnosis or Presenting Problem	
Number of Assessments/Admissions/ Discharges/Readmissions	
Referral Services	
Number of Medicaid-Eligible Clients	
Payment Source: Medicaid, Self-Pay, Other Insurance, Indigent, etc.	
Number of "No-Shows" and Any Follow-up	
Number of Child Abuse Cases Reported to the S.C. Department of Social Services (DSS)	
Number of Pregnant Women Reported to DSS for Child Abuse Because of Their Drug Use	

NOT FINAL

Women's Residential Medically Monitored/Clinically Managed (WRTC)

FY24 Year-End Report

Due: July 31, 2024

Subgrantee/Agency Name: ______________________________ Grant No.: _________-BG-23

Prepared by: ____ Date: ___________________

Telephone: ____________________ E-mail Address: _________________________________

Approved by: ____ Date: ___________________

Shall submit to DAODAS semi-annual narrative as specified on the Grant Deliverables list in program development focusing on accomplishments and obstacles. These reports will also contain information on:

1. Narrative:

2. Reports of the Quarterly Advisory Committee Meetings:

Complete the table below with data from July 1, 2023, through June 30, 2024.

Indicator		Data
Number of Women Served		
Number of Pregnant Women Served		
Number of Children Served		
Diagnosis or Presenting Problem		
Number of Assessments/Admissions/ Discharges/Readmissions		
Referral Services		
Number of Medicaid-Eligible Clients		
Payment Source: Medicaid, Self-Pay, Other Insurance, Indigent, etc.		
Number of "No-Shows" and Any Follow-up		
Number of Child Abuse Cases Reported to the S.C. Department of Social Services (DSS)		
Number of Pregnant Women Reported to DSS for Child Abuse Because of Their Drug Use		

NOT FINAL

ADSAP Clients Applying for and Performing Community Service Work

FY24 Year-End Report

Due: July 31, 2024

Complete the table below with data from July 1, 2023, through June 30, 2024.

Subgrantee/Agency Name: ______________________________ Grant No.: _________-BG-23

Prepared by: ____ Date: ___________________

Telephone: ____________________ E-mail Address: _________________________________

Approved by: ____ Date: ___________________

Submit annual summary report that addresses (at a minimum):

______ Number of clients approved for community service

______ Number of clients completing community service

______ Number of hours of community service completed

$_____ Total fees written off by agency for service work

NOT FINAL

Interstate ADSAP Management – Dorchester Alcohol and Drug Commission Only

FY24 Year-End Report

Due: July 31, 2024

Subgrantee/Agency Name: Dorchester Alcohol and Drug Commission

Grant No.: DOR-BG-23

Prepared by: ____ Date: ____________________

Telephone: _____________________ E-mail Address: ___________________________________

Approved by: ____ Date: ____________________

Submit annual summary report that addresses (at a minimum) relevant financial transactions and client flow data, number of clients served, and a narrative discussion of program progress, problems, and plans:

NOT FINAL

Hispanic Services – The ALPHA Behavioral Health Center Only

FY24 Year-End Report

Due: July 31, 2024

Subgrantee/Agency Name: The ALPHA Behavioral Health Center

Grant No.: KSC-BG-23

Prepared by: ____ Date: __________________

Telephone: ____________________ E-mail Address: ________________________________

Approved by: _______________________________________ Date: __________________

Submit annual summary report that addresses, at a minimum:

1. Description and dates of interpretation, translations, and other services provided:
2. Agency to whom services were provided:
3. Complete the table below with data from July 1, 2023, through June 30, 2024.

Indicator	Data
Total Number of Clients Served	
Total Number of Clients who Entered Treatment Services	
Total Number of Complaints	

4. Lessons learned include:
   a. How was addiction perceived by the Hispanic/Latino community?
   b. Did they receive services in a specified time frame?
   c. Did the alcohol and drug abuse authorities provide adequate follow-up?
   d. Did the alcohol and drug abuse authorities provide services in a culturally sensitive manner?
   e. Recommendations for improvement:

NOT FINAL

CAPACITY MONITORING REPORT

Agency: ____

Quarterly (1st,2nd, 3rd,4th): ____

Prepared by: ___________________________________ Approved by: ______________________________

CAPACITY

1. Did you reach 90% or more of capacity in any of the services that you provide? (Check next to the applicable service levels.)

☐ I ☐ ID ☐ II.1 ☐ IID ☐ II.5 ☐ III.1 ☐ III.2D ☐ III.5 ☐ III.7 ☐ III.7A ☐ III.7D

2. Did you have a waiting list for any of the following services? (Indicate number of clients next to the applicable levels of service)

☐ I ☐ ID ☐ II.1 ☐ IID ☐ II.5 ☐ III.1 ☐ III.2D ☐ III.5 ☐ III.7 ☐ III.7A ☐ III.7D

PRIORITY POPULATIONS

Intravenous Drug Users (IVDU)

Question	*Yes*	*No*
Were the services provided within 14-120 days after initial contact?		
Was the level(s) of care in which IVDU was placed at 90% or more of capacity?		

Pregnant Women

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

E-mail (lfrederick@daodas.sc.gov) or fax (803-896-5558) form to Lachelle Frederick.
See instructions on next page.

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Instructions

Frequency of Submission

Submit form monthly. However, submit form *weekly* if:

- Under Capacity, 90% or more of capacity is reached.
- Under Priority Populations – IVDU
  - The answer to the first question is "No,"

    OR
  - The answer to the second question is "Yes."
- Under Priority Populations – Pregnant Women, the answer to any of the questions is "No."

Special Reports/Actions

In addition to Capacity Reporting, the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS) requires grantees and subgrantees to comply with a number of requirements for Priority Populations. If these requirements are not complied with, action must be taken to return to compliance. Therefore, the DAODAS Block Grant Subgrantees must be diligent in identifying, reporting, and correcting any non-compliance with the requirements applicable to Priority Populations.

- Identification and reporting will be made via this Capacity Monitoring Form submitted within 24 hours after the problem is identified and submitted weekly thereafter.
- A Corrective Action Plan will be submitted to DAODAS for approval within three working days of the identification of non-compliance.

The SUPTRS requirements for Priority Populations are:

Pregnant Women. There are four separate and distinct requirements:

"Goal 9. An agreement to ensure that **(1) each pregnant woman be given preference in admission to treatment facilities**; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will **(2) refer the woman to a facility that does have capacity to admit the woman**, or if no such facility has the capacity to admit the woman, will make available **(3) interim services within 48 hours,** including a **(4) referral for prenatal care**."

Intravenous Drug Users (IVDU).

42 U.S.C. §300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug misuse is admitted to a program of such treatment within 14-120 days.

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NOT FINAL

Appendix A

Instructions
Financial Screening & Assessment Application – CONFIDENTIAL

If you receive public assistance (e.g., food stamps, housing), you may be eligible for financial assistance and will not need to complete this application. Provide documentation of the public assistance you are currently receiving. If you do not receive any public assistance and think you are eligible for financial assistance, fill out this form and return it with the necessary proof of income.

Do not proceed if you have agreed to a payment plan.

NOTE: Financial assistance will not be considered without proof of income and a completed and signed application. Provide all documents listed below that apply to you, your spouse/significant other, and any legal dependents. If you cannot provide proof of income or other documents listed below, explain why under Section 8 of the application.

1. Check stubs or statement from your employer giving your monthly gross income.
2. If self-employed, a copy of your most recent quarterly Business Financial Statement along with last year's Business Tax Return.
3. Social Security eligibility letter or a copy of your Social Security check. (If you have direct deposit, provide a copy of a bank statement showing this income.)
4. Latest signed income tax return. (If you are a minor, provide your legal guardian's tax return.)
5. Proof of South Carolina residency (e.g., rental agreement, utility bill, property tax notice).
6. Proof of any other income source such as child support, alimony, trust fund, or rental property.
7. If you have not had any income for the past three (3) months, submit:
   a. A statement from the S.C. Department of Employment and Workforce and/or the Social Security Office.

If you do not provide the required information or explain why this information is not available, your application might be delayed, or you could be denied financial assistance.

If there are questions regarding the Financial Screening & Assessment Application, contact:

Phone: ________________________________

E-mail: ________________________________

This application is valid for 90 days from your request for financial assistance.

NOT FINAL

FINANCIAL ASSISTANCE APPLICATION – CONFIDENTIAL

DATE OF APPLICATION: ______________

1. CLIENT INFORMATION* – PRINT ALL INFORMATION – ****If you are a minor (0-17 years of age), legal guardian's information will be required.***					
Client Name (Last, First, MI)					
Client ID#		Last 4 Digits of SSN	U.S. CITIZEN ☐ Yes ☐ No		
Date of Birth	Number of Dependents (other than self & co-applicant)	Ages of Dependents	Primary Contact - Phone ( )		
Street Address *(Do Not List PO Box)* ☐ Permanent Address ☐ Temporary Address	City	State	County	ZIP Code	
Current Employer	Street Address, City, State	Position			
If you are not working, how long have you been unemployed?					

2. CO-APPLICANT INFORMATION	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse / Domestic Partner ☐ Parent ☐ Other ______________				
Name (Last, First, MI)		Last 4 Digits of SSN	U.S. CITIZEN ☐ Yes ☐ No		
Date of Birth	Number of Dependents (other than self & co-applicant)	Ages of Dependents	Primary Contact - Phone ( )		
Street Address (*Do Not List PO Box)* ☐ Permanent Address ☐ Temporary Address	City	State	County	ZIP Code	
Current Employer	Street Address, City, State	Position			
If you are not working, how long have you been unemployed?					

3. INCOME INFORMATION

Monthly Income Sources	Applicant	Co-Applicant	Combined Monthly Income
Employment	$	$	$
Social Security	$	$	$
Disability	$	$	$
Unemployment	$	$	$
Spousal/Child Support	$	$	$
Rental Property	$	$	$
Investment Income	$	$	$
Other:			
	$	$	$
	$	$	$
	$	$	$
		Total Combined Monthly Income	**$**

NOT FINAL

UNEMPLOYMENT: If you do not have monthly income, explain how you take care of your monthly expenses.	
4. ADDITIONAL INFORMATION & COMMENTS ***(If you need more space, use the back of this page.)***	
5. SIGNATURES	
I certify that all financial information and statements disclosed are true and accurate.	
Applicant Signature	Date
Co-Applicant Signature	Date
Authorized Agency Signature	Date

NOT FINAL

Appendix B

Urine Drug Screen & Drug Testing Guidelines

Drug tests are tools that provide information about an individual's substance use; they should be used for supporting recovery rather than exacting punishment. These guidelines are intended to support the effective use of drug testing in the identification, diagnosis, treatment, and promotion of recovery for patients with a substance use disorder. They also serve as guidelines to be followed for reimbursement of services by DAODAS.

1) Each patient should initially be tested for opiates, benzodiazepines, amphetamines, cocaine, and THC (and other substances if they claim use [e.g., PCP, barbiturates]). NOTE: Oxycodone, fentanyl, methadone, and buprenorphine all require specific requests, as they will not show on the opiate screen.
2) Testing should initially be conducted weekly while "stabilizing," then every two weeks, then every three weeks, then monthly. While the duration of "stabilization" varies from patient to patient, a four- to eight-week stabilization period is the guideline. Progress (or lack of) regarding stabilization must be documented in the medical chart.
3) Each patient should have a minimum of one test per month.
4) If a patient returns to use, follow guidelines for screens during the stabilization period.
5) There is no need to test for antidepressants, antihistamines, antipsychotics, etc.
6) Once a person's typical "drugs-used" pattern is clear, testing can be pared down to testing for only those drugs used, adding others in the future as clinically indicated with documented justification.

Drug Testing Resources

NIDA Screening, Assessment, and Drug Testing Resources: Provides an evidence-based screening tool chart for adolescents and adults, drug use screening tool support materials, and a clinician resource and quick-reference guide for drug screening in general medical settings, including a brief version of the ASSIST-Lite (www.drugabuse.gov/nidamed-medical-health-professionals).

ASAM, *The ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine*: Discusses appropriate use of drug testing in identifying, diagnosing, and treating people with or at risk for SUDs (https://www.asam.org/resources/quality/drug-testing).

NOT FINAL

Appendix C

DAODAS Contact List for MAT-Related Questions

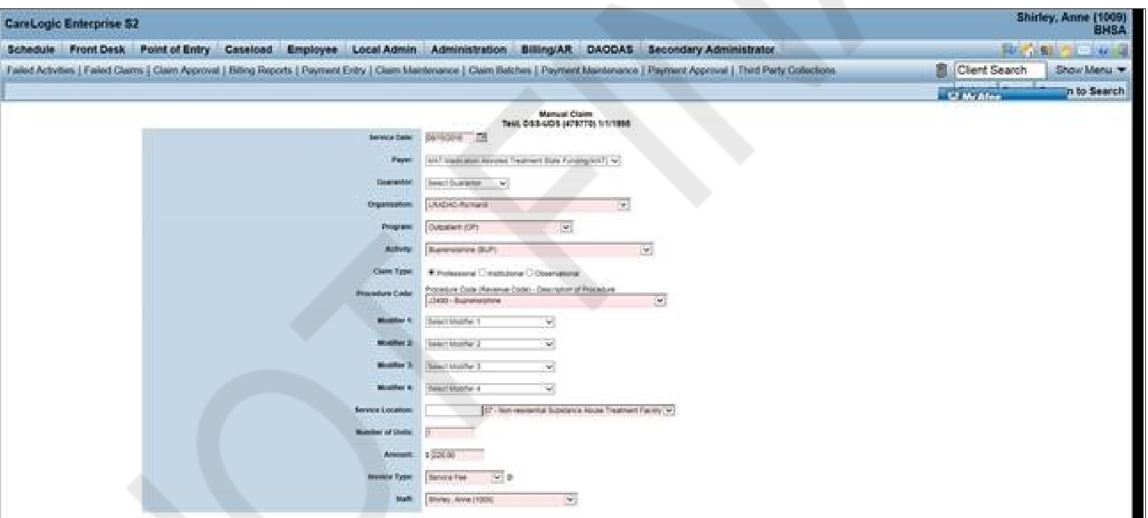
- Treatment and Recovery Questions: Hannah Bonsu
  E-mail: hbonsu@daodas.sc.gov
  Phone: 803-896-4198
- General MAT/Therapeutic Questions: Anita Ray
  E-mail: aray@daodas.sc.gov
  Phone: 803-896-4228
- General OTP Questions: Tracey Belcher
  E-mail: tbelcher@daodas.sc.gov
  Phone: 803-896-2822
- UR and Therapeutic Questions: Virginia Ervin
  E-mail: vervin@daodas.sc.gov
  Phone: 803-896-4860
- Overdose and Naloxone Questions: Linda Brown
  E-mail: lbrown@daodas.sc.gov
  Phone: 803-896-7387
- Billing Questions: Randa Golden
  E-mail: rgolden@daodas.sc.gov
  Phone: 803-896-4556
- Peer Support Services Questions: Dan Loffredo
  E-mail: dloffredo@daodas.sc.gov
  Phone: 803-896-5545
- Medicaid Questions: Margaret Garrett
  E-mail: mgarrett@daodas.sc.gov
  Phone: 803-896-4004
- Recovery Housing Questions: Jan Nerud
  E-mail: jnerud@daodas.sc.gov
  Phone: 803-896-1143
- EHR/Billing Questions: Christina Coker
  Email: ccoker@bhsasc.org
  Phone: 803-252-0268, option 1

NOT FINAL

Appendix D

Instructions for Billing SOR Funding – in CareLogic

1. Program **MAT – Medication-Assisted Treatment** should be entered as the primary program or a secondary program in the patient's electronic health record. The program is required if billing the DAODAS special projects payer.
2. Patient **must** have the appropriate DAODAS payer assigned to the client payer plan as primary.
3. Services/Activities are entered on schedule and billed at the standard rates, except for **Injection – Vivitrol** and **Buprenorphine**. These must be entered as manual claims and the actual cost entered as the amount.
4. Instructions for entering a Manual Claim: Billing/AR > Manual Claim – Enter patient name and/or ID > Select patient > Enter **Service Date, Payer = SOR Payer, Organization, Program, Activity, Claim Type = Professional, Procedure Code – Select code, Service Location, Number of Units, Amount, Invoice Type, Staff** as shown below.

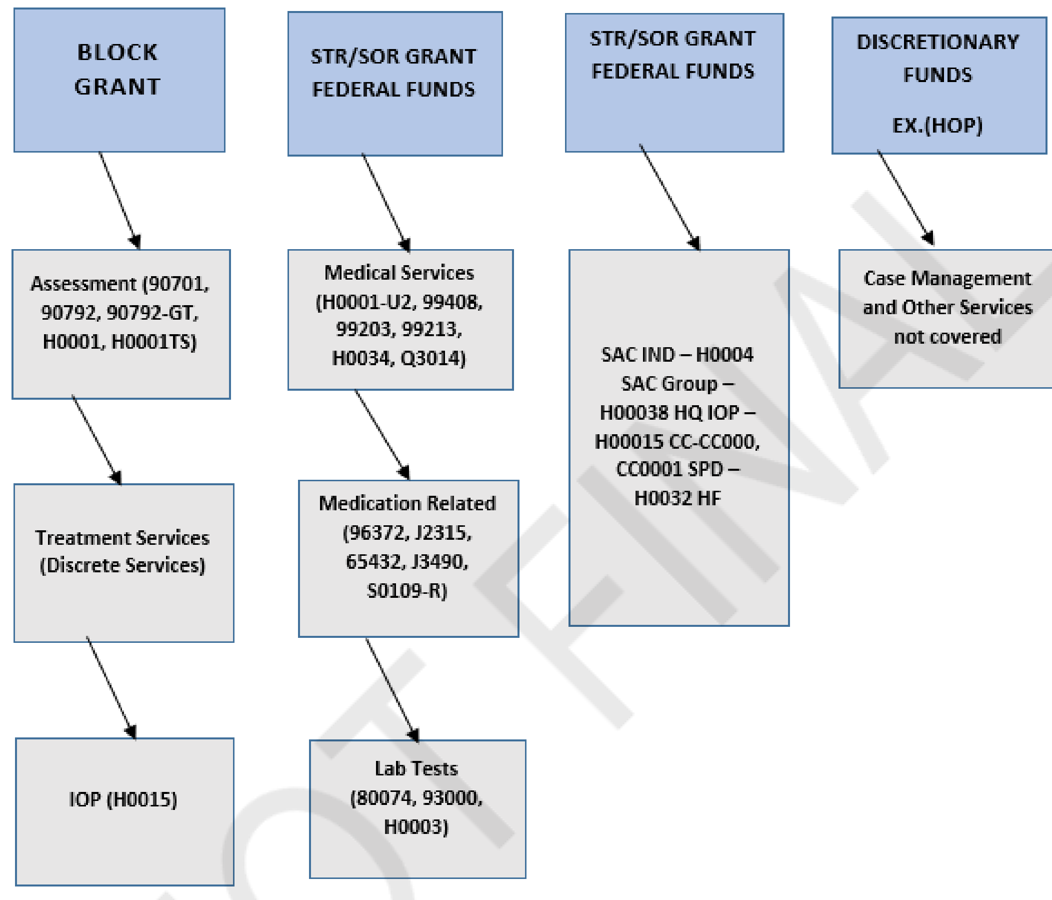


As stated above, the payment will be entered at the BHSA level, and DAODAS will approve those payments and disburse funds based on the approved payments.

Methadone and related medical services will be reimbursed at the daily bundled rates as they stand at agencies that provide methadone.

All claims will be reimbursed by **Randa Golden (803-896-5576)** upon confirmation of approved utilization, receipt of processed claims through CareLogic, and receipt of pharmacy invoices. Pharmacy invoices can be faxed to 803-896-5557, *Attn: Randa Golden*. Claims must be entered into CareLogic **on or before the eighth working day** of the month following the claim.

Appendix E



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Appendix F

EHR Notification

STR/SOR payer Provider Documentation

Please note the requirement for documentation of these services has been changed. There is no requirement for completing the clinical service note. All other requirements listed in the original notification shown below stay in effect.

Agencies will still be required to setup the accounts for the providers who are providing the services to the agency's clients. Agencies will continue to enter the services/activity on the date of the actual service, mark those kept and process the claims as before the only requirement is these activities will be mapped to No Documentation Required. This only applied to agency's who have an outside physician/provider who is keeping clients' records in their own system. If you have a physician/provider who is on your staff and documents in CareLogic, they should continue to document in CareLogic.

Previous EHR Notification shown below:

For agencies who are currently providing MAT services and billing to the STR payer, there are two methods of documenting services in CareLogic.

Method 1: *For agencies who have a provider on staff who logs into CareLogic and completes their own documentation, the appropriate service documents are mapped to those services. The provider should complete the service documentation as with any other activities/services or payers.*

Method 2: *For agencies who either contract with a provider or have a provider on staff who does not login to CareLogic, then local agency staff must document the services as follows:*

- *Setup a staff record for each physician*
- *The staff* ***should not*** *have a login to CareLogic. The staff* ***should not*** *login as the physician.*
- *Enter the appropriate information on the employee record (shown below):*

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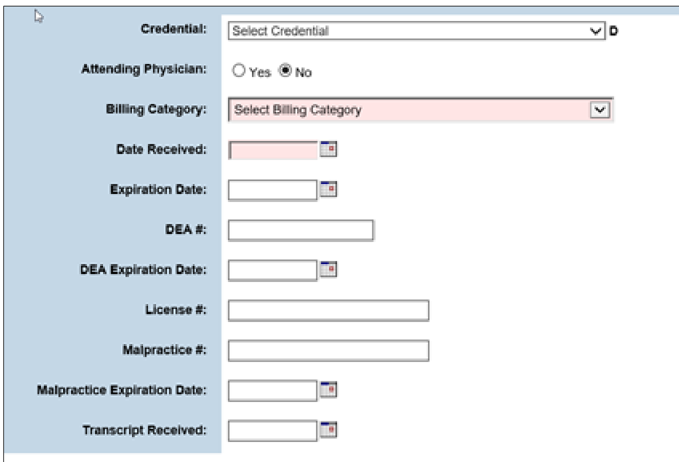

- *Enter activities on the schedule of the physician who actually completed the service (assigned staff at the agency can do this).*
- No Documentation Required should be chosen. However, documentation should be maintained at the agency or be accessible at the physician's office.
- *In simpler terms, if a physician uses CareLogic, they will complete the full CareLogic document.* the option for No Documentation Required should be chosen. However, documentation should be maintained at the agency or be accessible at the physician's office.

If you have any questions, please feel free to contact me.

Thanks.

Christina Coker
Director of CareLogic EHR
BHSA of SC

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Appendix G

Agency MAT Contacts

Agency/ County	Agency Name	Primary MAT Contact	Secondary MAT Contact	Main Address	Primary Contact Phone	Secondary Contact Phone	Primary Contact E-Mail	Secondary Contact E-Mail
DAODAS	S.C. Department of Alcohol and Other Drug Abuse Services	Anita Ray		1801 Main St., 12th Floor, Columbia, SC 29201	803-896-4228		aray@daodas.sc.gov	
DAODAS	S.C. Department of Alcohol and Other Drug Abuse Services	Hannah Bonsu		1801 Main St., 12th Floor, Columbia, SC 29201	803-896-4198		hbonsu@daodas.sc.gov	
DAODAS	S.C. Department of Alcohol and Other Drug Abuse Services	Virginia Ervin		1801 Main St., 12th Floor, Columbia, SC 29201	803-896-4860		vervin@daodas.sc.gov	
DAODAS	S.C. Department of Alcohol and Other Drug Abuse Services	Randa Golden		1801 Main St., 12th Floor, Columbia, SC 29201	803-896-4556		rgolden@daodas.sc.gov	
DAODAS	S.C. Department of Alcohol and Other Drug Abuse Services	Jan Nerud		1801 Main St., 12th Floor, Columbia, SC 29201	803-896-1143		jnerud@daodas.sc.gov	
DAODAS	S.C. Department of Alcohol and Other Drug Abuse Services	Margaret Garrett		1801 Main St., 12th Floor, Columbia, SC 29201	803-896-4004		mgarrett@daodas.sc.gov	
Aiken	Aiken Center	Margaret Key		1105 Gregg Hwy., Aiken, SC 29801	803-649-1900		mkey@aikencenter.org	
Allendale-Hampton-Jasper	New Life Center	Estelle Rivers		102 Ginn Altman Ave., Ste. C, Hampton, SC 29924	803-943-2800		erivers@nlcbhsa.org	

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Agency/ County	Agency Name	Primary MAT Contact	Secondary MAT Contact	Main Address	Primary Contact Phone	Secondary Contact Phone	Primary Contact E-Mail	Secondary Contact E-Mail
Anderson-Oconee	Anderson-Oconee Behavioral Health Services	Shannan McKinney	Karen B. Beck	226 McGee Rd., Anderson, SC 29625	864-260-4168		shannanmckinney@aobhs.org	karenbeck@aobhs.org
Barnwell	Axis I Center of Barnwell	Pam Rush	Christine Leonard	179 Fuldner Rd., Barnwell, SC 29812	803-541-1245		prush@axis1.org	cleonard@axis1.org
Beaufort	Beaufort County Alcohol and Drug Abuse Department	Rebecca Whitt-Burgess	Areatha Hamilton	1905 Duke St., Beaufort, SC 29902	843-255-6000		rebecca.whit@bcgov.net	ahamilton@bcgov.net
Berkeley	Ernest E. Kennedy Center	Wehme Hutto	John Karabees	306 Airport Dr., Moncks Corner, SC 29461	843-761-8272		whutto@ekcenter.org	jkarabees@ekcenter.org
Charleston	Charleston Center	Chanda Funcell	Holly Jordan	3685 Rivers Ave., Ste. 301, North Charleston, SC 29405	843-958-3300		cfuncell@charlestoncounty.org	hjordan@charlestoncounty.org
Cherokee	Cherokee County Commission on Alcohol and Drug Abuse	Chrissy Little	Robert (Bob) McCully	201 W. Montgomery St., Gaffney, SC 29341	864-487-2721		cccadacl@bellsouth.net	rmccully@cherokeerecovery.com
Chester	Hazel Pittman Center	Kristin Gibson	Kim Cannon	130 Hudson St., Chester, SC 29706	803-377-8111		kgibson@hazelpittman.org	kcannon@hazelpittman.org
Clarendon	Clarendon Behavioral Health Services	Natalie Scott	Jessica Green	14 N. Church St., Manning, SC 29102	803-435-9545		ngray@clarendonbhs.com	jgreen@clarendonbhs.com
Colleton	Pillars 4 Hope	Nikeyia Hammond	Saquanna Williams	1439 Thunderbolt Dr., Walterboro, SC 29488	843-538-4343		nhammond@lowcountrybhsa.org	swilliams@lowcountrybhsa.org
Darlington	Rubicon Family Counseling Services	Wendi Sutherlin	Heather Clark	510 E. Carolina Ave., Hartsville, SC 29550	843-332-4156		wsutherlin@rubiconsc.org	hclark@rubiconsc.org
Dillon-Marion-Marlboro	Trinity Behavioral Care	Donny Brock	Diane Godbolt-Hall	424 Guyton Ct. Mullins, SC 29574	843-423-8292		dbrock@trinitybehavioralcare.org	dhall@trinitybehavioralcare.org

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Agency/ County	Agency Name	Primary MAT Contact	Secondary MAT Contact	Main Address	Primary Contact Phone	Secondary Contact Phone	Primary Contact E-Mail	Secondary Contact E-Mail
Dorchester	Dorchester Alcohol and Drug Commission	Sammy Miller	Amy Friebel	320 Midland Pkwy., Ste. C., Summerville, SC 29485	843-871-4790		sjmiller@dadc.org	awheeler@dadc.org
Fairfield	Fairfield Behavioral Health Services	Vernon Kennedy Sr.	Danielle Filmore	178 U.S. Hwy. 321 Bypass N, Winnsboro, SC 29180	803-635-2335		vkennedy@fairfieldbhs.org	dfilmore@fairfieldbhs.org
Florence-Williamsburg	Circle Park Behavioral Health Services	Clyde Nance	Pam Williams	238 S. Coit St., Florence, SC 29501	843-664-9439		clyde.nance@circlepark.com	pam.williams@circlepark.com
Georgetown	Georgetown County Alcohol and Drug Abuse Commission	Raphael Carr	VaDonna Bartell	1423 Winyah St., Georgetown, SC 29440	843-546-6081		rcarr@gcadac.org	vbartell@gcadac.org
Greenville	The Phoenix Center	Rebecca Maddox	Priscilla Wilson	1400 Cleveland St., Greenville, SC 29602	864-467-3770		rmaddox@phoenixcenter.org	pwilson@phoenixcenter.org
Greenwood-Edgefield-McCormick-Abbeville	Cornerstone	Laurie Fallaw	Barbara Robinson	1612 Rivers St., Greenwood, SC 29649	864-227-1001		lfallaw@cornerstonecares.org	brobinson@cornerstonecares.org
Horry	Shoreline Behavioral Health Services	John Coffin	Eden Anderson	2404 Wise Rd., Conway, SC 29526	843-365-8884 ext 266	843-365-8884 ext 219	john.coffin@shorelinebhs.org	eden@shorelinebhs.org
Kershaw-Lee-Chesterfield	The ALPHA Behavioral Health Center	Mara Jones	Danielle McWhorter	208 King St., Camden, SC 29020	803-432-6902		mjones@alphacentersc.com	dmcwhorter@alphacentersc.com
Lancaster	Counseling Services of Lancaster	Donna Herchek	Jessica Lee	114 S. Main St., Lancaster, SC 29720	803-285-6911		donna@cslancaster.org	jessica@cslancaster.org
Laurens	GateWay Counseling Center	Charlie Stinson	Heather Keadle	219 Human Services Rd., Laurens, SC 29325	864-833-6500		cstinson@gatewaycounseling.org	hkeadle@gatewaycounseling.org

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Agency/ County	Agency Name	Primary MAT Contact	Secondary MAT Contact	Main Address	Primary Contact Phone	Secondary Contact Phone	Primary Contact E-Mail	Secondary Contact E-Mail
Lexington-Richland	LRADAC	Wendy Hughes	Jeremy Martin	2711 Colonial Dr., Columbia, SC 29203	803-726-9300		whughes@lradac.org	jmartin@lradac.org
Newberry-Saluda	Westview Behavioral Health Services	Hugh Gray	Sophia Reiser	800 Main St., Newberry, SC 29108	803-276-5690		hgray@westviewbehavioral.org	sreiser@westviewbehavioral.org
Orangeburg-Bamberg-Calhoun	Tri-County Commission on Alcohol and Drug Abuse	Mike Dennis	Dee Ward Robinson	910 Cook Rd., Orangeburg, SC 29118	803-536-4900		mdennis@tccada.state.sc.us	drobinson@tccada.state.sc.us
Pickens	Behavioral Health Services of Pickens County	Angie Farmer	Susanna Deming	309 E. Main St., Pickens, SC 29671	864-898-5800		afarmer@bhspickens.com	sdeming@bhspickens.com
Spartanburg	The Forrester Center for Behavioral Health	Sue O'Brien	Jamison Smith	187 W. Broad St., Ste.200 Spartanburg, SC 29306	864-582-7588		sobrien@tfcbh.org	jsmith@tfcbh.org
Sumter	Sumter Behavioral Health Services	Sarah Campbell	Tameka Lyles	755 Electric Drive Sumter, SC 29153	803-778-2835		scampbell@sumterbhs.org	tlyles@sumterbhs.org
Union	Healthy U Behavioral Health Services	Christina Crosby	Natausha Dendy	201 S. Herndon St., Union, SC 29379	803-276-5690		ccrosby@hubhs.org	ndendy@hubhs.org
York	Keystone Substance Abuse Services	Kerri McGuire	Cathy Caruthers	199 S. Herlong Ave., Rock Hill, SC 29732	803-324-1800		kmcguire@keystoneyork.org	ccaruthers@keystoneyork.org

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Appendix H

Additional MAT Resources

Below are links to the ASAM National Practice Standards; the Substance Abuse and Mental Health Services Administration (SAMHSA)'s Treatment Improvement Protocol 63 (TIP 63); and the Providers Clinical Support System (PCSS) to access required staff MAT trainings and other important information on MAT.

- ASAM National Practice Standards Supplement: https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf
- The ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine: https://www.asam.org/resources/guidelines-and-consensus-documents/drug-testing
- SAMHSA's Treatment Improvement Protocol (TIP 63): https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document-Including-Executive-Summary-and-Parts-1-5-/SMA18-5063FULLDOC
- Providers Clinical Support System: https://pcssnow.org/

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Appendix I

Medical Provider Information Form

Agency Name: Date:

Practitioner Name:

In Agency: ☐ yes ☐ no

Partner Organization: ☐ yes ☐ no Name of Organization:

SC License #:

Expiration Date:

DEA#:

Street Address:

City: State: ZIP Code:

Phone:

E-mail:

South Carolina
DAODAS
Department of Alcohol and Other Drug Abuse Services

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APPLICABLE PROVISIONS OF THIS CONTRACT ARE SUBJECT TO ARBITRATION PURSUANT TO THE SOUTH CAROLINA UNIFORM ARBITRATION ACT, S.C. CODE OF LAWS §15-48-10.

FY24 FUNDING AND COMPLIANCE CONTRACT

BETWEEN

SOUTH CAROLINA DEPARTMENT OF ALCOHOL AND OTHER DRUG ABUSE SERVICES

AND

COUNTY ALCOHOL AND DRUG ABUSE AUTHORITY

FOR THE PURCHASE OF PREVENTION, INTERVENTION, TREATMENT, AND RECOVERY SERVICES

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This Contract is entered into by and between the South Carolina Department of Alcohol and Other Drug Abuse Services (hereinafter referred to as “DAODAS”), located at 1801 Main St., Columbia, SC 29201, and the undersigned County Alcohol and Drug Abuse Authority (hereinafter referred to as “Subgrantee”).

Whereas, DAODAS is recognized as the Single State Agency for Substance Abuse Services in South Carolina by the federal Substance Abuse and Mental Health Services Administration (“SAMHSA”) and is responsible for administering the Federal Substance Abuse Prevention and Treatment Block Grant (SABG), State funding related to alcohol and substance use, and other similar federal and state funding sources, including, but not limited to, State funding under Chapter 12 of Title 61 of the S.C. Code of Laws, as amended.

WHEREAS, Subgrantee is a single existing organization, either public or private, designated as the sole agency in the county or counties in its catchment area for alcohol and other drug abuse services, as defined by S.C. Code Section 61-12-10(a).

WHEREAS, Subgrantee represents and warrants that it meets applicable standards to receive such funds for providing prevention, intervention, treatment, and recovery services as outlined in this Contract.

WHEREAS, Subgrantee desires to provide such services as outlined in this Contract.

NOW THEREFORE, the parties to this Contract, in consideration of the mutual promises, covenants, guidelines, and stipulations set forth herein, agree as follows:

ARTICLE I - CONTRACT PERIOD, CATCHMENT AREA & FUNDING

1. **Contract Period**
   The Contract Period shall be for one year beginning July 1, 2023 and ending June 30, 2024, unless terminated earlier pursuant to the Termination of Contract section below.

2. **Catchment Area**
   Subgrantee's "Catchment Area" shall be the following South Carolina county (or counties):

   ____.

3. **Initial Funding / Subsequent Funding**
   Subgrantee shall be provided with initial funding in the amount appearing on the Initial Funding Award Sheet that that will be presented to Subgrantee after execution of this Contract and approval of Subgrantee's initial grant funding application. During the Contract Period, DAODAS may provide additional award funding to Subgrantee for various services via supplemental grant funding award sheets or grant funding through its Grants Management System ("GMS"). The terms of this Contract shall apply to the Initial Funding Award Sheet and to the additional awards.

ARTICLE II – SERVICES/COMPLIANCE

1. **Accessibility of Services**
   Subgrantee shall accommodate the alcohol, substance and gambling use disorder prevention, intervention, treatment, and recovery services needs of the Subgrantee's catchment area and ensure that services are accessible to all citizens, by and through the implementation of extended hours or flexible schedules. If Subgrantee provides Withdrawal Management (Detoxification) and/or Residential services, Subgrantee must ensure that these services are continuously accessible 24 hours a day, seven days a week, and 365 days a year. Additionally, Subgrantee shall make every effort to admit prospective patients when beds are available, and where the prospective patients present for services and are appropriate for admission.

2. **Patient Non-Discrimination**
   Subgrantee shall ensure that all patients/clients and prospective patients/clients are treated without regard to race, color, religion, sex, age, national origin, disability, or ability to pay. Subgrantee shall not deny services to minors due to the inability or refusal of the minors' parents or legal guardians to pay for services. However, when providing services to minors, Subgrantee shall comply with S.C. Code Section 63-5-340 and 63-5-350. In 2008, Act No. 361 enacted Title 63, SC Children's Code, and repealed Title 20, Chapter 7.

3. **DHEC Licensure**
   Subgrantee shall be licensed by the South Carolina Department of Health and Environmental Control (DHEC) to deliver treatment services (i.e., outpatient, withdrawal management, residential) and be reimbursed through any funding from DAODAS. Subgrantee shall send a copy of DHEC report and related correspondence to DAODAS as a deliverable within thirty (30) days after a DHEC audit report is received by Subgrantee.

4. **Mandated Standards (45 CFR § 96.136)**
   At all times, Subgrantee shall strive to provide quality care that is appropriate to patients/clients' needs. The Code of Federal Regulations (45 C.F.R. §96.136) defines "quality" as provision of treatment services that, within the constraints of technology, resources, and patient/client

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circumstances, *will meet accepted standards and practices* [emphasis added] that will improve patient/client health and safety status in the context of recovery. Additionally, the Code defines "appropriateness" as the provision of treatment services consistent with the individual's identified clinical needs and level of functioning. Primarily, Subgrantee must adhere to the following standards:

- **a. Diagnostic and Statistical Manual of Mental Disorders ("DSM") –** Subgrantee shall utilize the latest edition for diagnosing patients (currently, DSM 5-TR).
- **b. American Society of Addiction Medicine (ASAM) Criteria –** Subgrantee shall utilize ASAM Criteria, as revised from time to time, in its decisions for placement, continued stay, transfer, or discharge of patients with addiction and co-occurring conditions.
- **c. South Carolina Department of Health and Human Services (SCDHHS) *Rehabilitative Behavioral Health Services (RBHS) Provider Manual* –** Subgrantee shall utilize the RBHS Manual, as revised from time to time, for all services that are provided to, or directed exclusively toward, the treatment of Medicaid-eligible beneficiaries for the purpose of ameliorating disabilities, improving the beneficiaries' ability to function independently, and restoring maximum functioning through the use of diagnostic and restorative services.
- **d. Accreditations –** Subgrantee shall obtain and maintain national accreditations by either The Joint Commission or CARF International in the specific program areas that are covered by this Contract. Subgrantee shall also maintain accreditations as required by DAODAS' *Treatment Programs Manual*, as revised from time to time, and as required by DAODAS' *Primary Prevention Services Manual*, as revised from time to time. Subgrantee must send copies of all required accreditation reports to DAODAS as a deliverable within thirty (30) days after each accreditation report is received by Subgrantee.
- **e. DAODAS' *Treatment Programs Manual* –** Subgrantee shall consult with, and adhere to, DAODAS' *Treatment Programs Manual*, as revised from time to time, for standards and requirements of specific programs, some of which are included in Article III, Subsections 3 and 4, of this Contract.
- **f. DAODAS' Primary Prevention Services Manual –** Subgrantee shall consult with, and adhere to, DAODAS' *Primary Prevention Services Manual*, as revised from time to time, for Prevention standards and requirements, some of which are included in Article IV, Subsections 2, 3, and 4, of this Contract.

5. Compliance Reviews

In Accordance with 45 C.F.R. §96.136, DAODAS will perform Compliance Reviews of some or all of Subgrantee's programmatic/financial documentation to ensure compliance with Subgrantee monitoring guidelines as published in 2CFR 200 – Uniform Guidance, SCDHHS *Rehabilitative Behavioral Health Services (RBHS) Provider Manual*, CARF, ASAM, and/or any other standards that DAODAS may deem appropriate. Compliance Reviews may include but are not limited to compliance, finance, clinical quality assurance, and prevention activities.

6. Quality Assurance and Mandatory Training

- **a.** Subgrantee shall maintain and use a current Quality Assurance plan for Subgrantee's continuum of services (including prevention services) addressing effectiveness (i.e., outcomes), efficiency, and patient satisfaction.
- **b.** Subgrantee shall conduct internal Quality Assurance activities in a manner consistent with the most current accreditation standards manual of either The Joint Commission or CARF International.

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c. Subgrantee shall ensure that all staff complete mandatory trainings offered by DAODAS that are stipulated by funding and compliance contracts as applicable to their job functions. Documentation of completed trainings shall be retained in the employee's privileging file and shall be available for review during DAODAS' Compliance Review visits.

d. Subgrantee shall collect and report patient evaluation data to ensure the effectiveness and efficiency of its programs as follows:
   i. Subgrantee shall complete an assessment within two (2) working days of intake on at least seventy-five percent (75%) of all patient episodes.
   ii. Subgrantee shall complete a qualifying service within six (6) working days of assessment on at least fifty percent (50%) of all patient episodes.
   iii. Subgrantee shall complete discharge forms on no less than ninety-nine percent (99%) of all admitted patients whose services have ended.
   iv. Subgrantee shall complete outcome follow-up surveys on a representative sample of at least twenty percent (20%) or more of admitted patients whose services have ended within seventy (70) to one hundred and ten (110) days of discharge.

7. Staff

a. Subgrantee shall secure all staff required in performing the services under the terms of this Contract. All of the services specified in this Contract and all personnel engaged in the work shall be fully qualified and authorized under state law to perform such services.

b. Subgrantee shall further have in existence personnel standards and a personnel compensation and classification system.

c. Subgrantee shall make reasonable efforts to ensure that employees working in any program component funded wholly or in part by SABG funds be afforded opportunities for continuing education per 45 CFR § 96.132 (b). These opportunities should be designed to meet the staff certification and licensing requirements to provide services under any grant. Records of such continuing education shall be maintained by Subgrantee.

d. In the event that Subgrantee discontinues a program or is not able to provide services for a specific program, Subgrantee must notify DAODAS within five (5) business days.

e. **Privileging and Certification –** All personnel providing services funded by DAODAS shall be privileged by Subgrantee to provide each service and shall meet the applicable standards enumerated in this contract. Privileging documentation shall be maintained in Subgrantee's privileging files.

8. Fees/Financial Assessment

a. Subgrantee shall provide its current established fee schedule to DAODAS. Fees charged shall be based on uniform financial assessment procedures as outlined in "**ATTACHMENT A"** to this Contract to determine patients' ability to pay. The financial assessment must include proper verification of income in all cases where the patient's indigence status is being determined. Subgrantee must adhere to the DAODAS Policy on Indigence and Financial Screening and Assessment. Subgrantee shall verify and maintain supporting documentation of patients' insurance coverage(s). All fees collected shall be reported via the monthly financial report in accordance with the procedures promulgated by DAODAS. If such fees collected by programs funded in whole or in part by DAODAS exceed budgetary requirements of said program, excess funds may be used to defray program costs and in other related programs/services as provided under this agreement, and Subgrantee is accountable for such income. Program income earned during the project period must be retained by the recipient and, in accordance with federal regulations, added to funds committed to the project

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by the federal awarding agency and DAODAS and used to further project or other related program objectives.

b. No person shall be required to pay any fee before receiving a clinical assessment and a financial assessment *(as described in 8.a.)*.

c. The Centers for Medicare & Medicaid Services (CMS) prohibit billing Medicaid beneficiaries for broken, missed, or cancelled appointments. Medicaid programs are State-designated and administered with federal policy established by CMS. Federal requirements mandate that providers participating in the Medicaid program must accept the agency's payment as payment in full. Providers cannot bill for scheduling appointments or holding appointment blocks. According to CMS Program Issuance Transmittal Notice MCD-43-94, broken or missed appointments are considered part of the overall cost of doing business.

9. Payor of Last Resort

Subgrantee shall consider DAODAS to be the payor of last resort. Subgrantee shall not use funds provided pursuant to this contract when a patient or client has primary coverage such as Medicaid or private insurance.

Further, Subgrantee shall make every reasonable effort, including the establishment of systems for determination of benefit eligibility, billing, and collection, to:

a. Collect reimbursement for the costs of providing such services to persons who are entitled to insurance benefits under the Social Security Act, including programs under Title XVIII and Title XIX, any State compensation program, any other public assistance program for medical expenses, any contract or grant, any private health insurance, or any other benefit program; and

b. Secure from patients/clients payment for services in accordance with their ability to pay.

Medicaid will be billed for all eligible patients and for all Medicaid services provided. Subgrantee shall assess whether each uninsured patient is potentially Medicaid eligible and shall either assist the patient in applying for Medicaid benefits or shall refer such potentially eligible patient to the nearest County Office of the South Carolina Department of Health and Human Services to apply for benefits.

10. Collaboration With Other State or Federal Agencies During Disease Outbreak and/or Public Health Crises

DAODAS and Subgrantee recognize that as a community-based health service organization, Subgrantee is uniquely positioned to assist other state and federal agencies in times of disease outbreak and/or public health crises. Therefore, Subgrantee agrees and accepts the following:

a. That the designation of "disease outbreak" and "public health crisis" under this subsection is solely within the authority and discretion of the Director of DAODAS.

b. That disease outbreaks and/or public health crises may differ from one another in Subgrantee's level of cooperation with other state or federal agencies and the type and scope of requested services.

c. That the type and scope of requested services per designation of a disease outbreak and/or public health crisis by the Director of DAODAS shall be listed in an official memorandum by the Director of DAODAS ("Disease Outbreak Memorandum" or "Public Health Crisis Memorandum").

d. That upon execution and signature by the Director of DAODAS, such memoranda shall be incorporated herein and become part of this Contract.

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e. That any Disease Outbreak Memorandum and/or Public Health Crisis Memorandum shall not exceed the duration of this Contract. However, nothing in this provision shall prohibit the Director of DAODAS from re-issuing such memoranda under a new funding contract.

f. That failure to comply with a DAODAS Disease Outbreak Memorandum and/or Public Health Crisis Memorandum may be considered by DAODAS as a breach of this Contract by the Subgrantee in whole or in part.

11. Requirements Related to Motor Vehicles

a. **Commercial Driver's License Act –** The South Carolina Commercial Driver's License (CDL) Drug Testing Act (Act No. 232), as enacted by the South Carolina General Assembly on May 21, 2008, requires individuals to be disqualified from driving a commercial vehicle when the South Carolina Department of Motor Vehicles (DMV) receives from a motor vehicle carrier a verified positive drug test or positive alcohol-confirmation test, or verification of a driver's refusal to take an alcohol or other drug test. DAODAS is required to certify Substance Abuse Professionals (SAPs) who meet the requirements of 49 C.F.R. 40. SAPs must report to DAODAS whether a person has successfully completed an alcohol or other drug treatment or education program as recommended by the SAP (Section 56-1-2110 {G}). This information is further reported by DAODAS to the DMV.

b. **Ignition Interlock Device Program –** Pursuant to The Prevention of Underage Drinking and Access to Alcohol Act of 2007, as amended by Act 158 ("Emma's Law of 2014"), the South Carolina Ignition Interlock Device Program (IIDP) was enacted to mandate the use of ignition interlock devices for certain first, and all second and subsequent DUI offenses. **Subgrantee shall develop individualized treatment plans and provide services for offenders participating in the IIDP who are in need of assessment and treatment, as necessary.**

c. **National Motor Voter Registration Act –** Subgrantee shall comply with the requirements of The National Voter Registration Act of 1993 (NVRA or "Motor Voter Act") designating "voter registration agencies" in accordance with the NVRA and SC Code Ann. § 7-5-310, et seq., as amended. Subgrantee shall offer voter registration services in accordance with procedures developed by DAODAS and S.C. Code § 7-5-310(F), and will report *totals* of completed registration forms and declinations, plus the number of individuals who have previously registered to vote and the number of individuals who are provided mail-in registration forms. *Totals* are due by the date listed on the Deliverables list.

12. State and Federal Funding Requirements

a. **Notification of Federal Funds Used to Supplement Program Operations –** Subgrantee shall comply with P.L. 101-517 § 511, as amended, that requires the federal funding source be clearly identified on any brochure, flyer, poster, press release, public service announcement, or other form of information dissemination, events (i.e., planning, production, or presentation of conferences, workshops, or trainings), publications, or any other document describing projects or programs funded in whole or in part with federal funds. Funding provided by DAODAS will be identified by the funding source and CFDA number if applicable. Subgrantee agrees by signing this Contract that it will include, without modification, the clause titled **"Notification of Federal Dollars Used to Supplement Program Operations"** in all lower-tier covered transactions (i.e., transactions with its subgrantees and/or subcontractors) and in all solicitations for lower-tier covered transactions in accordance with 45 CFR Part 76.

b. **Allowable Costs –** Allowable costs incurred under any DAODAS-funded grant or contract shall be determined in accordance with the general principles and standards for selected cost

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items as set forth in the applicable OMB Circulars referenced under "Audit Standards" and "Applicable Laws and Regulations."

c. **Non-Supplantation of Existing Programs –** Subgrantee agrees that funds made available by DAODAS will be used by Subgrantee to implement or increase the level of funding in the specified services only. Funds received through a DAODAS-funded grant shall not supplant any other federally funded projects.

d. **Procurement Policy –** Subgrantee shall have a board-approved written procurement policy in force. Subgrantee is encouraged to utilize qualified minority firms where cost and performance of major grant work will not conflict with funding or time schedules.

e. **Equipment –** Unless otherwise specified by DAODAS, equipment under this Contract is defined as an article of tangible property that has a useful life of more than one year and an acquisition cost of five thousand dollars ($5,000) or more. Single items priced $5,000 or more must have prior written approval of DAODAS for DAODAS-reimbursable class codes. Title to all equipment purchased with funds provided by DAODAS shall rest with Subgrantee as long as the equipment is used for the program for which it was purchased. When the equipment is no longer required for the program for which it was purchased, DAODAS shall be notified, and then instructions will be issued by DAODAS pertaining to the disposition of the property.

f. **Travel –** Subgrantee shall adhere to the travel policies and procedures of the State of South Carolina in all program areas that are funded partially or in full by DAODAS, except in instances where Subgrantee is operating under the policies and procedures of county government or when policies and procedures approved by the governing board of Subgrantee do not exceed the provisions of the State of South Carolina.

13. Records Retention

a. Records with respect to all matters covered by funding through DAODAS shall be made available to DAODAS or its duly appointed representatives for audit inspection or monitoring. All pertinent information, including financial records, supporting documents, statistical records, and patient records, shall be retained for a minimum of three (3) years after the final expenditure report. However, if any litigation, claim, or audit is started before the expiration of the three-year period, then records must be retained for three years after the litigation, claim, or audit is resolved. Subgrantee shall adhere to DHEC regulations for storage of outpatient and residential patient records.

b. The HIPAA Privacy Rule and federal regulations under 42 C.F.R. Part II require certain documentation to be available for a specified number of years (retention period) after it has been received or created. Other laws, usually State laws and regulations, govern the retention period for Protected Health Information (PHI). Also, documents relating to Subgrantee's policies and procedures, uses and disclosures, authorization forms, Business Associate contracts, Qualified Service Organization Agreements (QSOAs), Notices of Privacy Practices, responses to a patient/client who wants to amend or correct their information, the patient/client's statement of disagreement, complaint record, or any other written communication required by HIPAA or 42 C.F.R. Part II must be maintained for a period of six (6) years from the later of the creation date or when it was last in effect. Records must also be retained for two (2) years after a patient/client's death.

c. All paper records containing PHI that are no longer relevant must be shredded. If shredding is performed by an outside service, a certificate of destruction must be secured.

14. Confidentiality of Specific Work Products

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Any DAODAS reports, information, data, etc., given to, prepared by, or assembled by Subgrantee under a DAODAS-funded grant or contract that DAODAS represents as confidential per the Freedom of Information Act (SC Code Ann. § 30-4-10, et seq., as amended) shall not be made available to any individual or organization by DAODAS or Subgrantee without the prior written approval of DAODAS.

Subgrantee shall ensure that employees are educated about specific confidentiality requirements and informed that disciplinary action may be taken upon inappropriate disclosures of confidential information.

15. Copyrights

Subgrantee agrees that any work prepared by Subgrantee in the course of or under this Contract that is eligible for copyright protection under any U.S. or foreign law shall be a work made for hire and ownership of all copyrights (including all renewals and extensions therein) shall vest in DAODAS. In the event any such work prepared by Subcontractor is deemed not to be a work made for hire for any reason, Subgrantee hereby irrevocably grants, transfers, and assigns all right, title, and interest in such work and all copyrights in such work and all renewals and extensions thereof to DAODAS, and agrees to provide all assistance reasonably requested by DAODAS in the establishment, preservation, and enforcement of its copyright in such work. Subgrantee agrees to and does hereby irrevocably waive all moral rights with respect to the work developed or produced hereunder, including any and all rights of identification of authorship and any and all rights of approval, restriction, or limitation on use or subsequent modifications. Notwithstanding the foregoing, DAODAS hereby grants Subgrantee an irrevocable, non-exclusive, perpetual license to utilize the work for itself and its successors for non-commercial purposes. Any work contemplated by this provision that is prepared by Subgrantee shall be immediately provided to DAODAS upon request.

16. Political Activity

None of the funds, materials, property, or services provided directly or indirectly by DAODAS shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise to be in violation of the provisions of the Hatch Political Activity Act (5 U.S.C. § 7324).

17. Critical Incident Reporting

Following DAODAS' protocol for incident reports and in accordance with CARF International and corporate compliance standards, Subgrantee shall report in confidence directly to DAODAS any:

- **a. Fraudulent Activity –** If, at any time during the term of this Contract, Subgrantee becomes aware of or has reason to believe by whatever means that, under this or any other program administered by DAODAS, an applicant for services, an employee of Subgrantee, or any of their subcontractors have improperly or fraudulently applied for or received benefits, monies, or services pursuant to any contract or grant from DAODAS;
- **b. Patient/Client Death**; and
- **c. Critical Incident –** Any sudden or unexpected event that is a deviation from normal or safe operations that may have a significant impact on patients, staff, or the organization.

Subgrantee shall report items b. and c. above using the DAODAS "Incident Reporting Form" contained on **Attachment B**.

18. Conflict of Interest

No official or employee of Subgrantee shall participate personally through decision, approval, disapproval, recommendation, the rendering of advice, investigation, or otherwise in any proceeding,

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application, request for a ruling or other determination, contract, grant, cooperative agreement, claim, controversy, or other particular matter in which these funds are used, where to his knowledge he or his immediate family, partners, organization other than a public agency in which he is serving as officer, director, trustee, partner, or employee, or any person or organization with whom he is negotiating or has any arrangement concerning prospective employment, has a financial interest. In the use of these funds, officials or employees of Subgrantee shall avoid any action that might result in, or create the appearance of:

- **a.** Using his or her official position for private gain;
- **b.** Giving preferential treatment to any person;
- **c.** Losing complete independence or impartiality;
- **d.** Making an official decision outside official channels; or
- **e.** Affecting adversely the confidence of the public in the integrity of the government or the program.

19. Monitoring, County Assistance Plans and Managed Improvement Plans
DAODAS will monitor key performance indicators regarding Subgrantees obligations pursuant to the contract; Subgrantee's compliance with the Treatment and Prevention Manuals, as revised from time to time; and Subgrantee's general organizational stability. When deemed necessary by DAODAS, it may direct Subgrantee to make certain improvements through the implementation of a County Assistance Plan (CAP). The CAP will be designed by DAODAS to assist Subgrantee in the early detection and resolution of problems related to performance and/or general organizational stability. If DAODAS determines that implementation of the CAP has failed to correct the identified problems, Subgrantee shall be placed under a Managed Improvement Plan (MIP) and will be expected to make progress in resolving the problems in order to remain eligible for funding or other financial support from DAODAS.

20. Reporting Systems and Deliverables

- **a.** Subgrantee must collaborate to implement database, reporting system and electronic health record changes required by DAODAS. DAODAS, in collaboration with Behavioral Health Services Association of South Carolina Inc., will give Subgrantee as much advance notice as possible for software and hardware changes.
- **b.** All data must be submitted on time in accordance with defined schedules.
- **c.** Subgrantee must install and maintain updated virus protection on all personal computers, laptops, and file servers. Upon the first incident of virus detection, Subgrantee will be immediately notified via telephone by DAODAS of virus infection. Chronic (to be defined by DAODAS) virus-infected submissions will result in non-acceptance of all incoming data until Subgrantee can certify that the data is virus free.
- **d.** Subgrantee shall take all precautions to protect and secure data, including using HIPAA-compliant passwords, encrypting all electronic transmissions of PHI, and performing and testing regular backups of data systems. If a security or data breach of PHI occurs, Subgrantee shall promptly notify its Privacy Officer, who shall then notify each patient/client whose PHI was breached according to American Recovery and Reinvestment Act requirements.
- **e.** Subgrantee shall submit all deliverables by the due dates and in the appropriate format as required by the Deliverables List on "**ATTACHMENT C**". Requests for extensions to

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deliverables must be submitted on the form "Request for Deliverables Extension" to the appropriate DAODAS program manager for review.

f. Subgrantee will report all financial data, allocate administrative costs in accordance with guidelines supplied by DAODAS, and comply with all other budget, expenditure, and revenue reporting guidelines as enumerated in ARTICLE V of this Contract.

g. DAODAS may, in its sole discretion, provide Subgrantee's staff members with access to DAODAS's various data reporting and grants management systems. Subgrantee shall immediately notify the DAODAS System Administrator if any such staff member transitions into another employment role with Subgrantee, or if any such staff member ceases to be employed by Subgrantee.

h. Subgrantee acknowledges that data reporting pursuant to this section is both a federal funding requirement and a DAODAS funding requirement.

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21. Applicable Laws and Regulations

Subgrantee agrees to comply with all applicable federal and state laws and regulations, including but not limited to:

a. Title 2 U.S. Code of Federal Regulations (CFR) Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements, Cost Principles and Audit Requirements for Federal Awards (Uniform Guidance).

b. All applicable standards, orders, or regulations issued pursuant to the Clean Air Act, as amended (42 U.S.C. § 7401, et seq.).

c. The Civil Rights Act of 1964 (42 U.S.C. § 2000, et seq., and regulations issued pursuant thereto, 45 CFR Part 80).

d. Section 504 of the Rehabilitation Act of 1973, as amended, (29 U.S.C. § 791, et seq.), which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto (45 CFR Part 84).

e. The Age Discrimination Act of 1975, as amended (42 U.S.C. § 6101, et seq.), which prohibits discrimination based on age in programs or activities receiving or benefiting from federal financial assistance.

f. The Omnibus Budget Reconciliation Act of 1981, P.E. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance.

g. The Confidentiality of Alcohol and Drug Abuse Patient Records regulations, 42 CFR Part 2, which implements the federal statutory provision applicable to substance abuse patient records (42 U.S.C. § 290 dd-2) (45 CFR § 96.132 (e)).

h. The Americans with Disabilities Act (42 U.S.C. § 12101, et seq., and regulations issued pursuant thereto, 42 CFR Parts 35 and 36).

i. The Drug Free Workplace Acts, SC Code § 44-107-10, et seq., as amended, and the Federal Drug Free Workplace Act of 1988, Public Law 100-690 and regulations issued pursuant thereto, 45 CFR Part 76, Subpart F.

j. Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994, which imposes restrictions on smoking where federally funded children's services are provided.

k. All restrictions on lobbying found in 31 U.S.C. § 1352.

l. Occupational Safety and Health Administration regulations governing occupational exposure to bloodborne pathogens (29 CFR Part 1910.1030).

m. Requirement to actively publicize the availability of services to pregnant women and give priority admission to this population for services funded wholly or in part by federal block grant funds (45 CFR Part 96.131(b)).

n. 42 U.S.C. 300x-26 – State law regarding sale of tobacco products to underage individuals.

o. 42 U.S.C. 300x-56 – Prohibitions regarding receipt of funds.

p. 42 U.S.C. 300x-66 – Services for individuals with co-occurring disorders.

22. Marijuana Restriction

Grant funds may not be used to purchase, prescribe, or provide marijuana or treatment using marijuana. See, e.g., 45 CFR § 75.300(a) (requiring HHS to ensure that Federal funding is expended in full accordance with U.S. statutory and public policy requirements); 21 U.S.C. 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana).

23. Non-Waiver of Breach

The failure of DAODAS at any time to require Subgrantee's performance of any provision of this Contract or other DAODAS-funded grants/contracts or the continued payment of Subgrantee by DAODAS in the event of such failure shall in no way affect the right of DAODAS to enforce any provision of this Contract or other DAODAS-funded grants/contracts; nor shall the waiver by DAODAS of any breach of any provision hereof be taken or held to be a waiver of any succeeding breach of such provision or as a waiver of the provision itself.

24. Severability

Any provision of this Contract prohibited by the laws of the State of South Carolina shall be ineffective to the extent of such prohibition without invalidating the remaining provisions of this Contract.

25. Arbitration

If at any time the parties to this Contract in their rightful capacity cannot reach a decision based on the guidelines and stipulations within this operating agreement, a disinterested independent person shall be appointed to resolve the issue in accordance with the Uniform Arbitration Act (SC Code Ann. § 15-48-10, as amended).

a. **Appeals Procedures –** Administrative appeals shall be performed in accordance with the South Carolina Administrative Procedures Act (SC Code Ann. § 1-23-310, et seq., as amended). If any dispute shall arise subsequent to inconclusive arbitration, either party shall have the right to appeal within thirty (30) days of receiving written notice of arbitration conclusion that forms the basis of the appeal.

b. **Venue of Actions –** Any and all suits or actions for the enforcement of the obligations of this Contract and for any and every breach thereof, or for the review of a DAODAS final agency decision with respect to this Contract or audit disallowances, and any judicial review sought thereon and brought pursuant to the SC Code § 1-23-380, as amended, shall be instituted and

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maintained in any court of competent jurisdiction in the County of Richland, State of South Carolina.

26. Suspension of Work and/or Modification of Funding

- **a.** DAODAS will inform Subgrantee of pending suspension of work and/or modification of funding in whole or in part for failure of Subcontractor to comply with any of the requirements of this Contract.
- **b.** Upon written notice, DAODAS may order suspension of the work and/or modification of funding in whole or in part for such time as it deems necessary because of failure of Subcontractor to comply with any of the requirements of this Contract. The Contract's completion date shall not be extended on account of any such suspension of work and/or modification of funding.
- **c.** When DAODAS orders a suspension of the work under this section, Subgrantee shall not be entitled to any payment for work with respect to the period during which such work is suspended and shall not be entitled to any costs or damages resulting from such suspension.

27. Termination of Contract

- **a. Termination for Breach of Contract –** Either party may terminate this Contract at any time within the Contract period if the other party has materially breached or otherwise materially failed to comply with its obligations and has not cured such breach in the manner outlined below. The terminating party must give the other party thirty (30) days written notice explaining the nature of the alleged breach. The party receiving notification shall have the 30-day period, running from the date of notification, or any further period in which the parties may agree to cure the alleged breach. This Contract will automatically terminate upon expiration of the cure period if the notifying party is not satisfied that the alleged breach has been remedied, which shall be deemed a default.
  - **i.** In the event of an automatic termination, Subgrantee shall not be entitled to any costs or damages resulting from a termination under this Section.
  - **ii.** Subgrantee and its sureties shall be liable for any damage to DAODAS resulting from Subgrantee's default. Any wrongful termination for default shall be deemed by the parties as a termination for convenience.
- **b. Termination for Convenience** – DAODAS, with thirty (30) days advance written notice, may terminate this Contract when it is in the best interests of the South Carolina Department of Alcohol and Other Drug Abuse Services. If this Contract is so terminated, Subgrantee shall be compensated for all necessary and reasonable costs of performing the work actually accomplished. Subgrantee will not be compensated for any other costs in connection with a termination for convenience. Subgrantee will not be entitled to recover any damages in connection with a termination for convenience.
- **c. Termination for Lack of Available Funds** – The parties hereto covenant and agree that their liabilities and responsibilities, one to another, shall be contingent upon the availability of federal, state, and local funds for the funding of services and that this Contract may be reduced or terminated immediately if such funding ceases to be available. DAODAS will determine the availability of such funds and notify Subgrantee in writing if this Contract must be terminated under this provision.
- **d. Unilateral Termination** – Either party may terminate this Contract without cause by giving the other party ninety (90) days written notice.

28. Notice

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Notice to either party will be sent by certified mail, return receipt required, and postage prepaid to the address stated in the introductory paragraph of this Contract.

29. Independent Contractor
Subgrantee shall not be deemed as the agent or employee of DAODAS for any purpose whatsoever. Neither Subgrantee nor any of its members, employees, or agents shall identify themselves as an employee of DAODAS. Subgrantee shall have no power or authority to bind or obligate DAODAS in any manner, except that DAODAS shall make payments to Subgrantee for the work provided under this Contract. Subgrantee shall obtain and maintain all licenses and permits required by law for performance of any DAODAS-funded Contract by themselves or their employees, contractors, agents, and servants. Subgrantee shall be liable for and pay all taxes required by local, state, or federal governments, including but not limited to Social Security, Workers' Compensation, Employment Security, and any other taxes and licenses or insurance premiums required by law unless specified in the Contract.

30. Indemnification
Subgrantee shall be solely responsible, to the extent permitted by South Carolina law, for the payment of any and all claims for loss, personal injury, death, property damage, or otherwise arising out of any act or omission of its employees or agents acting within the scope of their employment in connection with the performance of work under any DAODAS-funded grants or contracts.

31. Force Majeure
Both parties will not be liable for any loss or delay resulting from causes, including but not limited to acts of God, vandalism, burglary, defective hardware, personal injury of either party or their agents, civil commotion, or any other causes beyond either party's control.

32. Assignment
Subgrantee shall not assign this Contract or any other DAODAS-funded grants or contracts without the prior written consent of DAODAS.

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ARTICLE III - TREATMENT AND INTERVENTION SERVICES

1. Staff Requirements for Clinical Patient Services

- **a. Minimum Qualifications** – To provide treatment services for substance use disorders as an employee of a county alcohol and drug abuse authority, staff must (at a minimum) have a Bachelor's or Masters degree in a health or human service-related field from an accredited college or university; and
  - **i.** be licensed pursuant to section b below,
  - **ii.** be certified pursuant to section c below,
  - **iii.** be classified as "in-process" staff member pursuant to section d below, or
  - **iv.** Possess one of the qualifications to provide clinical counselling services contained in SC Regulation 61-93 § 508(B).
- **b. Licensure**
  - **i.** Staff who are independently licensed to provide counselling by a professional South Carolina state licensing board, as further identified in South Carolina Regulation 61-93.508(B)(2) & (3), will not be required to be certified or credentialed pursuant to section c below.
  - **ii.** Licensed individuals will be required to maintain core competencies and substance use disorder experience by maintaining a written training plan. This plan will be

included in the privileging file of the counselor and shall be approved by Subgrantee's executive director.

iii. If a staff member is licensed in a state other than South Carolina, but is not licensed in South Carolina, they must obtain licensure in South Carolina, or certification pursuant to section c below.

c. Certification

i. In order to meet the required qualification contained in Section 1.a.ii above, a staff member must:

1. be certified as an Alcohol and Drug Counselor (ADC, formerly a Certified Addictions Counselor I); Advanced Alcohol and Drug Counselor (AADC, formerly a Certified Addictions Counselor II); or a Clinical Supervisor (CS, formerly a Certified Clinical Supervisor) by the Addiction Professionals of South Carolina ("APSC") Certification Commission; or
2. be certified as an addiction counselor (NCAC I, NCAC II or MAC) by the National Association of Alcohol and Drug Abuse Counselors ("NAADAC"); or
3. be certified as an alcohol and drug counselor (ICADC or ICAADC) by an International Certification Reciprocity Consortium ("IC&RC") certification board.

d. In Process – In order to meet the required qualification contained in Section 1.a.iii above a staff member must be currently engaged, as verified and documented in the individual's personnel file, in the APSC certification process (an "in-process" staff member). The "in-process" staff member:

i. must be in the process of becoming certified as an addictions counselor and must be under active and ongoing clinical supervision *(see "Clinical Supervision" section below)*;

ii. shall not be privileged to provide any type of direct service until application for certification is submitted (Evidence of certification application shall be available in either the person's privileging file or personnel file.); and

iii. shall have a plan to obtain certification within three (3) years of application, and must achieve certification by the end of this three (3) year period. A staff member who has not completed the APSC certification process within a three (3) year period shall no longer be qualified as "in-process" pursuant to this section. The foregoing notwithstanding, a staff member may submit a request for extension to the Director of DAODAS detailing the reason or reasons as to why the process was not completed within three (3) years. The Director of DAODAS may, in consultation with the Behavioral Health Association of South Carolina ("BHSA") Treatment and Committee Chair, either grant or deny the request for extension. If the request is granted, then the staff member shall continue to be classified as "in-process" up to the extension date set by the Director of DAODAS.

e. Students/Interns

Students/interns in the process of obtaining a minimum of a master's degree in human services from an accredited program may offer direct patient services only under active and ongoing clinical supervision. There must be a designated clinical supervisor and a clinical supervision plan that outlines the clinical objectives of the internship/field placement. All clinical documentation for students/interns must be co-signed by the designated supervisor *(see "Clinical Supervision" section below)*.

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f. **Clinical Supervision** – Students/interns in the process of obtaining credentials as set forth in section III.1.e above:
   i. must be under clinical supervision by a person who:
      1. holds a master's degree, and
      2. is
         a. licensed by the South Carolina Department of Labor Licensing and Regulation (SCLLR), or
         b. certified as an AADC or CS by APSC, or
         c. certified as an NCAC II or MAC by the NAADAC.
   ii. must have all assessments, clinical assessment summaries, treatment plans, and discharge summaries co-signed by a designated clinical supervisor. All student/interns must have a clinical supervision plan that designates the frequency and number of clinical service notes being reviewed by the designated clinical supervisor and the frequency and type of clinical supervision being performed.

g. **Paraprofessional Patient Services –** Paraprofessional positions include: Child Service Professional, Substance Abuse Specialist (SAS), and Peer Support Specialist (PSS). Paraprofessionals must be certified and meet the minimum qualifications set in the South Carolina Department of Health and Human Services *Rehabilitative Behavioral Health Services (RBHS) Provider Manual* to provide these services. The SAS must complete a minimum of twenty (20) hours of continuing education every two (2) years; the PSS must complete a minimum of 20 hours of continuing education training annually of which at least twelve (12) hours must be face-to-face training.
   i. Paraprofessional staff shall have a supervision plan and receive at a minimum monthly supervision. If SAS staff are hired with three (3) years of experience, experience must be documented in their privileging file.

2. **Mandated Treatment Services and Priorities Pursuant to 45 C.F.R §96**
   a. **Intravenous Substance Users (45 CFR § 96.126) –** Subgrantee shall ensure that services funded by DAODAS are provided to persons identified as intravenous users of illicit drugs. Subgrantee further agrees to:
      i. provide DAODAS with a statement of capacity for each service or level of care funded in part with federal block grant funds;
      ii. notify DAODAS within seven (7) days of having reached 90 percent (90%) of its capacity to admit individuals to a particular service or level of care *(refer to Capacity Monitoring Report Form)*;
      iii. maintain a formal waiting list that shall include a unique patient identifier for each intravenous drug user seeking treatment;
      iv. notify DAODAS when any intravenous drug user is placed on a waiting list *(refer to Capacity Monitoring Report Form)*; and
      v. Provide interim services to those persons who cannot be admitted to treatment within fourteen (14) days of making a request. Interim services shall be made available not more than forty-eight (48) hours after the request for treatment and shall include at a minimum:
         1. counseling and education about HIV and tuberculosis;
         2. counseling and education about the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and tuberculosis transmission does not occur;
         3. referral for HIV or tuberculosis treatment services if necessary; and
         4. outreach efforts to encourage individuals in need of treatment services for intravenous drug use to undergo such treatment. Subgrantee shall actively

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publicize the availability of such services and the priority status of intravenous drug users through such means as ongoing public service announcements, regular advertisements in local/regional print media, posters placed in targeted areas, and communications to other community-based organizations, healthcare providers, and social service agencies. Subgrantee shall develop collaborative relationships with opioid treatment programs for the purpose of coordination of treatment services to intravenous drug users.

b. Women (45 CFR § 96.131)

- **i.** Subgrantee shall ensure that services awarded by DAODAS are made available to pregnant women. *Pregnant women* will be **given priority** for admission to all program components funded wholly or in part by federal block grant funds.
- **ii.** Subgrantee shall actively publicize the availability of such services and the priority status of pregnant women through such means as ongoing public service announcements, regular advertisements in local/regional print media, posters placed in targeted areas, and communications to other community-based organizations, healthcare providers, and social service agencies.
- **iii.** Subgrantee shall notify DAODAS when it is unable to admit a pregnant woman to treatment because of insufficient treatment capacity.
- **iv.** Subgrantee shall make available interim services to any pregnant woman who cannot be admitted to treatment within forty-eight (48) hours of having applied. Interim services for pregnant women include those enumerated in subsection (2)(v) above (Interim Services for Intravenous Substance Users), but shall also include counseling on the effects of alcohol and drug use on the fetus, as well as referral for prenatal care.

c. Human Immunodeficiency Virus (HIV) (45 CFR § 96.128)

- **i.** From time to time, and pursuant to a prevalence formula, the State of South Carolina may become a "designated state" under 45 C.F.R. §96.128. Under such designation, and pursuant to DAODAS' instructions, Subgrantee shall comply with all specific funding allocation and project instructions in compliance with 45 C.F.R. §96.128.
- **ii.** As a matter of routine, Subgrantee shall make available for inspection any written policies for service delivery to persons with HIV disease. Any revisions to policies shall be submitted to DAODAS upon adoption by Subgrantee's governing body.

d. Tuberculosis (TB) Services (45 CFR § 96.127)

- **i.** Subgrantee shall routinely make available, directly or through arrangements with other public or non-profit entities, tuberculosis services to each individual receiving treatment for alcohol and other drug use after being found to be at high risk by the assessment.
- **ii.** "Tuberculosis services" include:
  - **1.** counseling individuals with respect to tuberculosis;
  - **2.** making available necessary testing to determine whether individuals have been infected with mycobacterium tuberculosis to determine the appropriate form of treatment for each individual; and
  - **3.** providing for or referring individuals infected by mycobacterium tuberculosis for appropriate medical evaluation and treatment.
- **iii.** In the case of an individual in need of such treatment who is denied admission to the program based on lack of the capacity of the program to admit the individual, Subgrantee will refer the individual to another provider of tuberculosis services.

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iv. Subgrantee will implement infection-control procedures established by DAODAS, in cooperation with DHEC's Tuberculosis Control Officer, that are designed to prevent the transmission of tuberculosis, including the following:

1. screening of patients;
2. identification of those individuals who are at high risk of becoming infected;
3. conduction of case management activities to ensure those individuals receive such services; and
4. reporting of all individuals identified with active tuberculosis by the testing organization to the appropriate state officials.

v. Subgrantee shall comply with DAODAS' reporting instructions to ensure that all recipients of tuberculosis services are appropriately identified and all services documented.

3. Statewide Base Treatment Services

Subgrantee shall provide the following statewide base services. Subgrantee shall adhere to the program guidelines as published in the DAODAS *Treatment Programs Manual, as revised from time to time*:

Program	Cost Center Code
Traditional Outpatient, Adolescent, Group, Individual, Family Counseling, Outpatient Services (Outpatient-Tx) (Level I)	Cost Center Code 3001-30xx
Alcohol and Drug Safety Action Program (INT-ADSAP)	Cost Center Code 4001
Youth and Adolescent Services (YAS), Intervention	Cost Center Code 5501
Alcohol Intervention Program	
Gambling Services	Cost Center Code 3701

4. Extended Services

Subgrantee shall provide the following extended services. Subgrantee shall adhere to the program guidelines as published in the DAODAS *Treatment Programs Manual, as revised from time to time*:

Program	Level	Cost Center Code
Medically Monitored Inpatient Withdrawal Management	Level 3.7 WM	Cost Center Code 1001
Clinically Managed Residential Withdrawal Management	Level 3.2 WM	Cost Center Code 1101
Outpatient Withdrawal Management Ambulatory Withdrawal Management with Extended On-site Monitoring	Level 2 WM	Cost Center Code 3602
Clinically Managed High-Intensity Residential	Level 3.5	Cost Center Code 1501
Medically Monitored Intensive Inpatient Treatment	Level 3.7	Cost Center Code 1505
Women's Residential Medically Monitored/Clinically Managed (WRTC)	Level 3.7 with step-down to Level 3.5	Cost Center Code 1601

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Program	Level	Cost Center Code
Adolescent Residential Medically Monitored/Clinically Managed	Level 3.7 with step-down to Level 3.5	Cost Center Code 1701
Intensive Outpatient Treatment Program (9-19 hours/week)	(IOP – General) Level 2.1	Cost Center Code 2501
Women's Intensive Outpatient Treatment Program (9-19 hours/week)	(IOP-W) Level 2.1	Cost Center Code 2601
Adolescent Intensive Outpatient Treatment (6-19 hours/week)	(IOP-A) Level 2.1	Cost Center Code 2701
Day Treatment/ Partial Hospitalization Treatment Program (20+ hours/week)	Level 2.5	Cost Center Code 2801
The Bridge (Adolescent Services)		Cost Center Code 3404

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ARTICLE IV – PREVENTION SERVICES

1. **Staff Requirements for Prevention Services**

   In each county contained in its catchment area, Subgrantee shall provide staff dedicated to the provision of primary prevention services as it relates to funding provided through the Substance Abuse Prevention and Treatment Block Grant (SABG).

   a. **Minimum Qualifications** – To provide or coordinate prevention services as an employee of a county alcohol and drug abuse authority, staff who were hired by a county authority after July 1, 2006, must hold a minimum of a bachelor's degree from an accredited college or university, be certified or in the process of becoming certified pursuant to sections c and d below, and be under active and ongoing prevention mentoring.

   b. **New Hires/Position Changes** – Subgrantee must inform the DAODAS Manager of Prevention and Intervention Services in writing within five (5) days of a new position hire/change in SABG or other DAODAS-funded prevention staff positions. Agencies should submit the following information: name, position, e-mail address, and telephone number. Changes and/or updates must also be made into the prevention database as soon as the change/hire takes effect.

   c. **Certification**
      - **i.** Staff shall be certified by:
        1. the South Carolina Association of Prevention Professionals and Advocates (SCAPPA) Certification Commission as a Certified Prevention Specialist (CPS); or
        2. the SCAPPA Certification Commission as a Certified Senior Prevention Specialist (CSPS).
      - **ii.** Certified prevention staff must have a written training plan, updated annually, pertinent to maintaining SCAPPA certification.

   d. **In Process –** Staff may be privileged to provide prevention services while in the process of earning certification. The "in-process" person:

i. Must apply for certification by SCAPPA as a CPS or CSPS within six (6) months of hire. (Evidence of the employee's application for SCAPPA certification must be placed in his/her privileging or personnel file.)
ii. Must have a detailed written training plan to obtain certification within three (3) years of his or her application for certification, and must achieve certification by the end of this three (3)-year period. The certification timeframe does not restart if the employee leaves the agency and joins a different agency. The application is transferable to another agency where the person is employed during the 36-month time period. (A copy of the written plan, signed by the staff member and their manager, must be retained in their privileging or personnel file and updated on an annual basis.). A staff member who has not completed the certification process within a three (3) year period shall no longer be qualified as "in-process" pursuant to this section. The foregoing notwithstanding, a staff member may submit a request for extension to the Director of DAODAS detailing the reason or reasons as to why the process was not completed within three (3) years. The Director of DAODAS may, in consultation with the Behavioral Health Association of South Carolina ("BHSA") Prevention Committee Chair, either grant or deny the request for extension. If the request is granted, then the staff member shall continue to be "in-process" until the extension date set by the Director of DAODAS, assuming all other requirements of this section continue to be met.
iii. Must be under active and ongoing prevention supervision.
iv. Must be engaged in an active and ongoing prevention supervision process. Supervision must be provided by an individual approved by SCAPPA. A written plan that addresses information on the supervision progress shall be placed in the employee's privileging or personnel file. Both the staff member and their manager must sign this plan and update it on an annual basis. Documentation that SCAPPA has approved the prevention supervisor must be attached.

2. **Primary Prevention/Education Program (PREV-CG), Class Code 8001**
Subgrantee shall adhere to and maintain compliance with all DAODAS prevention requirements, including but not limited to any funding set-asides, reporting, expenditure, and training requirements. Subgrantee shall adhere to the DAODAS *Primary Prevention Services Manual* as revised from time to time, as well as any specific instructional memoranda, in the execution of this provision.

3. **Alcohol Enforcement Team (AET) / Class Code 8016**
Subgrantee shall adhere to and maintain compliance with DAODAS' prevention requirements that are associated with the Alcohol Enforcement Team (AET) program. Subgrantee shall adhere to the DAODAS *Primary Prevention Services Manual*, as revised from time to time, as well as any specific instructional memoranda, in the execution of this provision.

4. **Prevention Reporting Requirements and Evaluations**
Subgrantee shall adhere to and maintain compliance with DAODAS' reporting and evaluations requirements. Subgrantee shall adhere to DAODAS' *Primary Prevention Services Manual*, as revised from time to time, as well as any specific instructional memoranda, in the execution of this provision.

ARTICLE V - FINANCES

1. **Budget**
Subgrantee shall notify and receive prior approval from DAODAS of budget changes that exceed fifteen percent (15%) of total budget and/or any changes that result in reduction or elimination of

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services. Subgrantee agrees to complete the "Reduction in Staff Impact on the Community and Agency Questionnaire" form when there is a reduction and/or elimination of services.

2. **Reimbursements – General**
Subgrantee shall provide by e-mail total agency expenditures incurred and total agency revenue collected by cost center code (program) by the due dates noted on the Deliverables Schedule or as requested. All three (3) components of the deliverable (data, cover letter, and data reports) must be submitted to DAODAS in order to be logged in as "received." Subgrantee will be reimbursed monthly via the monthly financial report (REBA) and reporting codes promulgated by DAODAS. A final Profit and Loss Statement or Income Statement by program is due as specified on the Contract Deliverables list for the previous fiscal year.

Requests for reimbursement must be submitted in the format promulgated by DAODAS. Failure of Subgrantee to provide financial reports within the specified time and in the required format shall result in delay of reimbursement payable under this Contract and any other grants or contracts. Unless otherwise indicated in this Contract, reimbursement totals for each quarter will not exceed one-fourth (¼) of the total Contract amount. Whenever possible, reimbursements will be by electronic funds transfer (EFT). Agencies must submit necessary information to the State Treasurer's Office and inform DAODAS.

3. **Block Grant Reimbursements for Assessments**
   a. In utilizing the Substance Abuse Prevention and Treatment Block Grant (SABG) funding, DAODAS agrees to reimburse Subgrantee for initial assessments and assessment update services that are provided to *potential patients who do not have insurance coverage, and who are unable to pay for a clinical assessment*. This reimbursement process seeks to remove financial barriers and service charges for these potential patients who are exploring treatment options, and to reduce the financial burden on the Subgrantee that is associated with serving these potential patients.

   b. Subgrantee shall utilize its electronic health record (EHR) to identify assessment services billed to the SABG through DAODAS. DAODAS will utilize service-provision data and reimburse providers for assessments using the Medicaid fee schedule until the funding has been exhausted.

   c. DAODAS shall monitor Subgrantee's utilization of these funds through record reviews and analyses using data from the provider EHR.

4. **Block Grant Reimbursement for Treatment**
   a. In utilizing the SABG funding, DAODAS agrees to reimburse Subgrantee for outpatient or intensive outpatient treatment services that are provided to patients *who were deemed uninsured or unable to pay under Article II, Sections 6 and 7, of this Contract* (i.e., Subgrantee's obligation to conduct a comprehensive financial assessment; Subgrantee's obligation to consider DAODAS to be the payor of last resort). This reimbursement process seeks to remove financial barriers and service charges for these patients, and to reduce the financial burden on the Subgrantee that is associated with serving these patients.

   b. Only the following CareLogic programs are eligible for reimbursements under this payer source:
      i. Outpatient – Traditional
      ii. Outpatient – Adolescent
      iii. Outpatient – Women
      iv. Intensive Outpatient – Traditional
      v. Intensive Outpatient – Adolescent

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vi. Intensive Outpatient – Women
vii. Intensive Outpatient – Men

c. Programs that **are not** eligible for reimbursements under this payer source include:
  i. ADSAP Outpatient and ADSAP Intensive Outpatient
  ii. Alternative Services (ALTSERV)
  iii. Temporary Program – Admission Decision Delayed
  iv. Offender-Based Intervention (OBI). (While some providers have contracted funding for OBI services, there is no payment source for OBI-type services through DAODAS. If individuals in an OBI program qualify for service provision as uninsured, they should be billed under the outpatient or intensive outpatient [IOP] option.)

d. Patients with an opioid use disorder who are found in need of subsidized treatment services after clinical and financial assessments shall receive services billed to the State Opioid Response Payor.

e. Subgrantee shall utilize its EHR to identify treatment services billed to the SABG through DAODAS. DAODAS will utilize service-provision data and reimburse providers for treatment services using the Medicaid fee schedule until the funding has been exhausted.

f. DAODAS shall monitor Subgrantee's utilization of these funds through record reviews and analyses using data from the provider EHR.

5. Accuracy of Data and Reports

Subgrantee agrees that all statements, reports, data, and claims shall be certified to the best of its knowledge as true, accurate, and complete. Subgrantee shall not submit statements, reports, claims, and data that it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, and DAODAS policies. DAODAS will use submitted statements, reports, claims, and data for compliance reviews.

6. Recording and Documenting of Receipts and Expenditures

Subgrantee accounting procedures must provide for accurate and timely recording of receipt of funds by source, of expenditures made from such funds, and of unexpended balances. These records must contain information pertaining to grants and contracts amounts, obligations, unobligated balances, assets, liabilities, expenditures, and program income. Controls must be established that are adequate to ensure that expenditures charged to any DAODAS-funded grants or contracts are for allowable purposes. Additionally, effective control and accountability must be maintained for all cash, real and personal property, and other assets. Accounting records must be supported by such source documentation as canceled checks, paid bills, payrolls, time and attendance records, contract documents, etc. However, documentation should be maintained by Subgrantee; it should not be sent to DAODAS unless requested.

7. Audits and Financial Reviews

a. The intent of DAODAS' audit & financial review policy, the Single Audit Act (Public Law 98-502), the Single Audit Act Amendments of 1996 (Public Law 104-502), and Title 2 U.S. Code of Federal Regulations (CFR) Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements, Cost Principles and Audit Requirements for Federal Awards (Uniform Guidance), is to establish uniform audit requirements, promote the efficient and effective use of audit services, and monitor program expenditures according to the provisions of the grants or contracts.

b. To comply with this intent, DAODAS requires Subgrantee to have a *single* audit conducted for the Contract Period as referenced in Article I of this Contract by an independent auditor if

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Subgrantee expends $750,000 or more in federal awards. The audit must comply with the provisions of the Uniform Guidance, Audits of States, Local Governments and Non-Profit Organizations. The audit should be conducted in accordance with generally accepted auditing standards and the standards applicable to financial audits contained in Government Auditing Standards issued by the Comptroller General of the United States. Whenever possible, make a positive effort to utilize small businesses, minority-owned firms, and women's business enterprises in procuring audit services as stated in the Uniform Guidance.

c. Uniform Guidance audits place substantial additional emphasis on the study and evaluation of internal controls and the testing of compliance with laws and regulations. This evaluation is needed to fulfill DAODAS' responsibility to ensure that federal funds are properly expended.

d. If Subgrantee expends less than $750,000.00 in federal awards, Subgrantee shall be subject to DAODAS' monitoring procedures that will include reviews by independent accounting firms for the Contract Period as referenced in Article I of this Contract. In such event, Subgrantee shall engage and pay for an independent, outside accounting firm to prepare annual reviews of Subgrantee's financial statements for the contract year. Such financial statement reviews shall be conducted in accordance with the American Institute of Certified Public Accountants (AICPA) most recent S*tatements on Standards for Accounting and Review Services (SSARSs)*. The financial reviews shall be provided to DAODAS for monitoring and approval. DAODAS may elect to engage an outside firm to assist it with monitoring and approval of the financial reviews. Should DAODAS engage an outside firm, DAODAS shall pay for the services of such firm. In addition to financial reviews, Subgrantee shall provide DAODAS, or DAODAS' outside firm, with any supplemental financial information requested by DAODAS, or DAODAS' outside firm, during the period of this contract. In accordance with the Uniform Guidance, the costs of audits of non-federal entities with less than $750,000 in federal awards expended may not be charged to the federal award as an allowable cost.

e. The independent auditor's reports and reviews required by subsection b and d of this section shall be delivered to DOADAS no later than January 29 of the calendar year immediately following the Contract Period.

8. Payroll Audits and Reports

a. If Subgrantee maintains one or more separate payroll accounts during the Contract Period, and it does not contract with a full-service payroll services provider to administer its payroll, then such separate payroll account or accounts shall be audited by an independent auditor for the Contract Period. The auditor's report shall be delivered to Subgrantee's Board Chairperson no later than no later than January 29 of the calendar year immediately following the Contract Period. Subgrantee shall not be required to deliver the independent auditor's report to DAODAS, however, Subgrantee's independent auditor shall deliver certification to DAODAS that such payroll account or accounts were audited and that the auditor's report was delivered to Subgrantee's Board Chairperson. The auditor's certification shall be delivered to DAODAS no later than January 29 of the calendar year immediately following the Contract Period.

b. If Subgrantee contracts with a full-service payroll services provider to administer its payroll, a detailed payroll services report generated by the payroll services provider covering all payroll expenditures for the Contract Period shall be delivered to Subgrantee's Board Chairperson no later than no later than January 29 of the calendar year immediately following the Contract Period. Subgrantee shall not be required to deliver the payroll services report to DAODAS, however, Subgrantee shall deliver certification to DAODAS that such payroll services report was delivered to Subgrantee's Board Chairperson. The certification shall be

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delivered to DAODAS no later than January 29 of the calendar year immediately following the Contract Period.

c. This requirements of this section (Article V, Section 8) shall not apply if the Subgrantee is wholly owned and operated by a political subdivision of the state of South Carolina (such as a South Carolina county) and if all staff members are employees of such political subdivision.

9. Audit and Financial Review Standards

a. The audit or financial review will be designed to increase the accountability for the expenditure of federal, state, local, and other funds utilized by the subcontractors and subgrantees of DAODAS. The audit or financial review will apply to the entire operation of an agency. Audits of individual departments and agencies may be considered a single audit when conducted on a county government body by an independent auditor, and will comply with 2CFR 200 Uniform Guidance.

b. DAODAS audit policy hereby defines "audit" as including financial as well as economy and efficiency audits according to the Generally Accepted Government Auditing Standards (also known as The Yellow Book), to include SAS 112 (Statement on Auditing Standards), which requires the auditor to report in writing to management and the governing body any control deficiencies found during the audit that are considered significant deficiencies and/or material weaknesses.

c. As governmental funds are accounted for on the modified accrual basis of accounting, the audit report or financial review must be prepared on the same basis. In addition, the financial statements and schedules must be in conformity with Generally Accepted Accounting Principles (GAAP). Under the modified accrual basis of accounting, expenditures are measurable and should be recorded when the related liability is incurred. Revenues are recognized in the accounting period when they become available and measurable. DAODAS reimbursements not received before the end of the state fiscal year must be shown as accounts receivable in the programs in which they are due in order to match revenue with the proper year.

d. DAODAS adopts the principles for determining allowable and unallowable costs as provided in the Uniform Guidance. All costs allocated to a program must be recorded in that program, supported by proper documentation, and procured competitively.

e. The audit report shall include the following:

- **i.** An auditor's opinion on whether the basic financial statements present fairly the financial position of the agency and the results of its financial operations in accordance with GAAP, and an opinion as to whether the schedule of expenditures of federal awards is fairly stated in relation to the financial statements taken as a whole.
- **ii.** A report on compliance and internal control over financial reporting based on an audit of financial statements in accordance with Generally Accepted Government Auditing Standards. The report shall describe the scope of testing, the results of the tests and, where applicable, refer to a separate schedule of findings and questioned costs. An opinion on the overall internal control system is not required.
- **iii.** A Supplementary Schedule of Expenditures of Federal Awards that complies with the Uniform Guidance. Federal programs or grants that have not been assigned a catalog number shall be identified under the caption "Other Federal Assistance." In addition, an opinion on this supplementary information schedule must be provided either in the report on the financial statements or in a separate report.
- **iv.** A report on compliance with requirements applicable to each major program and internal control over compliance in accordance with the Uniform Guidance. The

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report shall include the auditor's opinion regarding compliance and, where applicable, refer to a separate schedule of findings and questioned costs.

v. A schedule of findings and questioned costs in accordance with 2CFR 200 Uniform Guidance.

vi. A schedule of findings and responses for subcontractors and subgrantees of DAODAS not subject to the 2CFR 200 Uniform Guidance audit.

f. Subgrantee receiving DAODAS funds will prepare as part of the audit report or financial review, at a minimum, the following financial statements and schedules:

i. combined balance sheet – all fund types and account groups;

ii. combined statement of revenues, expenditures, and changes in fund balances – budget and actual – general and special revenue fund types;

iii. individual statements of revenues, expenditures, and changes in fund balances for each cost center code (i.e., program {Outpatient, ADSAP, etc.}) to demonstrate compliance with Contract provisions. These statements must be in accordance with the requirements promulgated by DAODAS and must be reconciled to the disbursement schedule issued by DAODAS. Any discrepancies must be noted in the agency's audit;

iv. supplementary schedule concerning any investments, reporting the amount invested in each (such as money market account, certificate of deposit, savings account) and the interest earned on each investment.

g. After the above mandatory schedules and statements, any of the following that pertain must be submitted:

i. any management letter associated with the audit or financial review;

ii. a list of federal, state, or local agencies to which the report was distributed;

iii. any corrective actions that were recommended or taken on current or prior audit or financial review findings; and

iv. status of recommendations in prior audits or financial reviews.

h. Subgrantee shall provide – at the time of submission of any audit report or financial review to DAODAS – comments on the findings and recommendations contained in the audit report or financial review. The submission must include corrective actions planned or taken for each finding and comments on the status of said corrective actions taken before the finalization of the audit or financial review. If Subgrantee does not agree with a finding, or believes that corrective action is not required, the corrective action plan shall include an explanation and specific reasons.

i. Subgrantee shall forward two (2) original copies of the audit report or financial review to the DAODAS Division of Finance and Operations no later than six (6) months following the end of the fiscal year or thirty (30) days after the audit or financial review is completed, whichever is earlier. A copy of the engagement letter and the audit firm's peer-review document(s) must accompany the audit report or financial review.

j. Subgrantee agrees to engage reliable and competent audit services by a firm licensed by the South Carolina Board of Accountancy or other State Board of Accountancy to ensure that the above deadline is met.

k. Subgrantee further understands that federal funding may be suspended by DAODAS if the above deadline is not met, and that suspension of funding will exist until such time as the audit report is received and accepted by DAODAS.

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ARTICLE VI – ASSURANCES/CERTIFICATIONS

1. **Assurances**
   a. **HIPAA, 42 CFR Part 2, HITECH Act Subtitle D (Business Associate Agreement)**
      i. Subgrantee agrees that, to the extent that some or all of the activities within the scope of this Contract are subject to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, P.L. 104-91, as amended, or its implementing regulations, it will comply with the HIPAA requirements as well as Subtitle D of the Health Information Technology for Economic and Clinical Health Act (HITECH Act), enacted as part of the American Recovery and Reinvestment Act of 2009, and will execute such agreements and practices as DAODAS will require to ensure compliance.
      ii. Subgrantee agrees that to the extent that some or all of the activities within the scope of this Contract are subject to the provisions of 42 CFR, Part 2, as well as Subtitle D of the HITECH Act enacted as part of the American Recovery and Reinvestment Act of 2009 (regarding the confidentiality of alcohol and other drug patient treatment records), Subgrantee will comply with the requirements of 42 C.F.R., Part 2, as well as Subtitle D of the HITECH Act, and will execute such agreements and practices as DAODAS will require to ensure compliance.
      iii. All employees and associated staff of Subgrantee are responsible for ensuring and maintaining the confidentiality, privacy, and security of all protected health information (PHI) (electronic, written, verbal, or in any other format) that is provided or made available to any employee or staff or that is obtained, handled, learned, heard, or viewed in the course of work or association with Subgrantee.
      iv. Subgrantee further agrees to follow all federal and state statutes and regulations regarding identity theft, privacy, data protection, and data destruction.
      v. Subgrantee shall not use or further disclose PHI or other sensitive information other than as permitted or required by the Contract or as required by law. Subgrantee agrees to use administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the information that it creates, receives, maintains, or transmits in the execution of this Contract. It is the responsibility of Subgrantee to ensure that any agent, including a subcontractor to whom it provides such information, implements reasonable and appropriate safeguards to protect this information and shall document any such disclosures of information to such parties.
      vi. A breach by Subgrantee of this clause may subject Subgrantee to termination under any applicable default or termination provision of this Contract. Subgrantee will hold DAODAS harmless from any liability as a result of Subgrantee's failure to follow or comply with these requirements.
      vii. Subgrantee shall provide to DAODAS patient data in accordance with the standards established by DAODAS. The patient data include protected patient health information. This patient information will be protected by Subgrantee and DAODAS in accordance with HIPAAA and 42 CFR, Part 2, as well as Subtitle D of the HITECH Act.

2. **Certifications**
   a. **Certification Regarding Debarment and Suspension –** By signing this Contract, Subgrantee's authorized agent certifies that Subgrantee, defined as the primary participant in accordance with 45 CFR Part 76, and/or its principals:
      i. are not presently debarred, suspended, proposed for debarment, or declared ineligible for the award of contracts by any state or federal agency;

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- **ii.** have not, within a three (3)-year period preceding this offer, been convicted of or had a civil judgment rendered against them for: commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) contract or subcontract; violation of federal or state antitrust statutes relating to the submission of offers; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property;
- **iii.** are not presently indicted for, or otherwise criminally or civilly charged by a governmental entity with, commission of any of the offenses enumerated in paragraph (ii) of this provision; or
- **iv.** has not, within a three (3)-year period preceding this Contract, had one (1) or more contracts terminated for default by any public (federal, state, or local) entity.

"Principals," for the purposes of this certification, means officers; directors; owners; partners; and, persons having primary management or supervisory responsibilities within a business entity (e.g., general manager; plant manager; head of a subsidiary, division, or business segment, and similar positions). For the purpose of this certification, the term "*Principals*" includes both present principals as well as individuals who served in the capacity of principals within a three-year period preceding this Contract.

Subgrantee shall provide immediate written notice to the DAODAS if, at any time prior to contract award, Subgrantee learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

If Subgrantee is unable to certify the representations stated in paragraph (a), Subgrantee must submit a written explanation regarding its inability to make the certification. The certification will be considered in connection with a review of the Subgrantee's responsibility. DAODAS will make a binding determination of responsibility in every case where the Subgrantee or other Certifying party is unable to make the Certification after review of the written explanation. Failure of the Subgrantee to furnish additional information as requested by DAODAS may render the Subgrantee nonresponsive.

Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render, in good faith, the certification required by paragraph (a) of this provision. The knowledge and information of a Subgrantee is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

Subgrantee agrees by signing this Contract that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion – Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or subcontractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76. Subgrantee may search the List of Excluded Individuals and Entities (LEIE) website located at http://www.oig.hhs.gov/fraud/exclusions.asp for individuals or entities that are debarred or suspended. Anyone who hires an individual or entity on the LEIE may be subject to civil monetary penalties.

The certification in paragraph (a) of this provision is a material representation of fact upon which reliance was placed when making awards under this Contract. If it is later determined that the Subgrantee, or a subcontractor of Subgrantee, knowingly or in bad faith rendered an erroneous certification, in addition to other remedies available, DAODAS may terminate this contract for default.

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b. Certification Regarding Drug-Free Workplace Requirements – The undersigned (authorized official signing for Subgrantee's organization) certifies that Subgrantee will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- **i.** publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the Subgrantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- **ii.** establishing an ongoing drug-free awareness program to inform employees about:
  - **1.** the dangers of drug use in the workplace;
  - **2.** Subgrantee's policy of maintaining a drug-free workplace;
  - **3.** Any available drug counseling, rehabilitation, and employee assistance programs; and
  - **4.** the penalties that may be imposed upon employees for drug use violations occurring in the workplace;
- **iii.** making it a requirement that each employee to be engaged in the performance of the Contract be given a copy of the statement required by paragraph (1) above;
- **iv.** notifying the employee in the statement regarding conditions of employment under the Contract that the employee will:
  - **1.** abide by the terms of the statement; and
  - **2.** notify the employer in writing of their conviction for violation of a criminal drug statute occurring in the workplace no later than five (5) calendar days after such conviction;
- **v.** notifying DAODAS in writing within ten (10) calendar days after receiving notice under paragraph (iv)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant or contract;
- **vi.** taking one of the following actions, within forty (40) calendar days of receiving notice under paragraph 4(b), with respect to any employee who is so convicted:
  - **1.** taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  - **2.** requiring such employee to participate satisfactorily in substance use disorder services or an employee assistance program approved for such purposes by a federal, state, or local health, law enforcement, or other appropriate agency; and
- **vii.** making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs i-vi.

c. Certification Regarding Lobbying – Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal Contracting and financial transactions," generally prohibits recipients of federal grants and cooperative agreements from using federal funds for lobbying the executive or legislative branches of the federal government in connection with a specific grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a federal grant or cooperative agreement must disclose lobbying undertaken with non-federal funds. These requirements apply to grants and cooperative agreements exceeding $100,000 in total costs (45 CFR Part 93). The undersigned (authorized official signing for Subgrantee's organization) certifies, to the best of his or her knowledge and belief, that:

NOT FINAL

i. No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agent or member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

ii. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal grant, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

iii. The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

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

d. **Certification Regarding Program Fraud Civil Remedies Act (PFCRA) –** The undersigned (authorized official signing for Subgrantee's organization) certifies that the statements herein are true, complete, and accurate to the best of their knowledge, and that they are aware that any false, fictitious, or fraudulent statements or claims may subject them to criminal, civil, or administrative penalties. The undersigned agrees that Subgrantee will comply with the Public Health Service terms and conditions of award if a grant is awarded.

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

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

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

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iii. Subgrantee agrees that it will require that the language of this certification be included in any sub-awards that contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

f. **Miscellaneous Certifications –** By signing this Contract, Subgrantee certifies that Subgrantee:

i. has the legal authority to apply for federal assistance, and the institutional, managerial, and financial capability (including funds sufficient to pay the non-federal share of project costs) to ensure proper planning, management, and completion of the project described in this Contract;

ii. will give DAODAS, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the Contract, and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives;

iii. will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest or personal gain;

iv. will initiate and complete the work within the applicable period after receipt of approval of DAODAS;

v. will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen (19) statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F);

vi. will comply with all federal statutes relating to nondiscrimination, including but not limited to: (1) Title VI of the Civil Rights Act of 1964 (P.L. 88-352), as amended, which prohibits discrimination on the basis of race, color, or national origin; (2) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (3) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (4) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (5) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (6) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (7) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (8) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 *et seq.*), as amended, relating to nondiscrimination in the sale, rental, or financing of housing; (9) any other nondiscrimination provisions in the specific statute(s) under which application for federal assistance is being made; and (10) the requirements of any other nondiscrimination statute(s) that may apply to the application;

vii. will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P. L. 91-646), as amended, which provide for fair and equitable treatment of persons

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displaced or whose property is acquired as a result of federal or federally assisted programs (These requirements apply to all interests in real property acquired for project purposes regardless of federal participation in purchases.);

viii. will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328), as amended, that limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds;

ix. will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Grant Work House and Safety Standards Act (40 U.S.C. §§327-333) regarding labor standards for federally assisted construction sub-agreements;

x. will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L.93-234), as amended, which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of the insurable construction and acquisition is $10,000 or more;

xi. will comply with environmental standards that may be prescribed pursuant to the following: (1) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (2) notification of violating facilities pursuant to EO 11738; (3) protection of wetland pursuant to EO 11990; (4) evaluation of flood hazards in floodplains in accordance with EO 11988; (5) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 *et seq.*); (6) conformity of federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 *et seq.*); (7) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (8) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205);

xii. will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 *et seq.*) related to protecting components or potential components of the national wild and scenic rivers system;

xiii. will assist DAODAS in ensuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 *et seq*.);

xiv. will comply with P.L. 93-348, as amended, regarding the protection of human subjects involved in research, development, and related activities supported by this Contract;

xv. will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 *et seq.*) pertaining to the care, handling, and treatment of warm-blooded animals held for research, teaching, or other activities supported by this Contract;

xvi. will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 *et seq*.) that prohibits the use of lead-based paint in construction or rehabilitation of residence structures;

xvii. will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984;

xviii. will comply with all applicable requirements of all other federal laws, executive orders, regulations, and policies governing this Contract; and

xix. will comply with all funding agreements as required by the Substance Abuse Prevention and Treatment Block Grant, U.S. Department of Health and Human

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Services, Substance Abuse and Mental Health Services Administration; funding agreements as required by the Substance Abuse Prevention and Treatment Block Grant Program as authorized by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act and Tile 42, Chapter 6A, Subchapter XVII of the United States Code; Assurances – Non-construction Programs; and List of Certifications as follows: https://www.samhsa.gov/sites/default/files/grants/fy18-19-sabg-funding-agreements.pdf.

SIGNATURES PAGE

IN WITNESS WHEREOF, DAODAS and Subgrantee, by their authorized agents, in consideration of mutual promises, covenants, and conditions exchanged between them, hereby execute this FY23 Funding and Compliance Contract.

SOUTH CAROLINA DEPARTMENT OF ALCOHOL AND OTHER DRUG ABUSE SERVICES (DAODAS)	COUNTY ALCOHOL AND DRUG ABUSE AUTHORITY (SUBGRANTEE)
Sara Goldsby, Director	Director
Date	Print Name
	Name of Subgrantee
	Date

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FY24 Funding and Compliance Contract (“Contract”) Acknowledgement Form

I, ___________________________________, Director of ____,
First and Last Name *Name of Subgrantee*

hereby confirm that I have read this Contract in its entirety and that I understand its terms. I further confirm that I have given copies of this Contract to all of my organization’s executives and key personnel (including Director, CFO, Finance Director, Compliance Officer, Prevention Director, Treatment Director, and similarly situated staff members).

____ _______________
Signature of Director Date

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ATTACHMENT A – FINANCIAL ASSESSMENT

Instructions – Financial Screening & Assessment Application - CONFIDENTIAL

If you receive public assistance (e.g., food stamps, housing), you may be eligible for financial assistance and will not need to complete this application. Please provide documentation of the public assistance you are currently receiving. If you do not receive any public assistance and think you are eligible for financial assistance, fill out this form and return it with the necessary proof of income.

Do not proceed if you have agreed to a payment plan.

NOTE: Financial assistance will not be considered without proof of income and a completed and signed application. Provide all documents listed below that apply to you, your spouse/significant other, and any legal dependents. If you cannot provide proof of income or other documents listed below, explain why under Section 4 of the application.

1. Check stubs or statement from your employer giving your monthly gross income.
2. If self-employed, a copy of your most recent quarterly Business Financial Statement along with last year's Business Tax Return.
3. Social Security eligibility letter or a copy of your Social Security check. (If you have direct deposit, provide a copy of a bank statement showing this income.)
4. Latest signed income tax return (if you are a minor, your legal guardian's tax return).
5. Proof of South Carolina residency (e.g., rental agreement, utility bill, property tax notice).
6. Proof of any other income source such as child support, alimony, trust funds, or rental property.
7. If you have not had any income for the past three (3) months, please submit:
   a. A statement from the South Carolina Department of Employment and Workforce and/or the Social Security Administration.

If you do not provide the required information or explain why this information is not available, your application might be delayed or you could be denied financial assistance.

If there are questions regarding the Financial Screening and Assessment Application, please contact:

Phone: ________________________________ E-mail: ______________________________

This application is valid for 90 days from your request for financial assistance.

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FINANCIAL ASSISTANCE APPLICATION –CONFIDENTIAL

DATE OF APPLICATION: _______________________

1. PATIENT INFORMATION* – PLEASE PRINT ALL INFORMATION – ****If you are a minor (0-17 years of age), legal guardian's information will be required***						
Patient Name (Last, First, MI)						
Patient ID#			Last 4 Digits of SSN		U.S. CITIZEN ☐ Yes ☐ No	
Date of Birth	Number of Dependents (other than self & co-applicant)		Ages of Dependents		Primary Contact - Phone ( )	
Street Address *(Do Not Provide PO Box)* ☐ Permanent Address ☐ Temporary Address		City	State	County	ZIP Code	
Current Employer		Street Address, City, State		Position		
If you are not working, how long have you been unemployed?						
2. CO-APPLICANT INFORMATION	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse / Domestic Partner ☐ Parent ☐ Other ________________________					
Name (Last, First, MI)			Last 4 Digits of SSN		U.S. CITIZEN ☐ Yes ☐ No	
Date of Birth	Number of Dependents (other than self & co-applicant)		Ages of Dependents		Primary Contact - Phone ( )	
Street Address *(Do Not Provide PO Box)* ☐ Permanent Address ☐ Temporary Address		City	State	County	ZIP Code	
Current Employer		Street Address, City, State		Position		
If you are not working, how long have you been unemployed?						

3. INCOME INFORMATION			
Monthly Income Sources	**Applicant**	**Co-Applicant**	**Combined Monthly Income**
Employment	$	$	$
Social Security	$	$	$
Disability	$	$	$
Unemployment	$	$	$
Spousal/Child Support	$	$	$
Rental Property	$	$	$
Investment Income	$	$	$

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Other:			
	$	$	$
	$	$	$
	$	$	$
		Total Combined Monthly Income	**$**

UNEMPLOYMENT: If you do not have monthly income, please explain how you take care of your monthly expenses.

4. ADDITIONAL INFORMATION & COMMENTS
(If you need more space, use the back of this page.)

5. SIGNATURES

I certify that all financial information and statements disclosed are true and accurate.

Applicant Signature	Date
Co-Applicant Signature	Date
Authorized Agency Signature*	Date

*The authorized agency official acknowledges that DAODAS is a payor of last resort. The agency official, therefore, represents that they have assessed whether the patient making this application is potentially eligible for Medicaid benefits, and, if the patient is potentially eligible, the agency official either has assisted the patient in applying for benefits or has referred the patient to the nearest county office of the South Carolina Department of Health and Human Services to apply for benefits.

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ATTACHMENT B – INCIDENT REPORTING FORM

<table>
<tr><td> </td><td>INCIDENT REPORTING FORM
SOUTH CAROLINA DEPARTMENT OF ALCOHOL AND OTHER DRUG ABUSE SERVICES</td><td>This section is to be completed by SC DAODAS
Log Number:</td></tr>
</table>

FACILITY INFORMATION	
Date/Time of Telephonic Report (if completed):	
Date/Time of Electronic Report:	
Reporting Agency Name:	
Contact Name:	
Telephone:	**E-mail Address:**

KEY PERSON INFORMATION		
Please use this section to describe the individuals involved. This may include but is not limited to staff, visitors, clients, client family members. If a client is involved, please provide CareLogic identification number, the client's age, and the client's gender.		
Number of clients directly affected by incident:		
Client Identification Number:	**Age:**	**Gender:** Male Female Other
Client Identification Number:	**Age:**	**Gender:** Male Female Other
Client Identification Number:	**Age:**	**Gender:** Male Female Other
Client Identification Number:	**Age:**	**Gender:** Male Female Other
Number of staff directly affected by the incident:		
Number of visitors directly affected by the incident:		
Witness Name(s):		

INCIDENT INFORMATION

Type of Incident:

Homicide involving clients, staff or visitors.

Death of active client (including clients discharged within the past year) or staff member.

Any elopement or unauthorized absence from a residential treatment facility.

Major injuries to clients or visitors sustained on-site.

Arrest, criminal violation, or suspected abuse, neglect, or exploitation that allegedly occurs on agency premises or involving agency staff.

Any disaster or event (e.g., fire, tornado) that substantially interferes with service delivery.

Any other major occurrence or tragic event that the director of the county authority feels should be reported.

Any sudden change in the local provider's ability to provide services.

Suspected overdose and/or naloxone administration

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Date/Time the incident occurred:
Incident Location: On-site Off-site
In what county did the incident occur?
Give a brief description of the incident including the location and naloxone distribution/administration, if appropriate.
Please select all suspected causes of death in the event of a fatality. Utilize the free response space to note other causes not listed.
Cause of death: Intentional self-harm — Assault Cardiac Event — Transport/Vehicle Accidents Other external causes of accidental injury — Infectious disease Overdose/Poisoning (accidental) — Overdose/Poisoning (intentional) Overdose/Poisoning (unknown) — Unknown
Other cause of death/Additional information:
ADDITIONAL AGENCY INVOLVEMENT
Please select all agencies/law enforcement groups that are involved: Department of Social Services — Department of Justice Probation, Parole and Pardon Services — Department of Juvenile Justice Department of Mental Health — Local Law Enforcement
Please include additional agencies not included in the selection above:
Please describe the response by the involved agencies:
POST INCIDENT FOLLOW-UP
Was the cause investigated and/or identified? Yes No
Please describe the response of the County Authority. This may include any action plan, follow-up, debriefing, reviews to be completed, steps to prevent future occurrence etc.
Has there been media involvement/interest? Yes No

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Please describe any media involvement/interest:	
By checking this box, I hereby attest that all information is accurate to the best of my knowledge.	
THIS SECTION IS TO BE COMPLETED BY DAODAS	
Agency comments:	**Check this box to flag**

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Primary Prevention Services Manual Definitions, Quality Assurance Standards, and Forms – FY24

South Carolina Department of Alcohol and Other Drug Abuse Services

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Preface

The Department of Alcohol and Other Drug Abuse Services (DAODAS) has designed these prevention quality assurance standards with the needs of all South Carolina citizens uppermost in mind; they are intended to be flexible and responsive enough to allow for the continued development and improvement of innovative prevention services.

These standards have been developed to ensure that basic requirements for providing the highest-quality prevention services to all South Carolinians are met; to ensure that organizations providing prevention services promote the health and well-being of all whom they serve; and to ensure that providers utilize an ethical code of conduct in accordance with national prevention certification criteria. The standards are intended to provide a framework for prevention program planning and service delivery.

In order to comply with these standards, all DAODAS-funded organizations providing prevention services must ensure that all locations where prevention services are conducted meet safety and Americans with Disabilities Act requirements; that prevention staffing is adequate in number and properly trained to carry out the goals/objectives of each DAODAS-funded prevention program; and that the overall philosophy, objectives, and services are responsive to the needs of those served and are consistent with the substance abuse prevention quality assurance standards contained herein.

DAODAS Mission: To ensure the availability and quality of a continuum of substance use services, thereby improving the health status, safety, and quality of life of individuals, families, and communities across South Carolina.

DAODAS Vision: DAODAS will be an innovative leader, facilitating effective services and compassionate care through a network of community partnerships and strategic collaborations.

DAODAS Strategic Visions:

- Ensure an accessible continuum of effective services within each community.
- Coordinate continuous quality improvement of services and promote service innovation.
- Lead in community engagement and interagency collaboration for the integration of physical and behavioral health services.

DAODAS Overarching Indicators:

- Reduce the state's substance use disorder prevalence rate.
- Reduce youth and young adult use of alcohol, tobacco, and other drugs.
- Reduce consequences associated with substance use.
- Increase access to a continuum of evidence-based substance use disorder services within all communities in the state.
- Reduce consequences associated with substance use:
  - Substance use-related overdose fatalities
  - Substance use-related child maltreatment
  - Substance use-related criminal justice system involvement
  - Substance use-related emergency room visits and inpatient hospitalizations
  - Impaired driving crashes and fatalities

Mission of the Prevention & Intervention Services Division: To provide support to prevent substance misuse and abuse.

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South Carolina's Prevention System Framework

South Carolina's prevention system focuses on planning, implementing, and evaluating culturally appropriate evidence-based programs, environmental strategies, and best practices that are aligned with local needs through utilization of the Strategic Prevention Framework (SPF) at the county level. Counties are supported from the state level through funding, training, and technical assistance.

South Carolina utilizes the risk and protective factor model for prevention developed by Hawkins & Catalano (1992) to identify root causes at the local level. The basis for this model is the identification of underlying conditions – personal and environmental – that contribute to or are associated with a specific problem behavior or set of behaviors, as well as conditions that mitigate the behavior(s).

This framework incorporates five spheres of influence referred to as "domains," within which these risk and protective factors operate: individual, peer, family, school, and community/society. Risk factors include biological, psychological/behavioral, and social/environmental characteristics, such as a family history of substance misuse or abuse, depression, or antisocial personality disorders; residence in neighborhoods where substance abuse is tolerated; and access to or ready availability of alcohol and other drugs. Prevention interventions seek to reduce or mitigate these factors. Protective factors include positive personal characteristics and circumstances such as family, peer, school, and community norms that do not support alcohol, tobacco, and other drug use/abuse. Prevention interventions seek to strengthen and sustain these factors.

Current research has demonstrated that a comprehensive approach is most effective in reducing risk factors and supporting protective factors within a target population. Therefore, DAODAS promotes the planning and delivery of multiple prevention strategies to multiple target populations, youth and adults, within multiple domains utilizing the SPF.

The prevention system in South Carolina also implements the Institutes of Medicine (IOM) model for prevention. This model divides the prevention category within the healthcare continuum of prevention, treatment, and maintenance into three classifications: universal, selective, and indicated interventions. Definitions of each are provided on the next page. These classifications are intended to ensure that the intensity of prevention interventions is consistent with and appropriate for the level of need within the target populations(s).

The state also funds counties to plan, implement, and evaluate prevention efforts consistent with the strategy categories developed by the federal Center for Substance Abuse Prevention (CSAP). These categories include: Information Dissemination, Education, Alternatives, Community-Based Process, Environmental, and Problem Identification and Referral. Definitions are provided on pages 7-12.

All of the state's prevention efforts are designed to promote implementation of prevention programs, strategies, and practices that have been shown by research and "best practice" to be effective in preventing substance abuse and related problems, particularly through the development of an outcome-based prevention service-delivery system.

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Definitions

Primary Prevention: Primary prevention includes all services that reduce the risk of developing a substance use disorder, or services that enhance factors that protect individuals and groups from developing substance use disorders. Programs, services, and prevention strategies are directed at individuals who have been determined not to require treatment for substance use.

Strategies may include diverse outcome work plans in the universal, selected, and indicated prevention interventions. Strategies may also focus on strengthening the host or individual who may develop these problems, reducing the availability of the agent (alcohol, tobacco, and other drugs), or modifying the environment in which these problems occur.

The primary focus of prevention strategies is on individuals, targeted high-risk groups, environmental policies and norms, and influencing behavior of persons within the community who are not patients with diagnoses. The Substance Abuse Prevention and Treatment Block Grant (SABG) requires the state to spend not less than 20% of SABG funds on a broad array of primary prevention strategies.

Comprehensive primary prevention services shall include, but not be limited to, the six CSAP strategies and the use of the IOM models of universal, selective, and indicated interventions to target populations with different levels of risk and shall be provided in a variety of settings for both the general population and targeted sub-groups.

Alcohol and Other Drugs (AOD): The term "alcohol and other drugs" includes, but is not limited to, the following substances – alcohol, tobacco (including vapes/electronic nicotine devices), illicit drugs, prescription medicines, and over-the-counter medications.

Cultural Awareness: The service-delivery systems respond to the needs of the community being served as defined by the community and demonstrated through needs assessment activities, capacity development efforts, policy, strategy and prevention practice implementation, program implementation, evaluation, quality improvement, and sustainability activities.

Evidence-Based Prevention: This includes the prevention policies, strategies, programs, and practices that are consistent with prevention principles found through research to be fundamental in the delivery of prevention services, and the prevention policies, strategies, programs, and practices that have been identified through research to be effective. The service-delivery system evaluates its policies, strategies, programs, and practices to determine effectiveness, using the evaluation results to make appropriate adjustments to service-delivery policies, strategies, programs, and practices to improve outcomes.

Work Plan: This is an outcomes-focused plan that contains goals, objectives, performance indicators, and strategies to address risk and protective factors identified by the annual community needs assessment.

Prevention Service Categories by Population Served:

> **Universal Prevention:** These services target everyone, regardless of level of risk, before there is an indication of an AOD problem.
>
> **Selected Prevention:** These services target persons or groups that can be identified as "at risk" for developing an AOD problem.
>
> **Indicated Prevention:** These services target individuals identified as experiencing a problem behavior related to AOD use to prevent the progression of the problem. The services do not include clinical assessment and/or treatment for a substance use disorder.

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Standards

National Accreditation:

As a key element for ensuring that the highest-quality prevention services are provided to all South Carolina citizens, organizations funded by DAODAS through the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) shall obtain and maintain national accreditation by either the Joint Commission or CARF International for their primary prevention programs that target children, youth/adolescents, and adults. (The SUBG is awarded by the federal Substance Abuse and Mental Health Services Administration [SAMHSA].) It is recognized that prevention services can be provided in service programs as varied as those focused on or around primary prevention, diversion/intervention, and employee assistance. Due to the SUBG requirement of a 20% set-aside for primary prevention, it is anticipated that – at a minimum – the primary prevention programs of organizations receiving funding from DAODAS through the 20% set-aside would be based on primary prevention principles and therefore would be accredited.

Staffing and Workforce Standards:

All employees (full-time or part-time) of a county alcohol and drug abuse authority who are hired to provide or coordinate prevention services supported through SAMHSA primary prevention block grant funding must comply with the workforce standards as stated below.

Any contract employee supported through SAMHSA primary prevention block grant funding to provide direct primary prevention services through the implementation of programs and strategies under the six CSAP strategies must be supervised by a full-time or part-time employee of the county alcohol and drug abuse authority that also provides primary prevention programs and services. Contract employees providing direct primary prevention services must also comply with the workforce standards as stated below.

All staff or contract employees hired with after July 1, 2006, must hold a minimum of a bachelor's degree from an accredited college or university, be certified or in the process of becoming certified as a prevention professional, and be under active and ongoing prevention mentoring.

All full- and part-time employees and contracted staff delivering primary prevention services shall have a period of 36 months from their permanent date of hire to obtain prevention certification through the South Carolina Association of Prevention Professionals and Advocates. This certification timeline allows agencies to include a probationary period, not to exceed six months, if they desire.

All prevention professionals must have a training plan for obtaining and maintaining certification. This plan must be updated annually, signed by the staff member and their supervisor, and included in the staff member's personnel file.

All prevention staff shall attend the SPF Application for Prevention Success Training (SAPST) within two years of their hire date.

Each agency shall have at least one representative attend the Prevention Quarterly Meetings that are held by DAODAS on the first Thursday (unless notified of a change by DAODAS) of the following months: August, November, February, and May.

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Agencies delivering primary prevention services shall provide an initial orientation, within 30 days of employment, for all new employees and contracted staff. The orientation shall be documented in the personnel record of the employee. The orientation shall include at least the following:

1) policies and procedures, expected codes of conduct, and expected practices for prevention staff, including use of current prevention concepts and program strategies, theory, research, and evidence-based best practice findings upon which prevention services and programs of the agency are based;
2) the philosophical approach to prevention service delivery, including the manner in which prevention reinforces and supports other agency services;
3) maintaining confidentiality of participant information, including a review of 42 CFR, Part II, and the Health Insurance Portability and Accountability Act;
4) proper maintenance and handling of participant program records;
5) procedures to follow in the event of a medical emergency or natural disaster; and
6) the employee's specific job description and job responsibilities.

Individuals employed to provide primary prevention services shall meet the minimum standards for a qualified prevention specialist as outlined in Article IV (PREVENTION) of the Fiscal Year 2024 (FY24) Funding and Compliance Contract. Each agency shall maintain and annually update a description of its agency staffing pattern, including an organizational chart showing lines of authority for prevention services.

For agencies that conduct primary prevention services, the board of directors or agency director shall designate an individual responsible for the supervision of prevention professionals and services.

Primary Prevention Standards:

Primary prevention services are based on an annual needs assessment in the local community that includes data from key stakeholders, community surveys, demographic analysis, analysis of inferential indicators, and review of individual data.

Interpretive Guidelines: The needs assessment considers ethnic, cultural, age, and gender diversity of the community. It documents and prioritizes the needs in the community. Work plan activities are targeted at the prioritized needs revealed in the assessment.

Each agency providing primary prevention services shall delineate the scope of services to be offered within each county that the agency serves through the annual Block Grant Prevention application. Such scope of services for primary prevention programs shall be approved by the agency's board of directors, and approval shall be documented in board meeting minutes.

All agencies providing primary prevention services funded by the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) Primary Prevention Set-aside shall abide by the standards set forth in this manual and/or the FY24 Funding and Compliance Contract. Primary prevention services shall be provided for the general population, as well as for youth and adults who might be at risk for substance abuse but are not necessarily in need of treatment services.

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Agencies/organizations/coalitions shall have the capability of providing services in the following six Center for Substance Abuse Prevention (CSAP) Outcome-Focused Primary Prevention Service Activities (or provide notification to DAODAS to opt out): Information Dissemination, Community-Based Process, Education, Problem Identification and Referral, Environmental, and Alternatives.

Outcome-Focused Primary Prevention Service Activities

To assist the State in fulfilling federal expectations and mandates, an agency shall demonstrate how implemented prevention service outcome-focused work plans incorporate activities that fall under each of the strategies designated by CSAP and indicated by a local needs assessment.

These outcome service activities shall be developed using the Strategic Prevention Framework (SPF), which DAODAS has adopted as its planning model. Prevention services shall follow the model for all services provided and be reflected and documented in the prevention reporting database.

If an agency is not utilizing all six CSAP strategy areas, the agency is asked to notify DAODAS regarding which strategy will not be utilized in its service area by completing and submitting to DAODAS the CSAP Strategy Checklist by the end of July. It is the responsibility of the agency to send a revised checklist to notify DAODAS if any plans change throughout the fiscal year. The notification shall state which CSAP strategy area is affected; a clear example of how the strategy is being met by another partner/organization; and/or documentation of the lack of need for the strategy to be conducted in the county based on relevant needs assessment data. The uploaded form will serve as documentation for DAODAS to incorporate in required federal reporting of the utilization of the SUBG in South Carolina.

Six CSAP Strategies:

1) *Information Dissemination*
   a) *Definition:* This strategy provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, substance use disorders, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the source to the audience, with limited contact between the two. Each agency/organization/coalition providing Information Dissemination services must provide a structured program of services consistent with the defined strategy and the identified service population(s). At a minimum, Information Dissemination shall include current legal, physiological, psychological, and pharmacological facts regarding alcohol, tobacco, and other drug use, abuse, or dependency, as well as information relevant to individuals, parents, families, schools, and communities at risk for substance abuse and related health and social problems.
   b) *Programs offered under this strategy shall meet the following standards:*
      i) Agencies providing prevention public information shall utilize Information Dissemination services to foster public attitudes and personal practices that discourage substance abuse and reduce risk factors associated with substance abuse and the health and social problems that accompany substance use disorders.

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They shall provide basic substance abuse information and how-to information regarding prevention techniques.

ii) Agencies shall use and make available current, culturally relevant, and age-appropriate written materials including, but not limited to, brochures, pamphlets, newsletters, and other appropriate print materials intended to inform individuals, families, schools, and communities about the nature and scope of AOD use, including primary prevention, intervention, and treatment services.

iii) Agencies/organizations/coalitions shall use and make available current, culturally relevant, and age-appropriate audiovisual materials including, but not limited to, films, tapes, public service announcements, and other materials concerning substance abuse primary prevention, intervention, and treatment services.

iv) Current and factual information and materials shall be made available in support of agency priorities for prevention activities.

v) Agencies/organizations/coalitions shall develop criteria for the selection and referral of knowledgeable speakers skilled in current prevention issues and topics to convey information to all levels of the service area concerning substance abuse prevention services and issues.

Agencies/organizations/coalitions conducting Information Dissemination services shall document coordination with other community resources providing prevention services.

2) *Education*

a) *Definition:* AOD prevention Education involves two-way communication and is distinguished from the Information Dissemination strategy by the fact that interaction between the educator and/or facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision making, refusal skills, critical analysis, and systematic judgment abilities. If indicated, prevention providers shall implement at least one multi-educational evidence-based educational program in each county. Examples of activities conducted and methods used for this strategy include, but are not limited to, the following: classroom and/or small-group sessions (all ages); parenting and family-management classes; education programs for youth groups; and children of substance abusers groups.

b) *Service Population:* The service population shall include, but is not limited to, persons both at risk and at high risk for substance abuse; families or friends, or both, of persons at risk for a substance abuse problem; school students and school officials; community groups mobilizing to combat substance abuse, including civic and volunteer organizations, churches, businesses, state and municipal governments, and related community organizations; or employers of persons at risk for a substance abuse problem.

c) *Service Provision:* Each provider of Education services shall maintain a culturally relevant, age-appropriate, and structured program of services consistent with the defined program content and this strategy.

d) *Programs offered under this strategy shall meet the following standards*:

i) Agencies/organizations/coalitions that provide youth education or adult education programs relative to alcohol, tobacco, and other drug (ATOD) prevention and related health and social consequences of such shall be provided by a structured

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program using evidence-based curricula concerning the prevention of ATOD abuse.

ii) Agencies/organizations/coalitions providing parenting education and family management classes, or other comparable activities, shall provide such programs to aid parents and families in reducing risk factors for substance abuse and to develop knowledge and skills to combat substance abuse within the family. Such services shall utilize current prevention research and best practices to equip parents and families to prevent or delay experimentation, and to prevent abuse and dependency.

iii) Educational resource services for parent support groups, youth groups, community organizations, and other prevention programs shall be provided in a manner consistent with current research, theory, and best practices.

iv) Structured training events, training of trainers, or community education events concerning activities conducted under this strategy shall be provided by qualified prevention staff and shall incorporate current research, theory, and best practices including youth and adult learning theory and the use of demonstrated effective training techniques.

v) All appropriate youth, parent, family, community education, and training services provided under this strategy shall be documented in program records as described in these standards.

vi) Agencies providing education services shall document coordination with other community resources providing prevention services.

3) Alternatives

a) Definition: Alternatives provide for the participation of target populations in activities that exclude ATOD use. The assumption is that constructive and healthy activities offset the attraction to – or otherwise meet the needs usually filled by – ATODs and would, therefore, minimize or obviate resort to these substances. Examples of activities conducted and methods used for this strategy include but are not limited to: community service activities; youth/adult leadership activities; and ATOD-free social and recreational events.

b) Service Population: The service population shall include, but is not limited to, persons who are at risk for ATOD use or abuse; families or friends (or both) of persons at risk for a substance abuse problem; school students and school officials; community groups mobilizing to combat substance abuse, including civic and volunteer organizations, churches, businesses, state and municipal governments, and related community organizations; or employers of persons at risk for a substance abuse problem.

c) Service Provision: Each provider of Alternative services shall maintain a culturally relevant, age-appropriate, and structured program of services consistent with the defined program content and this strategy.

d) *Programs offered under this strategy shall meet the following standards:*

i) Each provider conducting programming under the Alternatives strategy shall develop a plan that describes the ongoing and structured activities and events that will provide the opportunity for youth and adults to participate in programs and activities that specifically exclude the use of alcohol, tobacco, and other drugs. These shall include strategies for providing structured activities over a specified

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period of time to individuals or groups identified as subject to specific risk factors for substance abuse.

ii) Prevention technical assistance and support services conducted for ATOD-free social and recreational events and activities shall incorporate current research, theory, and best practices.

iii) Structured training events, training of trainers, or community education events concerning Alternative activities shall be provided by a qualified prevention specialist and shall incorporate current research, theory, and best practices, including learning theory and use of demonstrated effective training techniques.

iv) Community drop-in center services operated under this strategy shall provide posted hours of operation and supervision by staff or volunteers who have received training in the management of the center; shall have written and posted rules and regulations governing the conduct of persons participating in center activities; and shall have a structured program of activities and events intended to offer youth or adults a gathering place free of ATOD use.

v) Agencies/organizations/coalitions providing Alternative programs shall document coordination with other community resources to provide prevention services.

4) *Problem Identification and Referral*

a) *Definition:* The Problem Identification and Referral strategy aims to identify those who have indulged in illegal/age-inappropriate use of tobacco or alcohol, and those who have indulged in the first use of illicit drugs, in order to assess whether their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment. Examples of activities conducted, and methods used for this strategy include but are not limited to employee assistance programs, student assistance programs, and tobacco education programs.

b) *Service Population:* The service population shall include, but is not limited to, persons who are at risk for substance abuse; families or friends (or both) of persons at risk for a substance abuse problem; school students and school officials; community groups mobilizing to combat substance abuse, including civic and volunteer organizations, churches, businesses, state and municipal governments, and related community organizations; or employers of persons at risk for a substance abuse problem.

c) *Service Provision:* Each provider conducting Problem Identification and Referral services shall develop a schedule of ongoing, culturally relevant, age-appropriate, and structured activities appropriate to the defined program content.

d) *Services under this category shall meet the following standards:*

i) Agencies/organizations/coalitions conducting employee assistance programs shall provide relevant activities such as training and consultation, provision of written materials or other literature, and group discussion and information about prevention or treatment resources to assist persons for whom ATOD abuse may be interfering with their employment.

ii) Providers of tobacco education programs must meet standards to be determined by state law.

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iii) Agencies/organizations/coalitions conducting Problem Identification and Referral services shall document coordination with other community resources that are providing prevention services.

5) *Community-Based Process*
   a) *Definition:* The Community-Based Process strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for ATOD use disorders. This strategy provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of service implementation, interagency collaboration, coalition building, and networking. Examples of activities conducted and methods used for this strategy include but are not limited to: accessing services and funding, community teams/coalitions, community team activities, and training/technical assistance for coalitions.
   b) *Service Population:* The service population shall include, but is not limited to, persons at risk for substance abuse; community groups mobilizing to combat substance abuse, including civic and volunteer organizations; and churches, schools, businesses, state and municipal governments, and related community organizations.
   c) *Service Provision:* Each provider shall conduct Community-Based Process activities that are structured, that document specific services provided related to the defined program content, and that demonstrate community mobilization and community coordination.

   Agencies conducting Community-Based Process services shall meet the following standards:

   i) Structured community mobilization or community development services shall be based on current research, theory, and best practices. Such services shall be for the purpose of meeting the defined program content and the intent of this strategy.
   ii) Agencies/organizations/coalitions providing community mobilization services shall develop policies and procedures for recruiting and training coalition or task force members.
   iii) Training shall be provided by a qualified prevention specialist and shall reflect current prevention theory, research, and best practices, in particular as they pertain to community mobilization activities as described under this strategy and in these standards.
   iv) Program records shall document the provision of at least an annual orientation for coalition members to maintain their knowledge of current prevention theory, research, and best practices, particularly as they pertain to community mobilization activities.
   v) Coalitions shall develop and document an annual program plan that identifies the priority prevention activities and programs for that coalition.
   vi) Agencies/organizations/coalitions shall conduct and document evaluation of community mobilization activities based on their program plan, and shall include programs and activities undertaken, including process and outcome measures for those programs and activities.

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- *vii)* If appropriate, agencies/organizations/coalitions conducting community mobilization activities shall develop written policies and procedures relative to the recruiting and hiring of staff qualified in current community mobilization techniques and strategies.
- *viii)* Agencies/organizations/coalitions conducting prevention technical assistance services shall provide for the development, maintenance, and enhancement of the substance abuse-related efforts of community organizations and individuals involved in substance abuse programming.
- *ix)* Agencies/organizations/coalitions conducting prevention technical assistance services shall provide services that are designed to increase the effectiveness of other change agents to influence individuals, families, schools, and communities to make appropriate decisions regarding substance abuse.
- *x)* Agencies/organizations/coalitions shall document all technical assistance contacts and activities according to recordkeeping requirements described in the standards.
- *xi)* Agencies/organizations/coalitions conducting Community-Based Process services shall document coordination with other community resources to conduct prevention activities in the community served.

6) *Environmental*

- *a)* *Definition:* The Environmental strategy establishes or changes 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. This strategy is divided into two subcategories to permit distinction between activities that center on legal and regulatory initiatives and those that relate to the service and action-oriented initiatives. Two subsets of this strategy include Changing Institutional or Organizational Policies and Changing Law Enforcement and Regulatory Attention to ATOD use. Examples of activities conducted and methods used for this strategy shall include but are not limited to: preventing underage sale of tobacco and tobacco products; preventing underage alcoholic beverage sales and social access to alcohol; establishing and implementing ATOD-free policies; changing environmental codes, ordinances, regulations, and legislation; and public policy efforts, which might include influencing enforcement of laws.
- *b)* *Service Population:* The service population shall include, but is not limited to, persons at risk for substance abuse; community groups mobilizing to combat substance abuse, including civic and volunteer organizations, churches, schools, businesses, and state and municipal governments; and related community and youth organizations.
- *c)* *Service Provision:* Each agency/organization/coalition conducting Environmental services shall provide structured activities consistent with the defined program content and this strategy.
- *d)* *Providers of Environmental strategies shall meet the following standards:*
  - *i)* Agencies/organizations/coalitions providing environmental consultation and resources to inform and advise ATOD policies in schools, businesses, and other community organizations shall reflect current research, theory, and evidence-based best practices.

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ii) Agencies/organizations/coalitions shall be equipped to provide technical assistance to community organizations or coalitions that have Environmental strategies within their program plans.

iii) Agencies/organizations/coalitions providing services to educate or inform vendors of alcohol or tobacco products relative to sale of such to minors shall provide information as stated in South Carolina law. Agencies must submit documentation of the required forms used to implement the Palmetto Retailers Education Program (PREP) intended to reduce the sale of alcohol or tobacco products to underage youth.

iv) Agencies/organizations/coalitions providing public policy campaigns intended to impact environmental efforts shall develop such campaigns to reflect current prevention theory, research, and best practices.

v) Agencies/organizations/coalitions providing services under the Environmental strategy shall document coordination of such services with other community prevention activities.

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Prevention Priorities

1) *Target Priority Areas:* Through the utilization of the Strategic Prevention Framework (SPF) model, South Carolina has identified the following priority areas being addressed throughout the state utilizing the SUBG Primary Prevention Set-aside funding:
   a) Reducing underage alcohol use and the consequences of use;
   b) Reducing alcohol-related car crashes (including youth crashes);
   c) Reducing youth tobacco use (including smokeless tobacco use and vaping); and
   d) Preventing substance misuse and substance use disorder and improving the well-being of youth and families in South Carolina.

2) *State Priority Areas:* The following goals with associated outcomes have been established by the state as priorities for use of the SUBG Primary Prevention Set-aside funding. The priorities were selected based on a comprehensive needs assessment process and should be considered at the local level in order for the state to achieve outcomes for South Carolina:
   a) *Priority Substance: Alcohol (Required)*
      i) Goal 1: To reduce underage alcohol use in South Carolina.
         (1) Objectives:
            (a) Decrease past-month alcohol use (30-day use) among South Carolina high school students to 30% or less.
            (b) Reduce the underage alcohol buy rate for the state of South Carolina to 12%or less.
      ii) Goal 2: To reduce alcohol-related car crashes in South Carolina.
         (2) Objective:
            (a) Decrease the percentage of motor vehicle fatalities in which one or more drivers had a blood alcohol concentration (BAC) of 0.08% or higher to 40% or less.
         (3) Outcomes: In order for South Carolina to work toward achieving these goals, the agency shall have a work plan targeting alcohol if indicated by the agency's needs assessment. The work plan shall address the state goals outlined above to include local outcomes related to reducing underage alcohol use and alcohol-related crashes. County needs assessment data shall be utilized along with the information above to develop goals, objectives, and indicators at the local level that will link to the state targets outlined above. Agency shall implement evidence-based prevention programs, policies, and/or practices that reflect the utilization of the CSAP strategy areas for primary prevention. At a minimum, outcome plans should include the following evidence-based environmental prevention strategy to address youth access from retail sources: alcohol compliance checks (to include information dissemination and merchant education). These plans will be coordinated in collaboration with the judicial circuit's Alcohol Enforcement Team Coordinator for the county. DAODAS reserves the right to ask for an alcohol work plan if one is not submitted, and if the State needs assessment data, so indicate. Alcohol outcome plans that are submitted must be completed. Technical assistance will be provided upon request by DAODAS.

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b) *Priority Substance: Tobacco (Required)*
   i) Goal: To reduce tobacco use among youth in South Carolina.
      (1) Objectives:
         (a) Reduce the state Retailer Violation Rate (RVR) to 10% or less.
         (b) Reduce past-month tobacco use (30-day use) among South Carolina high school students to 15% or less.
   ii) Outcomes: In order for South Carolina to work toward achieving these goals, the agency shall have an outcome work plan targeting tobacco. This outcome work plan must be incorporated into the annual county plan. At a minimum, the plan should address the state goals outlined above, to include local outcomes related to reducing underage tobacco use. County needs assessment data shall be utilized along with the information above to develop goals, objectives, and indicators at the county level that will link to the state targets outlined above. The agency shall implement evidence-based prevention programs, policies, and/or practices that reflect the utilization of the CSAP strategy areas for primary prevention. The tobacco plan should also address the Synar regulation of the SUBG funding that must be implemented at the state and local levels as outlined by CSAP. The Synar requirements are as follows:
      (1) Enact laws prohibiting any manufacturer, retailer, or distributor of tobacco products from selling or distributing such products to any individual younger than age 18 (State).
      (2) Enforce these state laws (State and Local).
      (3) Conduct annual, unannounced inspections that provide a valid probability sample of tobacco sales outlets accessible to those under 21 (Synar Study) (Federal).
      (4) Maintain a noncompliance rate of no more than 20% (State and Local).
      (5) Submit an annual report detailing activities to enforce the law (State). Using the SPF planning model, the outcome-focused plans must include prevention strategies to address the local contributing factors related to underage tobacco use and access to tobacco. At a minimum, outcome plans shall include the following evidence-based environmental prevention strategy to address youth access from retail sources: tobacco compliance checks (to include information dissemination and merchant education). The representative of the agency conducting the study shall attend the required training and carry out the study following the guidelines provided by DAODAS. The agency must follow the guidelines provided by DAODAS to ensure fidelity of the study. The agency shall report to DAODAS the results of the Youth Access to Tobacco Study by the published deadline in order to be reimbursed for the cost incurred by the agency in completing the annual study. The agency may also submit tobacco plans outside the Synar-required tobacco outcome plan as needs assessment indicates.

c) *Priority Substance: Marijuana, Prescription Drugs, Heroin, Cocaine, Synthetic Drugs*
   i) Goal: To provide primary prevention programs and practices to prevent substance misuse and substance use disorder and improve the well-being of youth and families in South Carolina.

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(1) Objectives:
(a) To ensure that 95% or more of the participants served in primary prevention educational programs will be served using evidence-based universal, selected, and indicated programs.
(b) To reduce the percentage of South Carolina high school students reporting the use of any substance in the past 30 days to 45% or less.

ii) Outcomes: In order for South Carolina to work toward achieving these goals, the agency may have work plan(s) targeting other substances as outlined above, and as indicated by the local needs' assessment. The work plan(s) shall address the state goals outlined above, or other local goals, and include local outcomes related to a reduced number of high school students reporting the use of any other substance. County needs assessment data should be utilized along with the information above to develop goals, objectives, and indicators at the county level that will link to the state targets outlined above. The agency shall implement evidence-based prevention programs, policies, and/or practices that reflect the utilization of the CSAP strategy areas for primary prevention.

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Alcohol Enforcement Team (AET)

1) *Definition:* The AET Coordinators shall collaborate with the prevention coordinators and law enforcement partners in each county located in the circuit 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 of reducing underage alcohol use on the state and local levels.

2) *Special Conditions:* One county alcohol and drug abuse authority will receive the funds and oversee coordination of an AET's efforts throughout the judicial circuit. The county authorities in each circuit will support the agency that takes the lead, although every county will be served by this effort. The lead agency will be expected to maintain the AET Coordinator's position. The lead agency only will enter into agreements with law enforcement agencies in the circuit. While the lead agency only employs or contracts with an AET Coordinator, the AET Coordinator should be viewed as serving the entire circuit equally. Lead agencies that are the fiscal agents for this funding are expected to coordinate work with efforts in their partner county/counties that participate in the AET initiative. For that purpose, all county authorities in the circuit shall sign the Agency Commitment Form. The lead agency and other county authorities will follow guidelines for allowable/unallowable costs as outlined on the "AET Allowable-Unallowable Cost" form.

3) *Reporting Requirements*
   a) DAODAS calls for reporting through the required Grants Management System (GMS) for all prevention strategies implemented by the AETs at the local, county, and circuit levels. It is the responsibility of the AET Coordinator to ensure all prevention strategies are reported for the circuit for each county through the GMS. Data can be entered by law enforcement partners, prevention partners, and/or the AET Coordinator in each county's reporting system. The process for "who is entering what" at a local level should be discussed and documented at the beginning of the fiscal year. The AET Coordinator should have access to all of the data entry points for each county and should ensure that all data is entered accurately by the eighth working day of the month for the previous month's activities. Agencies are required to use the online reporting system for all prevention strategies implemented by the AETs in all counties throughout the circuit for the previous month.
   b) The AET Coordinator shall collaborate with the prevention coordinator for each county authority served through the circuit to either obtain a log-in for the GMS to enter data directly or ensure that all data is provided to the local prevention coordinators for county data entry into the GMS. The lead agency shall supply adequate computers and internet access to allow staff to submit data to the GMS in a timely manner. Minimal standards for timeliness are monthly entry of all data, with reporting completed by the eighth working day of the following month. If there is a need for an extension for data entry, a request shall be made by the agency to the state prevention manager at least five business days in advance of the deadline.
   c) Correct percentage of time for the AET Coordinator shall be reflected in each county's GMS, and the AET Coordinator shall report service hours to reflect that percentage each month in the GMS.

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d) DAODAS prevention staff will provide feedback on any data entry. If there is a requirement to resubmit or edit information for the circuit, the county authority shall comply with the deadline. If requirements are not met, DAODAS maintains the authority to withhold reimbursement, require technical assistance, and/or place county authorities on County Assistance Plans until issues are resolved.

e) Minimum standards for accuracy of monthly data entered into the GMS are as follows:

- *i)* correct application of service categories (direct vs. indirect) and populations served;
- *ii)* required monthly documentation of service hours for any organizational member or volunteer who is providing prevention services;
- *iii)* demographics of people served in prevention services as required for federal reporting; and
- *iv)* appropriate documentation of funding and reporting to ensure compliance.

f) It is the responsibility of the AET Coordinator to work with each county authority's prevention coordinator in their circuit on the development of outcome work plans for each county that reflect strategies around the target substance of alcohol. The AET Coordinator shall assist county authorities in documenting the coordinated outcome work plans in the GMS.

g) Prevention forms, templates, etc., can be accessed at http://ncweb.pire.org/scdocuments.

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Mandatory Prevention Reporting Requirements

Primary prevention services will submit all service activity information to the Grants Management System (GMS) in accordance with the guidelines outlined by DAODAS. The GMS will be used by DAODAS to collect the required prevention information to meet the reporting requirements for the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG). These reporting requirements are established by the Substance Abuse and Mental Health Services Administration (SAMHSA) and are used to accomplish its vision across the United States. The requirements are as follows:

1) Agency shall supply adequate computers and internet access to allow all prevention staff to submit data to the GMS in a timely manner.
2) Any employee or contracted staff partially or fully funded through the SUBG Primary Prevention Set-aside is to be entered as a staff person with their funding allocations correctly reported in the GMS.
3) All prevention personnel funded through the SUBG Primary Prevention Set-aside (regardless of percentage of salary funded) are required to enter direct and indirect service hours into the reporting system each month. The percentage of staff time entered is expected to be direct/indirect service time in order to accomplish each agency's goals/objectives that have been set for primary prevention. Each agency is required to complete the Prevention Staffing Capacity Plan and send it to DAODAS by the end of July each year. It is the responsibility of the agency to send to DAODAS a revised Prevention Staffing Capacity Plan if there are any personnel changes, staff funding changes, etc., that occur throughout the fiscal year. Quarterly reviews of the reporting system will be based on the Prevention Staffing Capacity Plan submitted by the agency and approved by DAODAS. If staff funded through the SUBG Primary Prevention Set-aside are not reporting into the GMS as indicated in the approved plan, DAODAS maintains the authority to withhold reimbursement, require technical assistance, and/or place the county authority on a County Assistance Plan until the issues are resolved.
4) Each prevention staff member funded under the SUBG Primary Prevention Set-aside shall enter data by the end of each week. However, minimal standards for timeliness are that all data must be entered monthly, with reporting complete by the eighth working day of the following month. If there is a need for an extension for data entry, a request shall be made by the agency to the DAODAS Manager of Prevention and Intervention Services at least five business days in advance of the deadline.
5) DAODAS prevention staff will provide feedback on GMS data entry. If there is a requirement to re-submit or edit information for the county, the county authority shall comply with the deadline. If requirements are not met, DAODAS maintains the authority to withhold reimbursement, require technical assistance, and/or place the county authority on a County Assistance Plan until the issues are resolved.
6) Minimum standards for accuracy of monthly data entered into the GMS are as follows:
   a) correct application of service categories (direct vs. indirect) and populations served;
   b) required monthly documentation of service hours for any organizational member or volunteer who is providing prevention services;

   c) demographics of people served in prevention services as required for federal reporting;
   d) appropriate documentation of funding and reporting to ensure compliance.

7) Agency shall appropriately document funding and report to ensure compliance.

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Evaluation

Prevention providers are required to use the DAODAS Standard Survey *(provided separately)* as an evaluation tool for any multi-session education program aimed at youth ages 10 to 20. This applies to research-based and non-research-based programs. Program exceptions for the use of the DAODAS Standard Survey are noted and defined in the South Carolina Prevention Evaluation Handbook. There is a paper and online version of the survey available.

The DAODAS Standard Survey pre-/post-test must be submitted to DAODAS at the conclusion of a program. Minimum standards are as follows:

1) Starting in Fiscal Year 2020, deadlines were modified to better accommodate school schedules and to allow more time to prepare for paper survey submissions. However, it is recognized that some implemented prevention programs using the DAODAS Standard Survey may not easily fit the modified submission deadlines described below. Any organization utilizing the DAODAS Standard Survey that determines this to be the case is asked to send an e-mail to prevention@daodas.sc.gov to notify DAODAS as quickly as possible so that a meeting can be facilitated with the state prevention evaluation contractor. All prevention programs using the DAODAS Standard Survey that are administered January-May are required to submit their data to DAODAS by the published date in June.
2) All educational programming (curriculum-based) provided to youth between the ages of 10 and 20 must administer the DAODAS Standard Survey to participants prior to starting the curriculum and upon completion of the curriculum.
3) All counties implementing alcohol and/or tobacco environmental strategies in conjunction with law enforcement must complete the required data reporting forms in the DAODAS web-based reporting system. All service data related to the process data collected must be entered into the GMS.
4) All counties must implement the Synar tobacco survey following the timelines and guidelines provided by DAODAS.
5) All prevention service data must be entered into the GMS following the guidelines provided by DAODAS.
6) All PREP merchant education test scores, sign-in sheets, and fidelity tracking forms must be submitted to DAODAS following the provision of the service.

Prevention forms, templates, etc., can be accessed at http://ncweb.pire.org/scdocuments.

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Prevention Forms

NOT FINAL

FY24 Prevention Work Plan Requirement Checklist

Primary Prevention/Education Program (PREV-CG),
Cost Center Code 8001
Requirements

(Six CSAP Strategy Areas)

- ☐ Work Plan in Prevention Reporting System or Letter for Information Dissemination Strategy Area
- ☐ Work Plan in Prevention Reporting System or Letter for Evidence-Based Education Strategy Area
- ☐ Work Plan in Prevention Reporting System or Letter for Environmental Strategy Area
- ☐ Work Plan in Prevention Reporting System or Letter for Alternatives Strategy Area
- ☐ Work Plan in Prevention Reporting System or Letter for Community-Based Process Strategy Area
- ☐ Work Plan in Prevention Reporting System or Letter for Problem Identification/Referral Strategy Area

If an agency is not implementing all six strategy areas from CSAP, the agency is asked to notify DAODAS in writing. The letter should state which CSAP strategy area is affected; provide a clear example of how the strategy is being met by another partner/organization; and/or document the lack of need for the strategy to be conducted in the county based on relevant needs assessment data. The letter will serve as documentation that DAODAS can incorporate in required federal reporting on use of the Substance Use Prevention, Treatment, and Recovery Services Block Grant in South Carolina.

This completed checklist and letter should be uploaded in Box Enterprise following the instructions below:

The six CSAP strategies are as follows:

- **Information Dissemination** – This strategy provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the source to the audience, with limited contact between the two.
- **Education** – This strategy builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental abilities. There is more interaction between facilitators and participants than in the information strategy. If indicated, prevention providers should implement at least one multi-educational evidenced-based educational program in each county.
- **Alternatives** – This strategy provides participation in activities that exclude alcohol and other drugs. The purpose is to meet the needs filled by alcohol and other drugs with

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healthy activities, and to discourage the use of alcohol and other drugs through these activities.

- **Problem Identification and Referral** – This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess whether their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment.
- **Community-Based Process** – This strategy provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning.
- **Environmental** – This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing alcohol and other drug use by the general population.

NOT FINAL

Prevention Staffing Capacity Plan FY24

***Due July 17, 2023, in GMS**

As required by the Fiscal Year 2024 (FY24) Funding and Compliance Contract between DAODAS and each county alcohol and drug abuse authority, any employee partially or fully funded through the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) Primary Prevention Set-aside is required to be entered as a staff person, with their funding allocations correctly reported, in the DAODAS web-based Prevention Reporting System. All prevention personnel funded through the SUBG Primary Prevention Set-aside (regardless of percentage of salary funded) are required to enter direct/indirect service hours in the Prevention Reporting System each month. The majority, 50% or more, of staff time entered is expected to be direct/indirect service time in order to accomplish each agency's goals/objectives that have been set for primary prevention. Each agency is required to complete the Prevention Staffing Capacity Plan and upload the completed plan in GMS by 7/17/2023.

It is the responsibility of the agency to revise the Prevention Staffing Capacity Plan and upload the revised document into the GMS throughout the year. Agencies are to complete the notification and plan change within five (5) business days of a new position hire/change in SUBG or other DAODAS-funded prevention staff positions as stated in the FY24 Funding and Compliance Contract. (Article IV Prevention Services 1b).

Quarterly data reviews will be based on the Prevention Staffing Capacity Plan submitted by the agency and approved by DAODAS. If staff funded through the SUBG Primary Prevention Set-aside are not reporting in the web-based system on the approved plan, DAODAS maintains the authority to withhold reimbursement, require technical assistance, and/or place the county authority on a County Assistance Plan until the issues are resolved.

Agency: ____

County/Counties Served: ______________________________________

Facts by County/Counties Served: Please provide the information requested for each county the agency serves.

Population Estimates July 1, 2021 (US Census) https://www.census.gov/quickfacts/fact/table/SC,US	**# of Schools/ School Districts**	**Municipalities (list)**	**# of Colleges/ Universities/ Technical Colleges**	**Land Mass (square miles)**

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SYNAR:

Synar Coordinator Name: ____

E-mail: ____

Back-up Coordinator Name: ____

Email: ____

PREP:

PREP Trainer(s)

Name: ____

E-mail: ____

Date of Certification: ____

Name: ____

E-mail: ____

Date of Certification: ____

Name: ____

Email: ____

Date of Certification: ____

Primary Prevention Work Plan CSAP Strategy Checklist:

If an agency is not utilizing all six CSAP strategy areas, the agency is asked to notify DAODAS in writing regarding which strategy will not be utilized in its service area by completing and submitting to DAODAS the FY24 Prevention Capacity Plan and uploading the exemption letter into GMS. The notification letter shall state the following: which CSAP strategy area is affected; a clear example of how the strategy is being met by another partner/organization; and/or documentation of the lack of need for the strategy to be conducted in the county based on relevant needs assessment data. The uploaded exemption letter will serve as documentation for DAODAS to incorporate in required federal reporting of the utilization of the SUBG in South Carolina. It is the responsibility of the agency to upload a revised capacity plan and/or exemption letter to notify DAODAS if any plans change throughout the fiscal year.

NOT FINAL

Strategy	Work Plan to Address in FY24	Exemption Letter for FY24
Information Dissemination		
Education		
Environmental		
Alternatives		
Community-Based Process		
Problem Identification and Referral		

Prevention Staff Capacity by Staff Member*:

**Note about staff who provide prevention services in multiple counties: <u>Complete one row per staff member for each county that he/she serves to show the anticipated level of effort per county</u>. For example, the FTE, total number of hours in the reporting system, and strategies/programs for a staff member who works in both Sunny County and Rainy County will be recorded on two separate lines – line 1 for Sunny County and line 2 for Rainy County.*

Staff Member Name	% FTE Supported Through SUBG Primary Prevention Set-Aside (including AET)	% FTE Supported Through Other Funds (DFC, PFS, local, etc.)	Total # of Hours (based on % FTE supported through SUBG for direct and indirect services) Recorded in Prevention Database Per Month/County	Strategies/ Programs Staff Member Will Implement in FY24/County

Partners/Volunteers Agency Is Planning to Work With in FY24 to Implement Strategies/Programs:

Partner Agency/Volunteer	Strategies/Programs the Partner Will Provide Implementation Assistance for in FY24/County

NOT FINAL

Alcohol Enforcement Teams (AET):

One county alcohol and drug abuse authority will receive the funds and oversee coordination of an AET's efforts throughout the judicial circuit. The county authorities in each circuit will support the agency that takes the lead, although every county will be served by this effort. ***The lead agency will be expected to maintain the AET Coordinator's position.*** The lead agency only will enter into agreements with law enforcement agencies in the circuit. While the lead agency only employs or contracts with an AET Coordinator, the AET Coordinator should be viewed as serving the entire circuit equally. Lead agencies that are the fiscal agents for this funding are expected to coordinate work with efforts in their partner county/counties that participate in the AET initiative. For that purpose, all county authorities in the circuit shall sign the Agency Commitment Form. The lead agency and other county authorities will follow guidelines for allowable/unallowable costs as outlined on the "AET Allowable-Unallowable Cost" form.

The following should be completed by the lead agency in the circuit. If your agency is not the lead agency, please only complete the AET Commitment section.

AET Coordinator Name: ____

E-mail: ____

Type of Employment:

Employee _______ percentage of time dedicated to AET ________

Contractual ______ # hours per month contracted to work with AET __________

Law Enforcement Participation

Complete the table below. Please list all law enforcement agencies in your circuit (county, town, college/university municipalities, etc.) by county (add/delete lines as needed). Indicate the estimated amount of funding that they may receive via contract for achieving AET milestones.

LE Agency	Estimated \$ Contracted for Achieving Enforcement Milestones	Other Incentive Received for AET Activities (in-kind or other revenue sources)	Signed on to Participate for FY24 with MOA/MOU	Agree to Participate in AET for FY24 but No Formal Agreement in Place

LE Agency	Estimated $ Contracted for Achieving Enforcement Milestones	Other Incentive Received for AET Activities (in-kind or other revenue sources)	Signed on to Participate for FY24 with MOA/MOU	Agree to Participate in AET for FY24 but No Formal Agreement in Place

AET Agency Commitments – Please complete and sign the section that applies to your agency below:

LEAD COUNTY AUTHORITY AGREEMENT

As the lead agency, we will:

- Hire or contract for an AET Coordinator who will serve all counties in the judicial circuit, working with other county authorities' staff as appropriate.
- Be responsible for overall coordination of the AET, including providing financial and service information to DAODAS.
- Ensure that the circuit is represented at **all** State Bi-Monthly AET Coordinator meetings during FY24. Coordinators should remain until the close of the meeting. These meetings will be scheduled to occur in July, September, November, January, March, and May. The meetings will.be held in Columbia or via Zoom. **Failure of the circuit to have a representative present at 75% of the meetings (4 out of the 6) can result in a decrease in the circuit's level of AET funding available for the upcoming fiscal year.**
- At a minimum, facilitate quarterly meetings with county prevention directors/staff and law enforcement throughout the circuit. It is encouraged for the purpose of communicating successes and challenges of the AET activities in the circuit that these meeting may include other partners such as law enforcement representatives, solicitor's office representatives, members of the judicial community, city or local government leaders, and other community stakeholders. **Evidence of these meetings will include meeting agendas and notes submitted within the GMS as appropriate. Failure of the circuit to hold at minimum 4 meetings throughout the fiscal year can result in a decrease of the circuit's level of AET funding available for the upcoming fiscal year.**

Agency Director Signature: ______________________________ Date: _____________________

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OTHER COUNTY AUTHORITY AGREEMENT:

Our agency will:

- Support the overall success of the AET and ensure that strategic plans submitted are based on local county needs assessment data and align with the strategic plans entered into the prevention database or the county/counties served by our agency.
- Communicate with the AET Coordinator to ensure all AET service data is available and accurately reported in the DAODAS Prevention Portal and to DAODAS (as requested) through other reports/forms.
- Collaborate with the AET coordinator to ensure adequate effort in all circuit counties.
- Ensure that the agency prevention director/staff will participate in all AET meetings held in the circuit throughout the fiscal year

Agency Director Signature: ____________________________ Date: ____________________

Additional Comments:

____

____

____

____

Submitted by: ____________________________ Date: ____________

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FY24 Prevention Specialist Training Plan

Instructions: Please select or enter a response to each item to indicate the training plan for the prevention staff member during the fiscal year.

Organization: ____

Staff Name: ____

Date of Hire: _____________________

Certification Status: ____

THIS SECTION TO BE COMPLETED BY IN-PROCESS STAFF*

Type of certification in-process to receive	❑ CPS ❑ CSPS
Date certification file opened to be in process	
Date certification process must be completed	
Percentage of training hours completed	
Percentage of supervision hours completed	
Required prevention ethics training completed	❑ Yes ❑ No
SPF Application for Prevention Success Training (SAPST) completed	❑ Yes ❑ No If "Yes," Date: __________

**Certified Prevention Specialists who are in the process of becoming a Certified Senior Prevention Specialist also need to complete this section.*

THIS SECTION TO BE COMPLETED BY CERTIFIED STAFF

Type of certification held	❑ CPS ❑ CSPS
Date of certification	
Re-certification due date	
Percentage of training hours completed	
Required prevention ethics training completed	❑ Yes ❑ No
Date SPF Application for Prevention Success Training (SAPST) completed	

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THIS SECTION TO BE COMPLETED BY ALL STAFF

Instructions: Use the table below to indicate the training needs of the staff member in order of priority. Feel free to use fewer rows than included or to add rows as needed.

#	Training Topic	Benefit of Participation	Estimated Completion Date

Additional Notes:

____

____

____

____ ______________
Staff Signature Date

____ ______________
Supervisor Signature Date

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

State Agency:

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

DAODAS is a cabinet-level agency, with its Director nominated by the state's Governor and confirmed by the South Carolina Senate.

Service System of County Alcohol and Drug Abuse Authorities:

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

Each county authority is licensed by the S.C. Department of Health and Environmental Control and accredited by CARF International or the Joint Commission. Licensing and credentialing of substance use disorder counselors is regulated by state statute. This includes the requirement for certification of treatment counselors by Addiction Professionals of South Carolina and of prevention professionals by the S.C. Association of Prevention Professionals and Advocates. There are no financial intermediaries between DAODAS and the county authorities, nor are there separate child and adult systems. DAODAS and the county authorities' leaders have a strong relationship and work closely to optimize the efficiency and effectiveness of services.

DAODAS reviews and approves the county authorities' yearly priorities through county plan submissions, which aid in the collection of information able to describe county-level need and local provider efforts. These plans are structured according to the Strategic Prevention Framework (SPF) and focus on communicating county-level initiatives that influence priorities included in the state's SUBG application. The county authorities identify their priorities with multiple data sources and with input from local surveys, focus groups, advisory councils, and/or political entities that oversee them (either county governments or specially appointed commissions). All county authorities are required to address each of the six CSAP-established primary prevention strategy areas or to submit a waiver letter stating that a specified CSAP prevention strategy is being implemented by another entity in the county authority's service

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catchment area. A state team reviews the plans for identification of statewide priorities. Approval is granted by the DAODAS Director.

Primary Prevention:

Primary prevention is a priority for South Carolina and DAODAS, as demonstrated by the comprehensive nature of the state's prevention infrastructure and the diverse funding streams for prevention, including both state and federal funding. DAODAS will continue to spend a minimum of 20% set aside from the SUBG to ensure that alcohol, tobacco, and other drug primary prevention services are available throughout the state's 46 counties. DAODAS also receives a small amount of general state revenue that is earmarked for prevention and utilized by the local providers for general primary prevention services.

Each county authority submits a county plan at the beginning of the state fiscal year to DAODAS for approval. The county plan encapsulates the SPF approach and primary prevention services – as indicated by local needs assessment – are included in the county plans. To assist the State in fulfilling federal expectations and mandates, counties demonstrate, by utilizing the SPF, how primary prevention service activities that are outcome focused fall under each of the six strategies designated by CSAP – Information Dissemination, Education, Alternatives, Problem Identification and Referral, Community-Based Process, and Environmental.

Technical assistance is provided to county authorities by DAODAS and contracted vendors to broaden the understanding and build the capacity of the workforce throughout the continuum to utilize the SPF. Regional or multi-county trainings are conducted on topics such as community mobilization, evidence-based practices, integrating services throughout the continuum of care, the SPF process, grant writing, and coordinating/facilitating study groups for certification/credentialing purposes.

Treatment:

The 31 contracted county alcohol and drug abuse authorities provide the following core services in each of the 46 counties: traditional group, individual, and family outpatient counseling, to include the post-discharge period; Alcohol and Drug Safety Action Program (ADSAP) *(described in more detail below)*, which is the state's program for Driving Under the Influence (DUI) offenders; youth and adolescent services; primary prevention/education programs; and gambling addiction services.

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

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- **ASAM Level 0.5. Early Intervention Services**
  - Alcohol and Drug Safety Action Program (ADSAP)
  - Screening, Brief Intervention, and Referral to Treatment (SBIRT)
  - Offender-based intervention

- **ASAM Level 1. Outpatient Services**
  - The Bridge program
  - Gambling addiction services
  - Educational individual and group counseling
  - Youth and adolescent services

- **ASAM Level 2. Intensive Outpatient Services**
  - Intensive outpatient group treatment
  - Day treatment

- **ASAM Level 3. Inpatient Services**
  - Withdrawal management (social and medical)
  - Halfway housing
  - Inpatient treatment
  - Residential treatment

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Recovery Support:

DAODAS fully embraces SAMHSA's identified Guiding Principles of Recovery:

- There are many pathways to recovery.
- Recovery is self-directed and empowering.
- Recovery involves a personal recognition of the need for change and transformation.
- Recovery is holistic.
- Recovery has cultural dimensions.
- Recovery exists on a continuum of improved health and wellness.
- Recovery is supported by peers and allies.
- Recovery emerges from hope and gratitude.
- Recovery involves a process of healing and self-redefinition.
- Recovery involves addressing discrimination and transcending shame and stigma.
- Recovery involves (re)joining and (re)building a life in the community.
- Recovery is a reality. It can, will, and does happen.

DAODAS has focused on developing and working with recovery community organizations (RCOs) to expand their presence in communities across the state. The department has supported the formation of two new faith-based RCOs spanning six counties. These RCOs now offer a full spectrum of recovery support services to bridge the intersection of faith and recovery, particularly for African-American individuals living in rural areas of the state. Faces and Voices of Recovery South Carolina (FAVOR SC), now being rebranded as the S.C. Association of Recovery Community Organizations, has undergone a strategic planning effort to refocus its

efforts on building sustainable non-profit community organizations. This group's mission is to advocate for and implement a full continuum of recovery support services, operating in a recovery-oriented system of care and setting up multiple pathways for education, training, and intervention services in the recovery community.

Over the past several years, DAODAS has utilized partnerships with the RCOs to support collaborations that promote and strengthen strategies targeting recovery support bridging many organizations and localities such as hospitals, treatment centers, law enforcement agencies, and EMS service providers. The largest RCO in South Carolina is FAVOR SC. This is an organization with statewide reach, with a number of chapters in the various regions of the state. One vibrant RCO, FAVOR Upstate, has a full-time staff and a large number of volunteers functioning in various capacities, mainly as Recovery Coaches. In addition, there are 11 other active RCOs, and with State Opioid Response Grant and SUBG funding, DAODAS is providing more grant opportunities for RCOs to become established in areas of need.

DAODAS has also expanded its recovery efforts to develop Collegiate Recovery Programs (CRPs). With state appropriations, these CRPs have been established at four institutions of higher learning. All offer academic support in designated spaces that provide for group meetings, clinical support, technology access, and academic advising to assist students in recovery. One institution has expanded its services to include the Community Distribution of naloxone, and two others are in the discovery phases of Community Distribution. One program has begun providing services on satellite campuses to increase the delivery of recovery support services. Allen University, an HBCU, is in process to become a training hub for Certified Peer Support Specialists and other recovery-related trainings for all HBCUs across South Carolina.

Housing is a priority for recovery support. DAODAS has championed the safe recovery housing movement by leading the way on ensuring that recovery homes meet national standards of quality, and the department continues to identify existing recovery homes to engage in meeting quality measures for recovery residences through uniform standards with assistance from the S.C. Association of Recovery Residences (SCARR), which has implemented a robust strategy of certification for recovery houses using National Association of Recovery Residences (NARR)standards. Currently, 17 residences have been certified, with seven houses in various stages of the certification process.

An ongoing partnership that has increased access to and availability of recovery houses in South Carolina is between Oxford House Inc. and DAODAS. Currently, there are 105 Oxford Houses in our state, with a total of 769 beds – 70 for men, 20 for women, and 15 that serve women with dependent children. Oxford House reports that individuals prescribed medication for an opioid use disorder are welcome in all homes.

Additionally, DAODAS has been designated the recipient of a Congressional award of HUD funds to support recovery housing. Through the Recovery Housing Program, DAODAS has been awarded $1.8 million over five years to provide direct housing-related services to individuals in recovery from a substance use disorder. This innovative project allows individuals to apply for housing vouchers through DAODAS and to receive funding for up to two years or until permanent housing is established. To date, DAODAS has placed 1,013 South Carolinians

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in safe, stable recovery housing. This project is the first of its kind in the state and – when combined with quality housing through voluntary certification – has increased opportunities for citizens in recovery to obtain safe and stable housing.

Another effort to connect individuals in treatment or recovery services with needed resources is the Unite Us platform, which DAODAS supports all subgrantees in using. Coordinated referrals on the platform support service providers with warm handoffs to additional services and resources. The platform facilitates community connections that expand traditional services to include the recovery community, healthcare, and trusted local resource partners, closing gaps on the social needs that exacerbate substance use disorders. When used, the platform makes connections to organizations that support diverse needs of individuals such as legal help, food, housing, and clothing. Currently, the county alcohol and drug abuse authorities are onboarding with Unite Us, which has also onboarded local hospitals, community organizations, and other health systems across the state.

Other State Agencies:

Turning from an overview of the state's substance use disorder (SUD) prevention, early identification, treatment, and recovery support systems, below is a discussion of other state agencies with respect to the delivery of SUD services in South Carolina.

South Carolina Department of Mental Health

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

One example is a joint staff position that functions as a liaison between DMH and DAODAS, further promoting the emphasis on "no wrong door" to treatment for the citizens of South Carolina who are living with mental illnesses and substance use disorders. This staff position facilitates collaborative training for staff from each agency, as well as local staff of the county alcohol and drug abuse authorities and mental health centers. These trainings improve communication and collaboration overall and assist stakeholders in navigating access to each system as needed.

DAODAS is also working closely with DMH in readying Peer Support Specialists to care for the co-occurring population. The collaboration between DMH and DAODAS continues to align value systems, approaches, and perspectives, as well as improving communication at all levels of service delivery. DAODAS recognizes the importance of decreasing gaps in services and making transitions easier for sister behavioral health providers, such as DMH. DAODAS is committed to nurturing its established relationship with DMH to ensure consistent treatment for the two agencies' target populations. DAODAS has also maintained a memorandum of agreement with DMH to provide Dual Diagnosis Capabilities (DDC) assessment to DAODAS county providers and DMH local mental health sites. The DDC assessment initiative will evaluate the capabilities of DAODAS' county providers and DMH local mental health centers to

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serve the co-occurring population and will provide them with tools and techniques to help create or enhance services focused on the co-occurring population.

Two residential SUD treatment facilities are operated by DMH:

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

South Carolina Vocational Rehabilitation Department

Palmetto Center in Florence, operated by the Vocational Rehabilitation Department, is a residential treatment center for patients who voluntarily seek inpatient treatment for an SUD. The facility provides a full range of vocational and treatment services for people whose employment is jeopardized by substance use. Referred to the center by their vocational rehabilitation counselors, patients receive follow-up services once they return to their communities.

South Carolina Department of Employment and Workforce

DAODAS has collaborated with the Department of Employment and Workforce (DEW), both at the state and local levels, to provide direction on workforce development issues, particularly those pertaining to the Workforce Innovation and Opportunity Act (WIOA). The WIOA program helps businesses meet their need for skilled workers and provides individuals with access to training that helps them prepare for work.

This partnership has provided DAODAS and DEW with an opportunity to serve patients impacted by the opioid crisis or other SUDs and who wish to reenter the workforce. In three women's residential facilities operated by county authorities (Chrysalis Center in Florence, Serenity Place in Greenville, and the Sumter Women's Recovery Center), pilot programs are providing "boot camp"-style training and re-employment services for patients impacted by the health and economic effects of opioid and other substance use disorders. Through these programs, patients are being equipped to find skilled jobs while in the residential setting through career services and training that will allow them to support themselves and their families while working to build their recovery capital.

South Carolina Department of Health and Human Services

DAODAS providers have been delivering Medicaid-reimbursable services since 1993, and the agency continues collaborative efforts designed to increase access to quality substance use services. DAODAS, under contract with the Department of Health and Human Services

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(DHHS), the state's Medicaid authority, staffs two Medicaid Compliance Specialists who work collaboratively with county alcohol and drug abuse authorities and opioid treatment programs (OTPs) to ensure compliance with Medicaid standards for both inpatient and outpatient services. Their work has included providing technical support to local OTPs and county authorities at the request of DHHS to ensure beneficiaries' Medicaid re-enrollment after the end of the COVID-19 Public Health Emergency.

DAODAS works closely with DHHS to identify and implement steps to ensure workforce capacity, including adding Licensed Addiction Counselors as qualified providers within the Medicaid Rehabilitative Behavioral Health Services Manual and increasing reimbursement rates. These rate increases support the active engagement of medical health professionals to address substance use disorders, particularly opioid use disorder.

DAODAS leadership also serves on the Behavioral Health Oversight Committee that reviewed crisis-stabilization services for those patients who are experiencing behavioral health episodes, including those with mental health and SUDs. As a result, DHHS has announced crisis stabilization grants for hospital-based emergency departments and observational units dedicated to behavioral health. The goal of the program is to ease overcrowding at hospital emergency departments, initiate needed urgent psychiatric treatment, and reduce unnecessary hospital inpatient admissions.

DAODAS is an involved partner in the DHHS Birth Outcomes Initiative (BOI). Launched in July 2011, the BOI seeks to improve birth outcomes for newborns in South Carolina who are Medicaid beneficiaries. DAODAS, in conjunction with the BOI, is currently working to reduce the length of stay in neonatal intensive care units for infants exposed to opioids during pregnancy, as well as to create a link for referral to local behavioral health services for the mothers.

To build on the BOI's work, with the award of the State Pilot Program for Treatment for Pregnant and Partum Women Grant received by DAODAS, the agency is supporting telehealth connections and tele-consult connections of rural patients and providers to perinatal psychiatrists at a state medical university to expand access to care for women experiencing mental and substance use disorders while in the care of obstetrician-gynecologists.

Criminal Justice Agencies (South Carolina Department of Juvenile Justice and South Carolina Department of Corrections)

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

DAODAS and the Department of Corrections (SCDC) have continued to work on a seamless transition for offenders into outpatient treatment services in hopes of reflecting the outcomes of the Step UP! program for transitional-age 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

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offered by the DAODAS system. DAODAS developed a cross-training for both systems to support networking, education, and improved collaboration.

DAODAS is also assisting with re-integration of persons released from incarceration through the use of Certified Peer Support Specialists (CPSS). Volunteer inmates who identify as opioid users are offered naltrexone, combined with talk therapy, within 90 days of their release. A CPSS guides the inmates and serves as a support system during the transition from SCDC to a "warm handoff" to a county alcohol and drug abuse authority, recovery housing, and job opportunities. An additional program trains inmates to become CPSS within SCDC's institutions. DAODAS has trained 121 offenders as CPSS who provide recovery maintenance groups to other inmates at various facilities to support their recovery capital.

A highlight of the partnership between DAODAS and SCDC is the medications for opioid use disorder (MOUD) project, which focuses on inmates receiving a dose of Vivitrol before leaving the prison system. Three hundred inmates have been diagnosed with SUDs and received Vivitrol shots funded by DAODAS' State Opioid Response Grant. Fifty-two graduates of the MOUD program have entered the community transitioning to outpatient community-based treatment during fiscal year 2023 (FY23), as well as 44 inmates who were diagnosed with a stimulant use disorder. There were 429 active participants enrolled in the MOUD program as of FY23, as well as 3,011 Narcan kits distributed to inmates leaving prison. Additionally, inmates have been trained and certified as Peer Support Specialists (101 to date), enabling them to conduct meetings "behind the fence." In addition, 17 Narcan vending machines have been placed in SCDC facilities. The total effort of working with SCDC is a particularly noteworthy occurrence that demonstrates promising results for the project, as the average recidivism rate in South Carolina for inmates is 21.9%.

South Carolina Department of Social Services

DAODAS and the Department of Social Services (DSS) continue coordinating services and programming across agencies that address families involved in the DSS system for reasons related to alcohol and other drugs. A liaison has been working closely with child-serving agencies, and more importantly with hospitals and private providers, to develop a Family Wellness Support Plan for infants identified with substance exposure or neonatal abstinence syndrome to ensure coordinated care for the safety and well-being of the infants and families.

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

South Carolina Department of Motor Vehicles

DAODAS and the Department of Motor Vehicles (DMV) work together to provide the Alcohol and Drug Safety Action Program (ADSAP), which is the state's primary prevention and treatment program for addressing DUI offenders. Currently, all ADSAPs are operated by county alcohol and drug abuse authorities and are certified by DAODAS. Each county authority

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certified as an ADSAP provider offers a continuum of care in accordance with the American Society of Addiction Medicine Levels of Care. The required minimum services to be provided through the continuum of care are the PRIME FOR LIFE curriculum (Level 0.5); Individual and Group Counseling (Level I); Intensive Outpatient Services (Level II); and referral linkages to higher levels of care. All ADSAP clients are required to receive a DUI risk assessment and/or clinical biopsychosocial assessment for placement in the appropriate level of care. The risk assessment and/or the biopsychosocial assessment provide the basis for diagnostic classification according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition; placement in the PRIME FOR LIFE curriculum, individual and group counseling, and/or intensive outpatient services offered by a certified ADSAP provider; or referral to a higher level of care within the network of county authorities.

South Carolina Department of Public Safety

The Department of Public Safety (DPS) Office of Highway Safety and Justice Programs is charged with the administration of the federally funded State and Community Highway Safety Program (Section 402) and coordination of highway safety activities throughout the state on behalf of the Office of the Governor. DAODAS collaborates with DPS's Office of Highway Safety and Justice Programs on relevant issues in South Carolina, to include underage drinking, impaired driving, and public safety campaigns related to public health and safety.

South Carolina Department of Health and Environmental Control

The Department of Health and Environmental Control (DHEC) is charged with promoting and protecting the health of the public and the environment in South Carolina. DAODAS works with DHEC on tobacco control initiatives for the state, infectious disease prevention, and most recently with the DHEC Bureau of Emergency Medical Services to ensure that the state's law enforcement officers and firefighters are provided training and access to naloxone to respond to the opioid overdose deaths affecting the health of South Carolina. DAODAS is also working weekly with DHEC on surveillance of overdose response to coordinate local action with public health and public safety partners.

South Carolina Criminal Justice Academy

The Criminal Justice Academy (SCCJA) is charged with providing mandated basic and advanced training to law enforcement personnel and maintaining a continuous certification process to ensure that only the most qualified persons are sanctioned by the state to enforce its laws. As an institutional provider for the SCCJA, DAODAS established a South Carolina Alcohol Enforcement Team (SCAET) Training Team in 2007. The team is composed of personnel from state and local prevention and law enforcement agencies. The courses offered by the team were derived from trainings offered throughout the country by the Underage Drinking Enforcement Training Center. The SCAET Training Team has trained hundreds of law enforcement officers and prevention specialists across South Carolina. The team works with the state's 16 AETs, 31 contracted county alcohol and drug abuse authorities, state and local law enforcement agencies, and other partners to offer various training classes on alcohol compliance checks, fake and fraudulent IDs, source investigations, public safety checkpoints and saturation patrols, special alcohol event management, and party dispersal. The courses are accredited by the SCCJA for law enforcement training hours.

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Mothers Against Drunk Driving – South Carolina

Although not a state agency, DAODAS provides funding through the SUBG for the South Carolina chapter of Mothers Against Drunk Driving (MADD) to provide the *Power of Parents* and the *Power of Youth* curricula across the state through the 31 contracted county alcohol and drug abuse authorities, schools, churches, and other community forums.

Service to Diverse Racial and Ethnic Groups:

One of DAODAS's core principles is to serve the residents of South Carolina regardless of their race, ethnic background, or sexual orientation. Since cultural competency is interwoven in the Strategic Planning Framework, it is also addressed in the development of the county plans to ensure programs, policies, and practices are appropriate and effective for the populations served throughout the county. The county needs assessment process reflects the gathering of data to demonstrate the needs of various populations, including racial, ethnic, and sexual-gender minorities, as well as the American Indian population that is part of the fabric of the state.

DAODAS is an integral participant in the Cultural Competency and Linguistic Collaborative (CLC). The CLC is an interagency collective with a mission of providing information and training to communities and human services professionals in South Carolina to reduce/eliminate disparities and social determinants of health. The secondary purpose of the CLC is a commitment to the National Cultural and Linguistically Appropriate Services (CLAS) Standards to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred language, health literacy, and other communication needs. The CLC comes under the auspice of the South Carolina Joint Council on Children and Adolescents, a multi-agency partnership of DAODAS; the South Carolina Continuum of Care; and the South Carolina Departments of Mental Health, Juvenile Justice, Social Services, Education, Disabilities and Special Needs, and Health and Environmental Control. For the past nine years, the Joint Council has promoted and facilitated collaborative activities to improve access to quality, responsive, and cost-effective services for children and adolescents and their families. Each year, the CLC hosts a statewide Cultural Competency and Linguistics training to ensure adherence to the CLAS Standards.

SABG Priority Populations:

Pregnant Women and Women with Dependent Children

South Carolina, through the DAODAS Funding and Compliance Contract, requires subgrantees to comply with Article III – Treatment and Intervention, Section 2 – Mandated Treatment Services and Priorities Pursuant to **45 CFR § 96, b. Women (45 CFR § 96.131)** where it states:

i. *Subgrantee shall ensure that services awarded by DAODAS are made available to pregnant women. Pregnant women will be* ***given priority*** *for admission to all program components funded wholly or in part by federal SABG funds.*
ii. *Subgrantee shall actively publicize the availability of such services and the priority status of pregnant women through such means as ongoing public service announcements, regular advertisements in local/regional print media,*

posters placed in targeted areas, and communications to other community-based organizations, healthcare providers, and social service agencies.

iii. *Subgrantee shall notify DAODAS when it is unable to admit a pregnant woman to treatment because of insufficient treatment capacity.*

iv. *Subgrantee shall make available interim services to any pregnant woman who cannot be admitted to treatment within forty-eight (48) hours of having applied. Interim services for pregnant women include those enumerated in subsection (2)(v) above (Interim Services for Intravenous Substance Users), but shall also include counseling on the effects of alcohol and other drug use on the fetus, as well as referral for prenatal care.*

The subgrantees providing SUD services also send DAODAS their capacity management protocols each year. To monitor capacity and compliance with the above section (as well as other requirements that apply to priority populations), DAODAS requires each subgrantee to submit a Capacity Monitoring Form that captures data related to admission of pregnant women, appropriate referrals, interim services, and prenatal care. The Capacity Monitoring Form can be found in the attached Treatment Programs Manual for FY2024.

DAODAS monitors compliance with this requirement through periodic desk-review chart audits, on-site visits, and the data provided by the county authorities. If a county authority is unable to admit a pregnant woman, its staff will refer the patient to another county authority. As a last resort, the local agency will contact DAODAS for assistance in accessing services for that patient. In the past, DAODAS has received technical assistance from SAMHSA on capacity management. The DAODAS Manager of Treatment and Recovery Services is responsible for the oversight of this requirement.

Currently, three ASAM PPC II Level 3.5 and 3.7 residential treatment programs are offered by the county authorities, where a woman can go for treatment services and take up to two of her children. They are:

- New Life Center – A 16-bed program operated by Charleston Center in Charleston County that allows two children (age 5 and under)
- Chrysalis Center – A 16-bed program operated by Circle Park Behavioral Health Services in Florence County that allows up to two children (age 10 and under)
- Serenity Place – A 16-bed program operated by Phoenix Center in Greenville County that allows up to two children (age 5 and under)

There are two other residential treatment programs for pregnant and parenting women: Keystone Substance Abuse Services in York County accepts up to six women in Level 3.5 and 3.7; and Sumter Behavioral Health Services accepts 12 women in Level 3.5.

There are 11 women's intensive outpatient (IOP) treatment programs in South Carolina, 10 of which are funded by DAODAS and one of which is funded by another source. These programs are designed for women who are in need of more than traditional outpatient counseling, but for a variety of reasons are unable to receive inpatient care. Because the lack of child care has historically been a barrier to treatment for many women with children, all 11 of the women's IOPs provide on-site day care or have arrangements with local childcare facilities to provide

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these services for the children of women in treatment. These programs are available in Aiken, Anderson-Oconee, Berkeley, Charleston, Dorchester, Horry, Lexington-Richland, Pickens, Spartanburg, Sumter, and York counties.

Each of the DAODAS system's residential facilities are available to residents from all areas of the state, and patients can access services from a program in their region or statewide. If one of these programs is not able to provide medication-assisted treatment services or refer patients to a methadone clinic, the agency will refer the clients to the county authority in Charleston (Charleston Center) or a program in their region.

Persons Who Inject Drugs

South Carolina, through the DAODAS Funding and Compliance Contract, requires subgrantees to comply with Article III – Treatment and Intervention, Section 2 - Mandated Treatment Services and Priorities Pursuant to 45 CFR § 96, a. Intravenous Substance Users (45 CFR § 96.126), where it states:

> *Subgrantee shall ensure that services funded by DAODAS are provided to persons identified as intravenous users of illicit drugs. Subgrantee further agrees to:*
>
> *i. provide DAODAS with a statement of capacity for each service or level of care funded in part with federal SUBG funds;*
> *ii. notify DAODAS within seven (7) days of having reached 90 percent (90%) of its capacity to admit individuals to a particular service or level of care* (refer to Capacity Monitoring Report Form)*;*
> *iii. maintain a formal waiting list that shall include a unique patient identifier for each intravenous drug user seeking treatment;*
> *iv. notify DAODAS when any intravenous drug user is placed on a waiting list* (refer to Capacity Monitoring Report Form)*; and*
> *v. Provide interim services to those persons who cannot be admitted to treatment within fourteen (14) days of making a request. Interim services shall be made available not more than forty-eight (48) hours after the request for treatment and shall include at a minimum:*
>   1. *counseling and education about HIV and tuberculosis;*
>   2. *counseling and education about the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and tuberculosis transmission does not occur;*
>   3. *referral for HIV or tuberculosis treatment services if necessary; and*
>   4. *outreach efforts to encourage individuals in need of treatment services for intravenous drug use to undergo such treatment. Subgrantee shall actively publicize the availability of such services and the priority status of intravenous drug users through such means as ongoing public service announcements, regular advertisements in local/regional print media, posters placed in targeted areas, and communications to other community-based organizations, healthcare providers, and social service agencies. Subgrantee shall develop collaborative relationships with opioid treatment programs for the purpose of coordination of treatment services to intravenous drug users.*

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To monitor capacity and compliance with the above Section (as well as other requirements that apply to priority populations), DAODAS requires each subgrantee to submit the Capacity Monitoring Form, which can be found in the attached Treatment Programs Manual for FY2024

If a county authority is unable to admit a person who injects drugs, its staff will refer the patient to another county authority. As a last resort, the local agency will contact DAODAS for assistance in accessing services for that patient. In the past, DAODAS has received technical assistance from SAMHSA on capacity management.

DAODAS monitors compliance with this requirement through periodic desk-review chart audits, an on-site visit, and/or through the data provided by the county authorities. DAODAS has the ability to review a sample of patient files during a desk-review audit. The DAODAS Manager of Treatment and Recovery Services is responsible for this requirement. In addition, the Overdose Prevention/Infectious Disease Coordinator can also monitor compliance through a desk review and/or onsite visit.

Persons at Risk for Tuberculosis

South Carolina, through the DAODAS Funding and Compliance Contract, requires subgrantees to comply with Article III – Treatment and Intervention, Section 2 – Mandated Treatment Services and Priorities Pursuant to 45 CFR § 96, d. Tuberculous (TB) Services (45 CFR § 96.127) of the contract:

- i. *Subgrantee shall routinely make available, directly or through arrangements with other public or non-profit entities, tuberculosis services to each individual receiving treatment for alcohol and other drug use after being found to be at high risk by the assessment.*
- ii. *"Tuberculosis services" include:*
  1. *counseling individuals with respect to tuberculosis;*
  2. *making available necessary testing to determine whether individuals have been infected with mycobacterium tuberculosis to determine the appropriate form of treatment for each individual; and*
  3. *providing for or referring individuals infected by mycobacterium tuberculosis for appropriate medical evaluation and treatment.*
- iii. *In the case of an individual in need of such treatment who is denied admission to the program based on lack of capacity of the program to admit the individual, Subgrantee will refer the individual to another provider of tuberculosis services.*
- iv. *Subgrantee will implement infection-control procedures established by DAODAS, in cooperation with DHEC's Tuberculosis Control Officer, that are designed to prevent the transmission of tuberculosis, including the following:*
  1. *screening of patients;*
  2. *identification of those individuals who are at high risk of becoming infected;*
  3. *conduction of case management activities to ensure those individuals receive such services; and*
  4. *reporting of all individuals identified with active tuberculosis by the testing organization to the appropriate state officials.*

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Subgrantee shall comply with DAODAS' reporting instructions to ensure that all recipients of tuberculosis services are identified appropriately and all services are documented.

DAODAS can monitor program compliance related to tuberculosis services by a desk review and/or onsite visit.

Persons at High Risk for or Living With HIV Who Are Receiving a Treatment Service

South Carolina, through the DAODAS Funding and Compliance Contract, requires subgrantees to comply with Article III – Treatment and Intervention, Section 2 – Mandated Treatment Services and Priorities Pursuant to 45 CFR § 96, c. Human Immunodeficiency Virus (HIV) (45 CFR § 96.128) of the contract:

i. *From time to time, and pursuant to a prevalence formula, the State of South Carolina may become a "designated state" under 45 C.F.R. §96.128. Under such designation, and pursuant to DAODAS' instructions, Subgrantee shall comply with all specific funding allocation and project instructions in compliance with 45 C.F.R. §96.128.*
ii. *As a matter of routine, Subgrantee shall make available for inspection any written policies for service delivery to persons with HIV disease. Any revisions to policies shall be submitted to DAODAS upon adoption by Subgrantee's governing body.*

The last year for which South Carolina was identified as an HIV-designated state was 2020. DAODAS opted to continue using Substance Abuse Prevention and Treatment Block Grant (as it was then known) funds to implement HIV testing within select county authorities. Many of the sites that were located in counties of highest prevalence had phased out their HIV testing personnel during our 2019 close-out. In an effort to circumvent the lack of resources in personnel that naturally occurs with a loss of designation, while simultaneously building capacity to implement testing again, DAODAS changed its funding allocation strategy to award funding only for tests conducted rather than for personnel. DAODAS provided enough funding for each test to serve as an incentive to conduct testing and to offset some of the personnel costs.

Additionally, DAODAS contracted with the HIV/STD/HCV Testing program at the state health department to secure requisite training for selected county staff; to purchase HIV test kits/controls and have them stored at the state laboratory; and to cull testing data from the requisite HIV testing forms already submitted to the health department. This collaboration ensures that the HIV testing data that is reported to the state testing program at the health department (i.e., S.C. Department of Health and Environmental Control) is the same data that is submitted to DAODAS (and subsequently reported to SAMHSA).

All sites are aware of the challenges to funding that a state designation holds, and all are preparing to adjust to close-outs unless our HIV rates once again reach designation thresholds in the near future.

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Persons in Need of Primary Substance Abuse Prevention

South Carolina, through the DAODAS Funding and Compliance Contract, requires subgrantees to comply with Article IV of the contract. The provision of primary prevention services was described in the earlier portions of this document.

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

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Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

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

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Footnotes:

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Step 2: Identify the Unmet Service Needs and Critical Gaps Within the Current System.

Overview:

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

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

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

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

The SEOW's tasks include producing a Statewide Epidemiological Profile as a document that organizes, summarizes, and presents archival data for use in prevention planning and decision making for the state. These data include measures – or "indicators" – of ATOD consumption and consequences, primarily from periodic national surveys, which allow the state to report trends over multiple years and to compare South Carolina to national rates. The indicators included in the profile were carefully selected (most are from the State Epidemiological Data System [SEDS] developed by SAMHSA/CSAP) and met criteria for availability. In addition, national sources were supplemented with state data sources, all the while keeping in mind these selective criteria. The report includes graphs and tables that depict the use of alcohol, tobacco, and other drugs in South Carolina during recent years, along with the associated consequences of that use. Updates of the state profile have been completed in subsequent years by the SEOW.

South Carolina:

South Carolina is a small, rural state. In 2022, the Census Bureau reported the population of South Carolina to be 5,282,634. According to data available through the S.C. Revenue and Fiscal Affairs Office, approximately one-third of the state's inhabitants reside in a rural area.

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

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

The 2018-2019 SAMHSA National Survey on Drug Use and Health (NSDUH) estimated that 263,000 of individuals age 18 and older had an SUD for either alcohol or an illicit drug in the past year. Examining further, an estimated 63,000 of 18- to 25-year-olds had an SUD in the past year in 2018-2019.

DAODAS is also working toward reducing financial barriers associated with access to high-quality SUD treatment services. In State Fiscal Year 2022, 7,853 uninsured individuals received state-funded assessments, and those numbers are projected to increase, as DAODAS will continue to focus federal and state block grant dollars on service delivery for uninsured populations.

Adolescents With Substance Use Disorders:

According to the National Survey on Drug Use and Health – based on the 2018 and 2019 annual average – about 101,000 South Carolinians age 12 or older each year were dependent on or abused illicit drugs within the year prior to being surveyed. An estimated 11,000 treated for an illicit drug use-related disorder were within the 12- to 17-year-old age group. Overall, an estimated 15,000 individuals between the ages of 12 and 17 were treated for a substance use disorder (SUD) in the past year, and an additional 15,000 were estimated to need but did not receive treatment for their SUD.

The state's public SUD treatment system provides services to a fraction of those likely in need of treatment. Approximately 3,172 youth ages 12 to 17 entered treatment services during the past fiscal year. This represents about 11% of all treatment admissions occurring during fiscal year 2022.

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

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

Alcohol:

Figure 1 (next page) provides state estimates on the prevalence of alcohol use disorders (AUDs). Estimates indicate that the state's alcohol dependence prevalence rate mirrors national trends, decreasing slightly from 6.5% in 2010 to 5.1% in 2018-2019. There was an annual decrease in percentages estimated by the National Survey on Drug Use and Health before a slight spike in 2017-2018, followed by a decrease again.

These data, collected through the National Survey on Drug Use and Health, indicate that an estimated **221,000** individuals in South Carolina were dependent on or misused alcohol during the year prior to being surveyed (**215,000** estimated to be 18 years and older).

Figure 1: Alcohol Use Disorder (AUD) Estimates Among Individuals Age 12 or Older

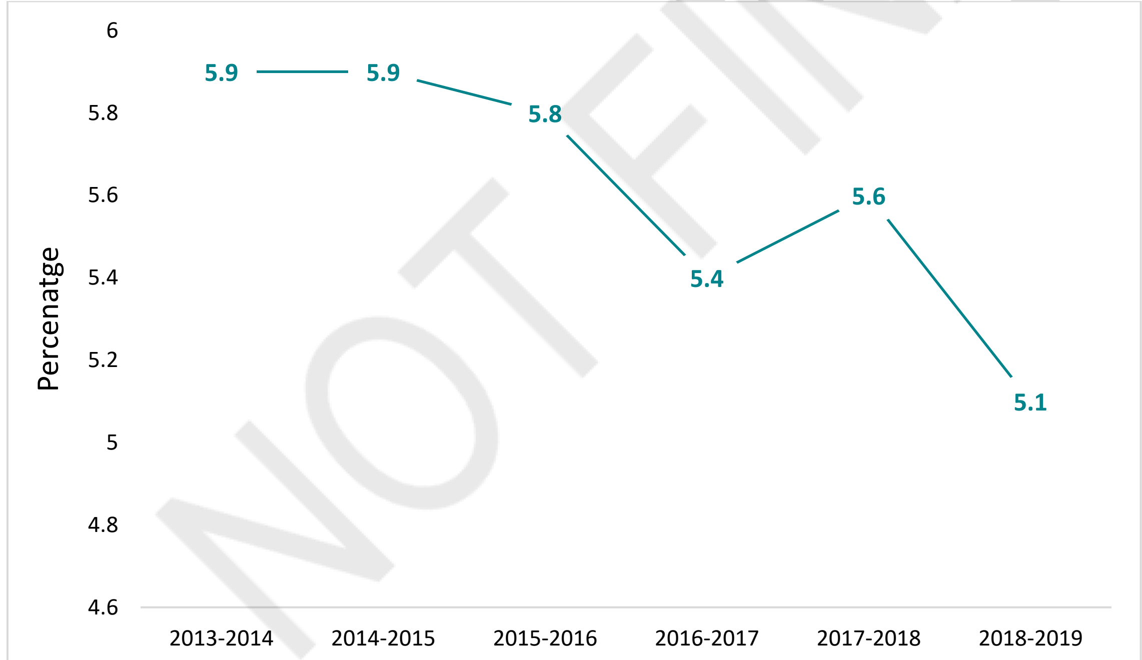

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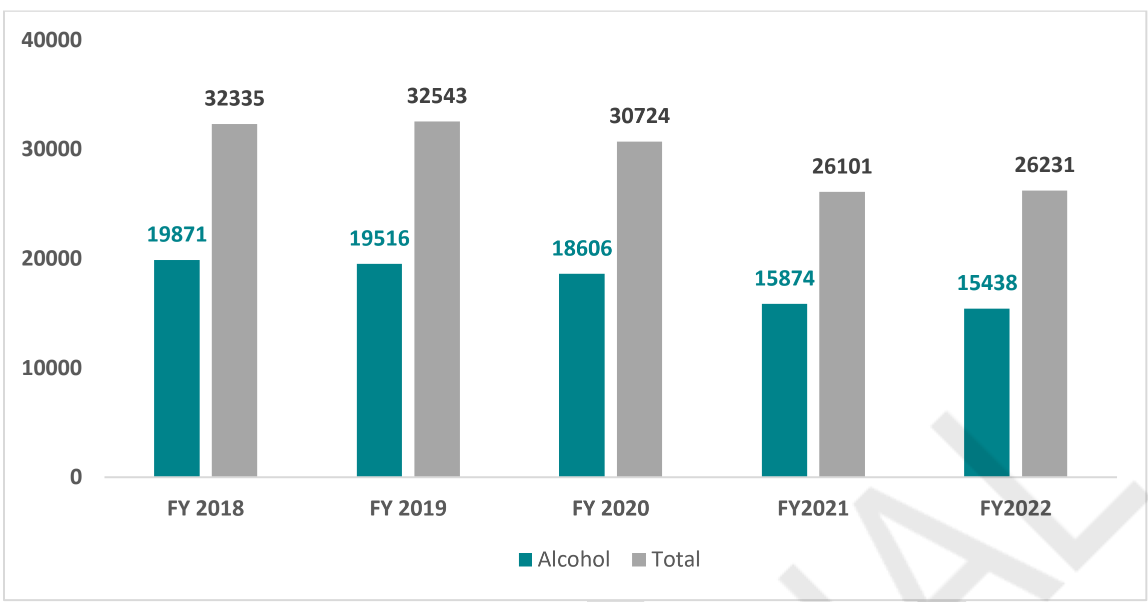
Figure 2 below indicates that the majority of South Carolinians discharged from substance use disorder (SUD) treatment at one of the state-funded county alcohol and drug abuse authorities were diagnosed with either a primary or secondary AUD during that fiscal year. In fiscal year 2022, 59% of discharged episodes had a primary or secondary diagnosis of an AUD.

Figure 2: Primary/Secondary AUD and Total SUD Diagnoses at Discharge by State Fiscal Year



Adolescents and Alcohol-Related Prevention:

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

Rates of binge alcohol use for individuals 12 to 20 years old have consistently hovered around the 15% mark during the past five years, according to the National Survey on Drug Use and Health (NSDUH). This rate has remained below the national average. South Carolina's percentage of **binge alcohol use among individuals age 12-20** was similar to the national percentage. In 2016-2017, 18,000 individuals engaged in binge alcohol use within the month prior to being surveyed, as per the NSDUH state-specific estimates.

Aligning with our priorities, prevention of underage alcohol use is a high priority. Research has shown that early age of onset for using alcohol leads to an increased risk of developing a substance use disorder later in life (Hingson, 2006). **The Centers for Disease Control and Prevention's 2019 Youth Risk Behavior Survey (YRBS)** indicates that 17.8% of South Carolina high school students reported using alcohol before age 13, and 23.1% reported they had at least one drink of alcohol within the 30 days prior to taking the survey.

According to the **2020 Communities That Care (CTC) Survey**, 26.3% of South Carolina high school students have used alcohol in their lifetimes. This begs the question of how so many young people manage to acquire alcohol. As per the CTC Survey, about one-fourth of South Carolina high school students reported that someone gave it to them at a party. Therefore, South Carolina plans to continue utilizing environmental strategies, such as high-visibility law enforcement, to decrease accessibility of alcohol for youth, and eventually to decrease the prevalence of underage drinking in South Carolina.

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

The National Highway Traffic Safety Administration reports the percentage of traffic fatalities that involved a driver with a blood alcohol concentration of 0.08% or higher. In **2017**, South Carolina reported that 313 out of 988 fatalities (32%) met these criteria for an alcohol-involved fatality. This is 3% higher than the nation's average of 29% (10,874 out of 37,133 fatalities).

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

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

Tobacco Use:

Figure 3 below provides state estimates on the prevalence of tobacco use among individuals age 12 and older. The data from the **National Survey on Drug Use and Health state-specific estimates** indicate a consistent decrease (with a slight increase in 2018-2019) among individuals using tobacco products at least once in the past month, with an estimated 1.1 million individuals in South Carolina having used tobacco products during the past month prior to being surveyed in 2018-2019.

However, **approximately 59% of patients seen by a county alcohol and drug abuse authority mentioned they were current smokers when entering treatment during fiscal year 2020**, and over 80% of all substance use-related hospitalizations statewide came with a secondary diagnosis of nicotine misuse in 2020.

Figure 3: Past-Month Tobacco Use Among Individuals 12 Years and Older

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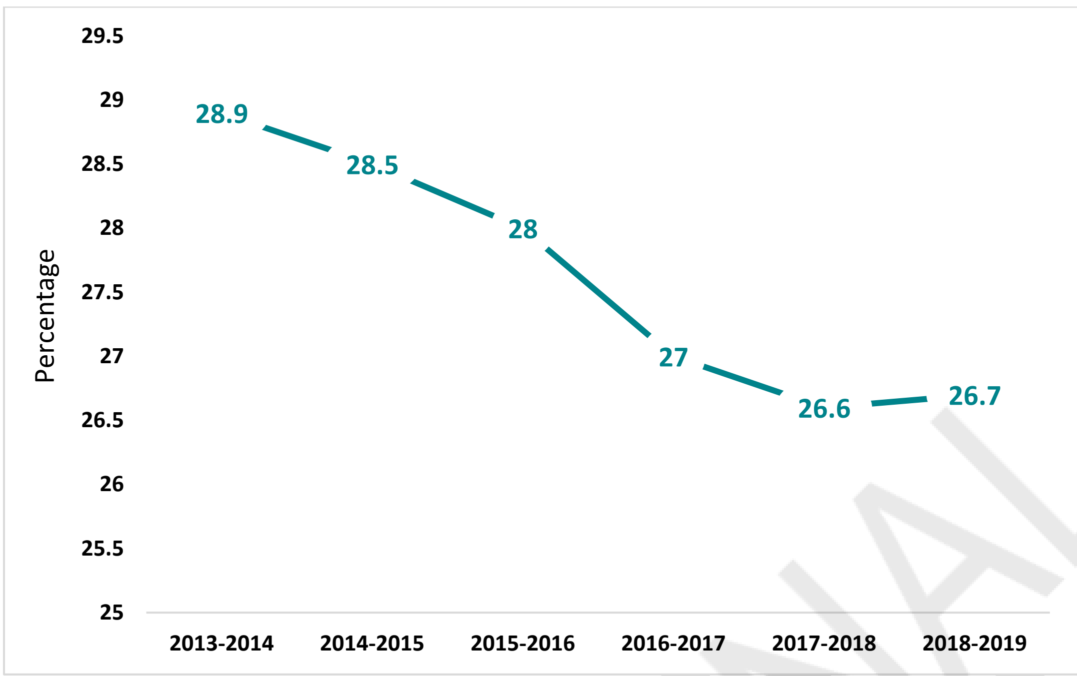

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Adolescents and Tobacco-Related Prevention:

Youth survey respondents were asked about the risks associated with substance use. South Carolina state-specific estimates from the National Survey on Drug Use and Health mirror national trends, indicating that in 2018-2019 37% of adolescents ages 12-17 perceived no great risk from smoking one or more packs of cigarettes a day.
While South Carolina is still working on reducing the prevalence of youth use of traditionally known forms of tobacco, there are other forms of tobacco emerging as threats to public health across the state. These forms of tobacco include roll-your-own cigarettes, flavored cigarettes, clove cigars, flavored "little cigarettes," smoking from a hookah or water pipe, snus, dissolvable products, and e-cigarettes.

According to the **2020 South Carolina Communities That Care (CTC) survey**, only 8.5% of respondents reported having ever tried a cigarette. However, over 20% of respondents reported having ever vaped, indicating the continuing shift in mode of nicotine-delivery methods. Additionally, 36% of respondents reported that it was "very easy" or "sort of easy" to obtain cigarettes, and a larger percentage (43%) reported ease of access to an e-cigarette or vaping pen, although both of these statistics are down from previous CTC surveys conducted.

Despite this continued accessibility issue, the Synar study results in recent years have demonstrated a decrease in the retailer violation rate. Rates have consistently been below 10% since 2014.

South Carolina will also continue to utilize its prevention staff to coordinate with local law enforcement and implement assorted evidence-based strategies to reduce youth-access to

tobacco. Specific environmental prevention activities could include tobacco compliance checks and merchant education.

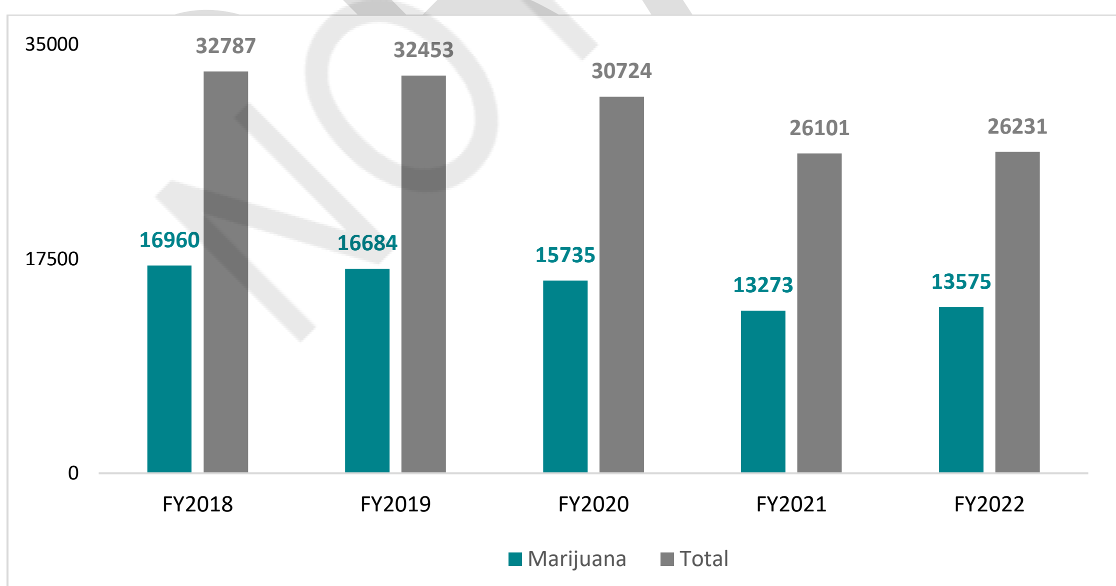
South Carolina county prevention providers will disseminate information to youth and adults about the dangers, laws, consequences, and harmfulness of underage tobacco use and will deliver the Tobacco Education Program (TEP) for youth identified as having violated South Carolina law prohibiting youth under 18 from attempting to possess or purchase tobacco products. Due to the increase in use and popularity of e-cigarettes and vaping among youth over the past few years, TEP has incorporated resources (from the Stanford toolkit and state laws) to address these new forms of tobacco use. There are fewer federal, state, and local policies focused on regulating these emerging tobacco products, and South Carolina will look to dedicate additional resources toward better understanding youth use, access, and perceptions of these products.

Cannabis Use:

Figure 4 (next page) indicates that South Carolinians in need of treatment for a diagnosed problem related to cannabis use who received care through a DAODAS-funded provider have been on similar levels over the past three years.

In fiscal year 2022, **52% of discharged episodes** (13,575 of 26,231) were associated with a cannabis use disorder (CUD) diagnosis, which is in line for both count and percentage of overall discharges related to CUD in **fiscal year 2019** among all discharges from a county alcohol and drug abuse authority (16,684 of 32,453).

Figure 4: DAODAS CUD and SUD-Related Discharged Episodes by State Fiscal Year, 2018-2022



Adolescents and Cannabis-Related Prevention:

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In South Carolina, as per the state-specific National Survey on Drug Use and Health estimates, almost a quarter of adolescents (24%) ages 12-17 in 2018-2019 perceived no great risk from smoking marijuana once a month. This percentage is slightly higher than the national average (23%).

According to the 2020 Communities That Care (CTC) Survey, 15% of South Carolina high school students have used marijuana or hashish in their lifetimes. Thirty-six percent of respondents reported that it was "very easy" or "sort of easy" to obtain marijuana, and 37% saw no risk or slight risk in marijuana use once or twice per week. These numbers are lower than reported numbers in the 2018 CTC Survey, but are a substantial percentage nonetheless.

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

Opioid Use:

Figure 5 (next page) indicates that the state's rate of treatment for problems related to opioid misuse has risen in recent history. Looking at state fiscal year 2022 (FY20), 23% of episode discharges had a primary or secondary diagnosis of an opioid use disorder (OUD), with the majority of patients with an OUD being male and white. The proportion of substance use disorder discharges associated with OUD has increased every fiscal year, with 23% being diagnosed as such in FY22.

Figure 5: DAODAS OUD and SUD-Related Discharged Episodes by State Fiscal Year, 2018-2022

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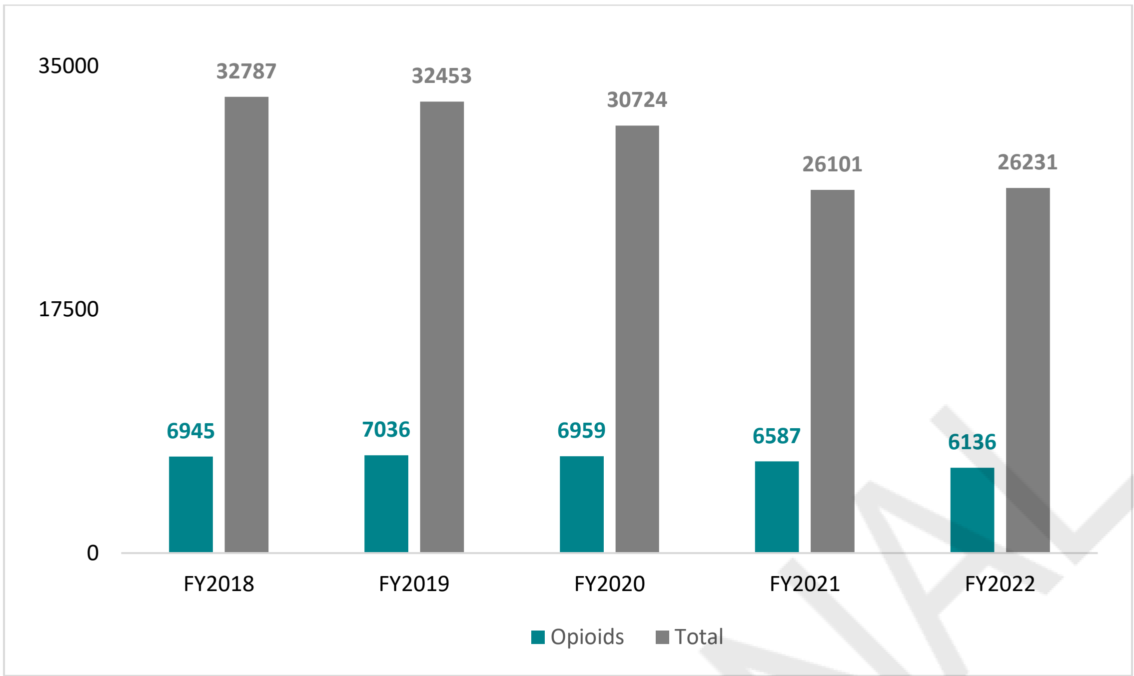

Figures 6 and 7, along with Tables 2 and 3, look further at the opioid epidemic in South Carolina over the past six years. Figure 6 displays the increase in opioid-involved overdose deaths since 2015 (565 in 2015 to 1,395 [provisionally] in 2020), for a 147% increase.

Table 2 identifies the "top 10" counties (rate per 100,000 population) in terms of opioid-involved overdose deaths in calendar year (CY) 2019, with Horry and Lancaster counties having the highest rate of death per 100,000. (County-level CY 2020 opioid-involved overdose mortality data is being validated at the time of this report.)

Figure 7 displays the increase in emergency medical service (EMS) naloxone administrations across South Carolina over the past six years (4,933 in 2015 to 8,642 in 2020, for a 75% increase).

Table 2 identifies the "top 10" counties (rate per 100,000 population) in terms of naloxone administrations recorded in CY 2019, with Fairfield and Georgetown counties having the highest rates of administration per 100,000. (County-level CY 2020 EMS data is being validated as of this report.)

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Figure 6: Opioid-Involved Overdose Deaths Across South Carolina, 2015-2021

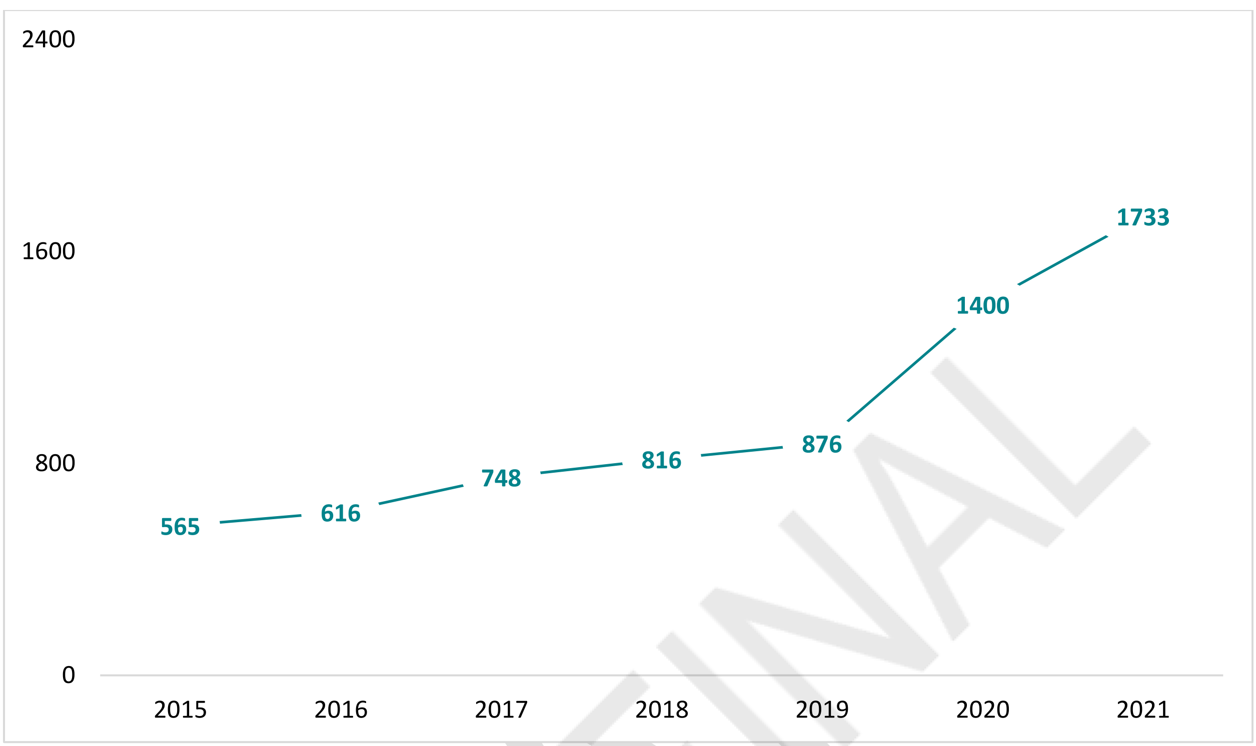

Table 2: Top Ten Counties, Opioid-Involved Overdose Death Rate Across South Carolina, 2021

County	*Opioid-Involved Overdose Death Rate / 100,000 Population*	*Rank*
Dillon	69.8	1
Horry	68.9	2
Greenwood	60.6	3
Georgetown	59.8	4
Union	53.8	5
Lancaster	52.1	6
Florence	46.6	7
Aiken	45.8	8
Barnwell	43.5	9
Williamsburg	43.0	10

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Figure 7: EMS Naloxone Administrations Across South Carolina, 2015-2021

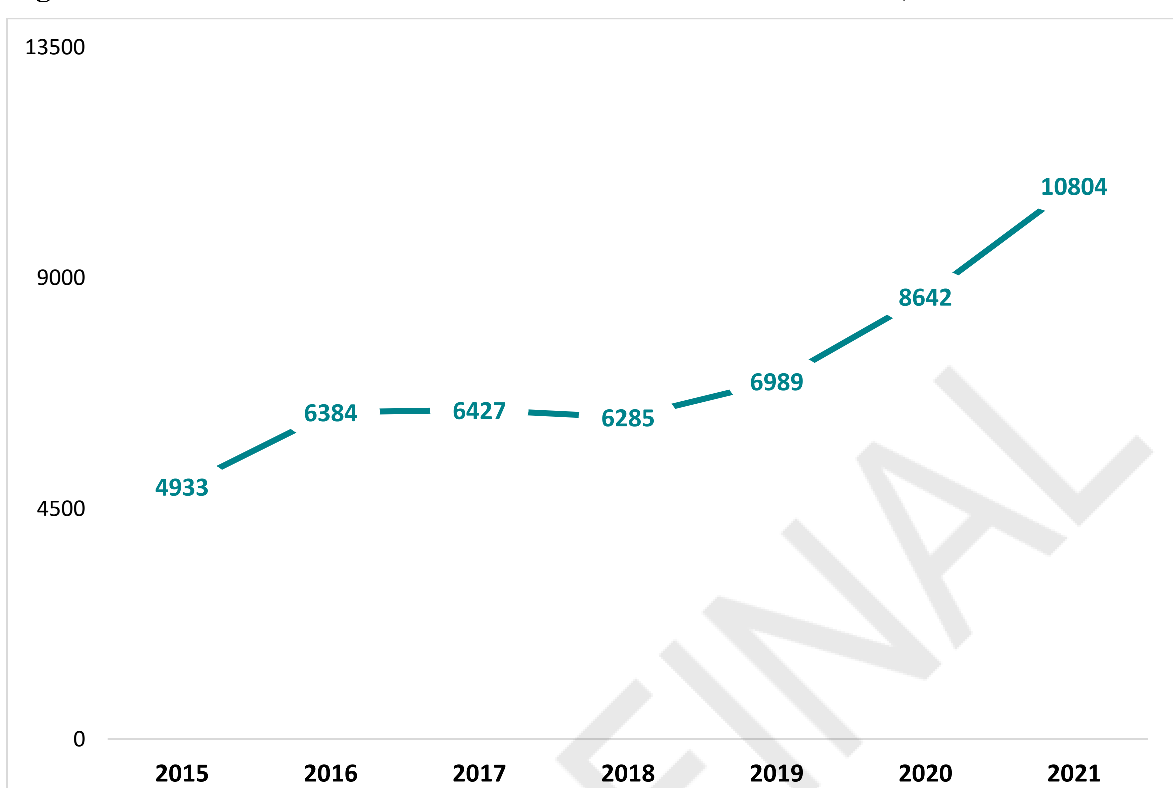

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Table 3: Top Ten Counties, Naloxone Administration Rate Across South Carolina, 2021

County	*Naloxone Administration Rate / 1,000 Population*	*Rank*
Fairfield	8.17	1
Union	4.37	2
Horry	3.76	3
Georgetown	3.69	4
Jasper	3.63	5
Dillon	3.60	6
Lancaster	3.58	7
Chester	3.17	8
Lee	3.01	9
Laurens	2.68	10

Additional data from the state health agency – the S.C. Department of Health and Environmental Control (DHEC) – provide some indication of the consequences related to opiates associated with injection drug use. Between 2015 and 2019, unintentional drug poisoning (overdose) deaths increased from 713 to 1,051. DHEC representatives suspect these data underrepresent the

true volume of overdose deaths. Deaths due to opioid overdose in South Carolina by occurrence has been on a steady rise from 2015 to 2019. (For Figure 8 [below], 2022 mortality data broken down by occurrence was not available at time of this reporting.)

There was a 53% increase in drug overdose deaths in South Carolina, up from 1,131 deaths in 2019 to 1,729 deaths in 2020. (Data is provided by the Centers for Disease Control and Prevention.). In 2016, 73.9% of all drug overdose deaths involved opioids.

Figure 8: Overdose Deaths by Occurrence Type Across South Carolina, 2015-2021

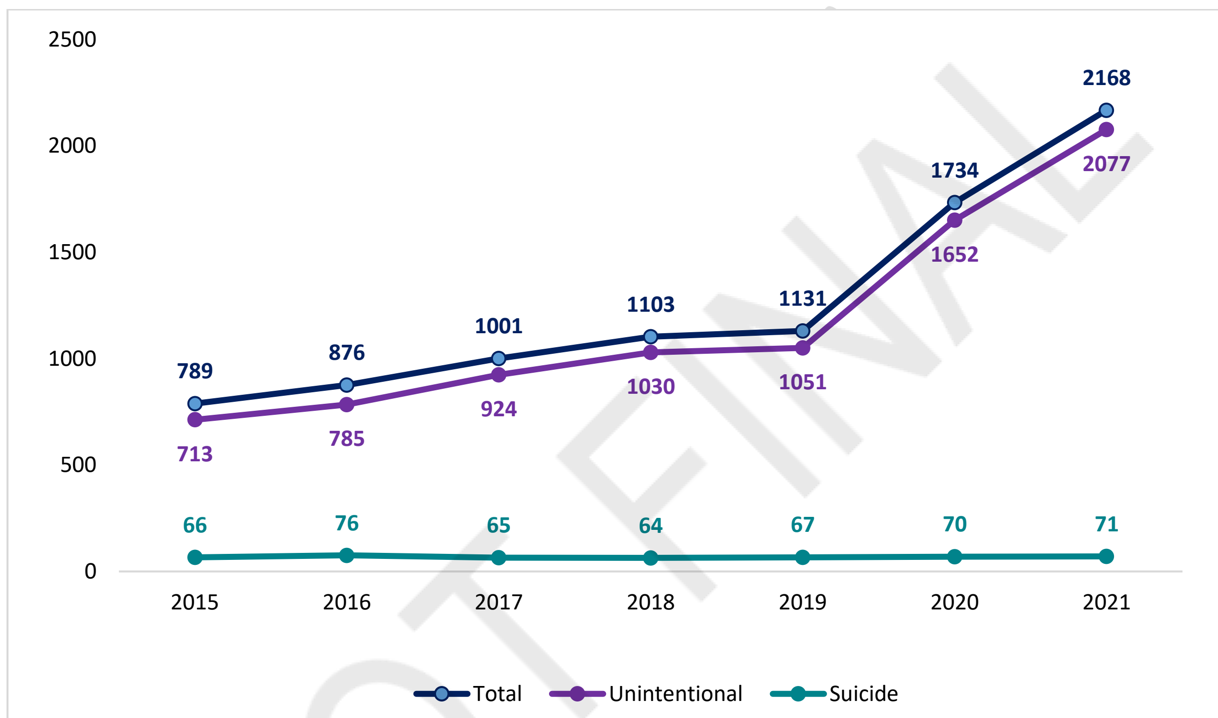

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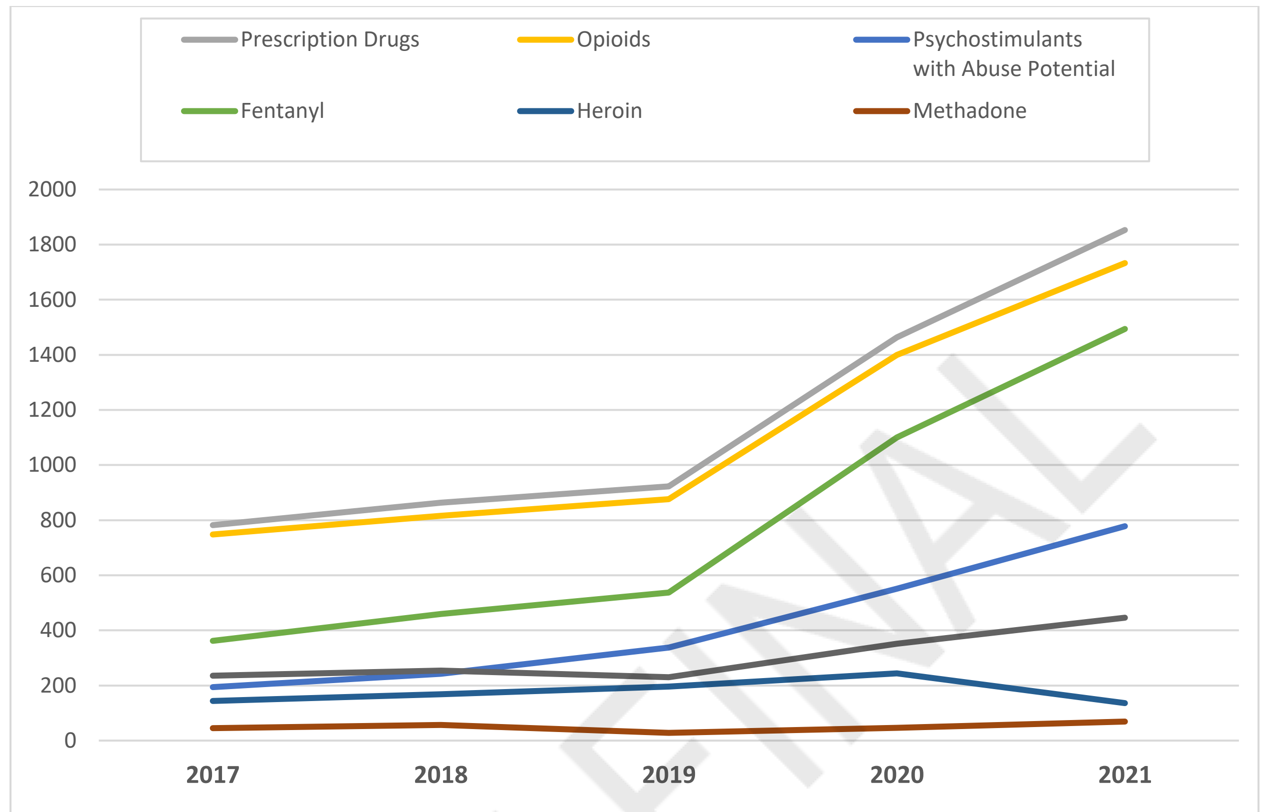
Figure 9 (next page) displays the number of drug overdose deaths by drug category over a five-year span from 2017 to 2021. (data is provided by the CDC.) The largest percent change in the past two years were deaths related to synthetic opioids (such as fentanyl), with a 97% increase (575 in 2019 to 1,133 in 2020).

There has been a consistent increase in overdose deaths by all drug categories listed since 2014, with major spikes occurring as a bi-product of the COVID-19 pandemic, when drug overdose deaths have spiked nationwide.

Figure 9: Overdose Deaths by Drug Category Across South Carolina, 2017-2021



Adolescents and Opioid-Related Prevention:

The National Survey on Drug Use and Health estimated in 2018-2019 that approximately 13,000 adolescents (ages 12-17) misused pain relievers in the past year. The percentage of South Carolina adolescents misusing pain relievers is slightly higher than the national averages (3.4% vs 2.5%).

Nine percent of respondents from the **2020 Communities That Care Survey** reported ever having misused prescription drugs (i.e., use without a doctor's prescription). Twenty-five percent of students stated that it was "easy" to obtain prescription drugs, and 27% reported getting the prescription drug from a family member.

DAODAS is focused on the potential risk associated with this population initiating injection-use practices and has created state and local priority areas that focus prevention and treatment services around both patients currently reporting intravenous drug use, as well as those at risk of transitioning to intravenous drug use. Associated strategies include treatment efforts to expand medication-assisted therapies able to reduce the symptoms of opiate dependence, as well as prevention efforts designed to reduce access to unused prescription pain medications and collaborative efforts with state entities across the spectrum of authority to mitigate use of illicit drugs.

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Federally Identified Priority Populations and Services:

The Substance Abuse Prevention and Treatment Block Grant requires that states address several priority populations and services:

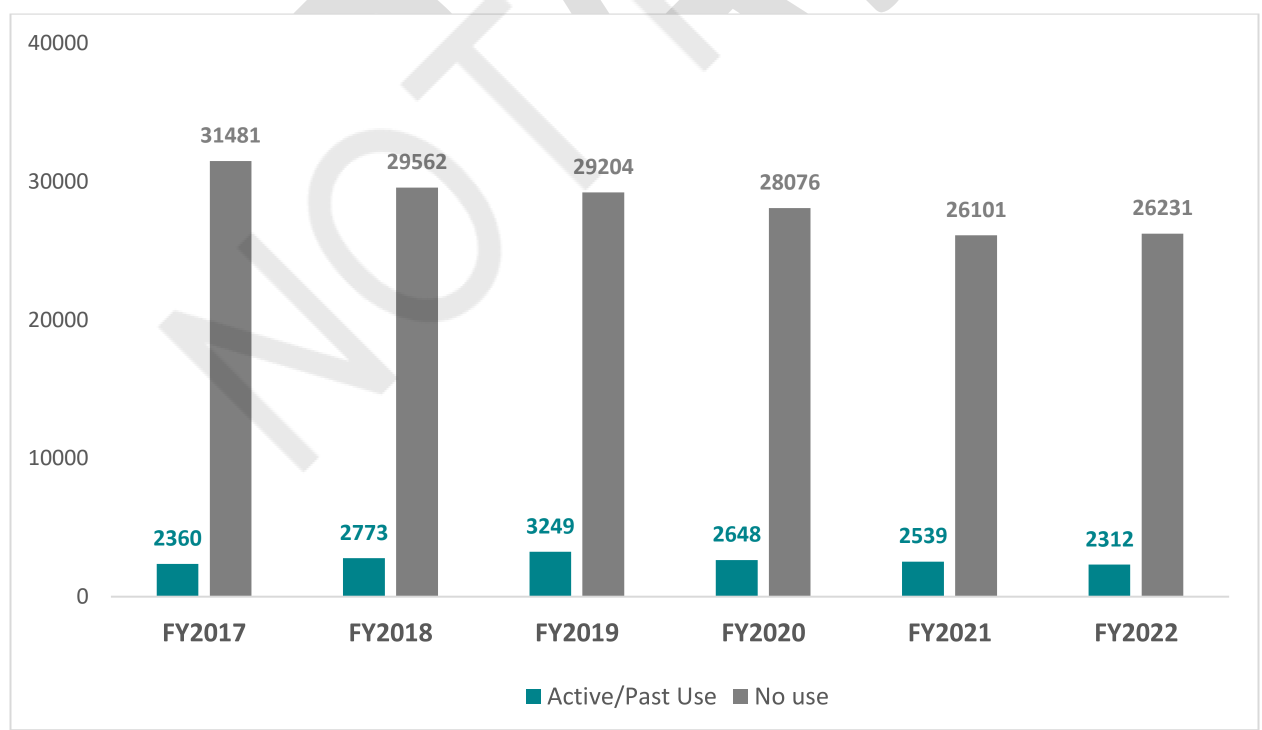
1) Persons who are intravenous drug users
2) Women who are pregnant and have a substance use disorder
3) Parents with substance use disorders who have dependent children
4) Individuals with tuberculosis
5) Persons living with or at risk for HIV/AIDS who are in need of substance misuse intervention, treatment,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

A discussion of these remaining priorities can be found below.

Persons who are intravenous drug users:

From DAODAS treatment data for state fiscal years (SFY) 2017-2022 (Figure 10), the number and percentage of patients treated for a substance use disorder at a DAODAS state-funded provider who self-reported as either an active or past intravenous drug user (IDU) has remained between 7% and 10% except for SFY 2019 which saw an increase of 11%.

Figure 10: DAODAS Patients Reporting Intravenous Drug Use Status at Admission, SFY 2017-2022



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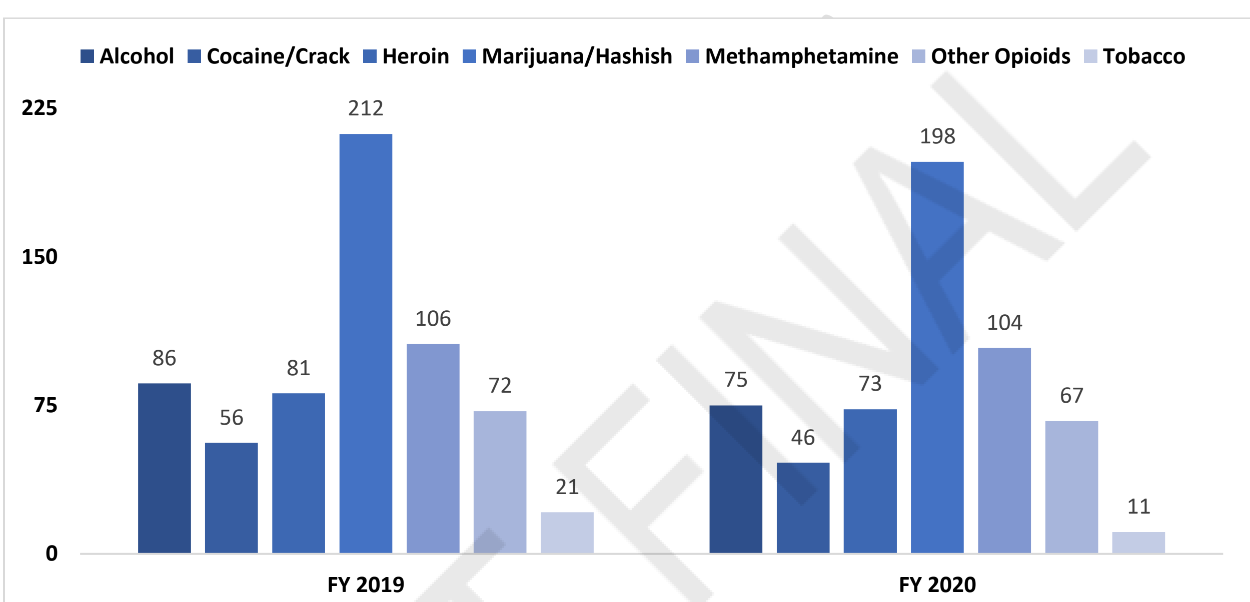
Women who are pregnant and have a substance use disorder:

Pregnant women are given priority access to treatment services available through the DAODAS-funded provider network. Residential, day treatment, and intensive outpatient services are available in every region of the state. Figure 11 provides trends for frequently reported primary substance use types for pregnant patients in the previous two fiscal years.

Figure 11: DAODAS Pregnant Women Patient Primary Substance Reported at Admission, SFY 2019-2020



There were 1,020 pregnant patients reported to have accessed care during SFY 2020. (Preliminary reporting indicates that this number will drop slightly for SFY 2021.) Thirty-one percent were treated for marijuana misuse, while 12% were treated for an alcohol use disorder in SFY 2020 and 22% for an opioid use disorder.

DAODAS will ensure that high-quality substance use disorder treatment services for pregnant females are available within each community. The agency will implement strategies, to include expansion of primary and specialty healthcare substance use screenings for pregnant females, increased collaboration with the state's social services agency responsible for child welfare through co-location of staff and improved screening/referral service delivery coordination, and continued collaboration with the state's Medicaid agency to engage OB/GYN service providers in screening, intervention, and referral to treatment service models.

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

DAODAS and its local provider network ensure that a continuum of quality treatment services for parents with dependent children is accessible throughout the state. Residential and intensive outpatient care focusing on the family unit are available in every region of the state. Thirty-two percent of DAODAS patients in fiscal year 2022 reported living with one or more dependent children. Figure 12 (next page) provides an illustration contrasting patients with and without

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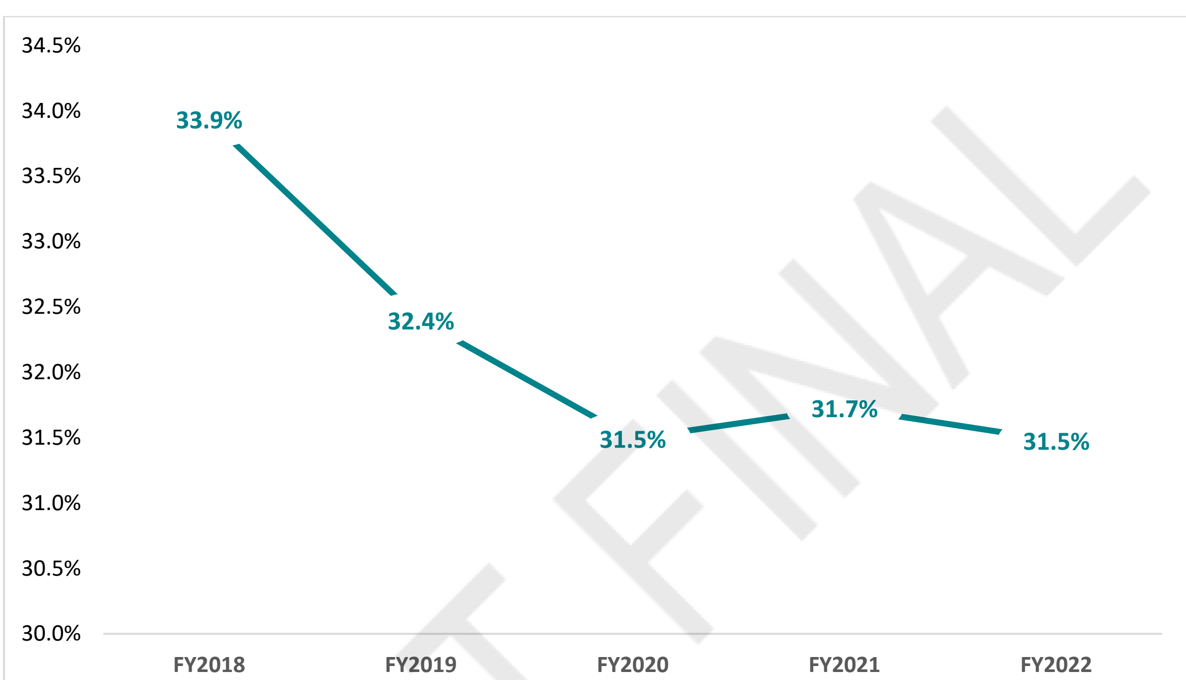
dependent children who were in care. The annual numbers and percentages have remained relatively consistent from state fiscal years (SFY) 2018 to 2022, showing the continued need and focus on the familial unit in regard to patient services. Service provision and child care targeting young family members are offered in addition to traditional substance use disorder (SUD) treatment in order to meet the needs of the entire family.

Figure 12: Reported Percentage of DAODAS Patients Living With Dependent Children, SFY 2018-2022



After the criminal justice system, social services represents the largest referral source for DAODAS and its local provider network. Over 4,700 discharges in SFY 2022 were referred by the S.C. Department of Social Services (DSS). In general, 50,000 or more calls are made regarding a suspected situation involving child abuse or neglect during a completed fiscal year. Of those, over one-sixth tend to be screened as having no risk. The remaining 40,000 or so calls indicate some level of risk requiring additional assessment and service delivery. Unknown by DSS is the proportion of calls prompting further service delivery associated with parent or guardian substance use.

DAODAS is continuing to strengthen its collaboration with DSS by funding full-time SUD counselors who are co-located in local DSS offices. These positions strengthen the assessment and service-delivery process for DSS, which is the state's Child Protective Services agency, by conducting screenings, assessments, and coordinated treatment referrals for parents or guardians with active abuse or neglect investigations. Additionally, DAODAS and DSS have jointly hired a liaison tasked with ensuring the efforts of the agencies along common topic areas are aligned and collaborative.

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

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

Healthcare providers in South Carolina are required to report detected cases of HIV/AIDS to DHEC. This data-collection standard has provided the state with a useful trend measure that can be used to track the incidence of HIV/AIDS. **There were 774 newly reported cases of HIV infection in the state in 2020**. As of December 2019, there were 20,334 individuals living in South Carolina who were HIV/AIDS positive, with 3% reporting as having injected drugs.

Approximately 33% of newly reported cases originated from the three metropolitan counties – Charleston, Richland, and Greenville (although the number of reported cases overall was slightly down, with 839 in 2019). Table 4 identifies the "top 10" counties for new HIV cases in calendar year 2020, and the highest number of new cases of HIV were in Richland County (115 cases), Greenville County (76 cases), and Charleston County (68 cases).

Table 4: Top 10 Counties, New HIV Cases Across South Carolina, CY 2020

County	Reported Number of New Cases
Richland	115
Greenville	76
Charleston	68
Horry	59
York	43
Lexington	38
Spartanburg	35
Florence	27
Orangeburg	24
Aiken	22

In the past, DAODAS funded multiple providers across the state to provide HIV early intervention services (EIS). Ten of the funded sites were classified as rural. Within these sites, HIV tests are administered to patients receiving SUD treatment and intervention services during the most recent reporting time frame.

Healthcare providers in South Carolina are also required to report detected cases of TB to DHEC. This data-collection standard has provided the state with a useful measure that can be used to track the incidence of TB. During 2020, there were 67 newly reported cases of TB

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infection in the state, down from 80 reported in 2019 and in line with the slow decline in new annual cases since 2016.

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

For HIV, DAODAS will fund/support testing services for providers in high-need counties with the highest numbers of incident cases of HIV (see Table 4 on previous page). DAODAS will provide direct funding to the county alcohol and drug abuse authorities that already have the infrastructure/capacity to test internally (as long as HIV EIS designation is maintained and – if designation is lost – the county authority will undergo transition to close out the services). DAODAS will require those directly funded authorities to provide HIV testing reports to DHEC, which will then be shared with DAODAS. For those county authorities that lack the current infrastructure/capacity, DAODAS will fund DHEC's STD/HIV division to contract sub-grantees to conduct the testing at the county authority's site. DAODAS will require that either a full-time or part-time employee is hired to go into the select authorities to conduct the testing. The county alcohol and drug abuse authority will then provide HIV testing reports to DHEC, which will also be shared with DAODAS. In terms of testing at the county authorities, as part of their intake/initial assessment for their substance-related diagnosis, all patients will be administered a HIV risk assessment, and patients who score above the risk threshold, will be tested for HIV.

For individuals with TB, DAODAS will enhance the availability of routine TB services for individuals receiving SUD treatment services. The agency will monitor the protocol and support local training efforts and utilize the county authority's EHR capability to track data associated with the provision of patient-focused routine TB screening.

Individuals in need of primary substance misuse prevention:

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

Service providers are also encouraged to: 1) deliver programs/strategies that touch on one of the six Center for Substance Abuse Prevention (CSAP) strategies; and 2) select approved evidence-based programs and strategies to reduce alcohol, tobacco, and other drug use among all South Carolinians. In fiscal year 2020, the majority of all participants served in primary prevention education programs were served using evidence-based universal, selected, and indicated programs.

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

Conclusion:

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

Overview of Plans to Address Data and System Gaps

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

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Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Underage Alcohol Use

Priority Type: SUP

Population(s): PP

Goal of the priority area:

To decrease underage alcohol use in South Carolina.

Strategies to attain the goal:

County prevention providers in South Carolina will provide information to youth and adults in South Carolina about the dangers, laws, consequences and harmfulness of underage alcohol use through the dissemination of information.

County prevention providers in South Carolina will work in collaboration with local law enforcement through the South Carolina Alcohol Enforcement Teams (AET) program. The AETs will focus on environmental prevention activities to reduce youth access to alcohol through both social and retail sources. Specific environmental prevention activities could include alcohol compliance checks, merchant education, controlled part dispersals and party prevention and shoulder taps.

County prevention providers will work in collaboration with community coalitions will work to create and/or revise local policies that may positively impact underage drinking.

Training will be provided to all key stakeholders on evidence-based practices to reduce underage drinking.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Decrease past-month (30-day use) alcohol use among South Carolina high school students as measured by the YRBS.

Baseline Measurement: 19.2% (2021 YRBS Data) SC and 22.7% (2021 YRBS Data) US

First-year target/outcome measurement: 20% or below

Second-year target/outcome measurement: 20% or below

Data Source:

Youth Risk Behavior Survey (YRBS)

Description of Data:

The YRBS is conducted every two years (odd years) in South Carolina. A representative sample of high school students is attempted.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Decrease past month alcohol use (30 day use) among South Carolina high school students as measured by the SC Communities That Care (CTC) Survey

Baseline Measurement: 9.8% (2022 CTC SC State Report)

First-year target/outcome measurement: 10% or below

Second-year target/outcome measurement: 10% or below

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Data Source:

South Carolina Communities That Care Survey

Description of Data:

The CTC is offered every two years (even years) for local counties to coordinate administration of the survey through the local school districts.

Data issues/caveats that affect outcome measures:

Participation is not required. In 2022, 26 of the 46 counties in South Carolina participated in the survey administration. The statewide report prepared by DAODAS is based on weighted data. The purpose of weighting the data is to better represent the larger student population in each county from which the student survey samples were drawn. The data was weighted according to characteristics that are known to be associated with substance use. For example, substance use is known to vary by grade and race/ethnicity. For this reason, we weighted the survey data by grade level and race/ethnicity (white, non-white) so that the students who were surveyed would better reflect the county's student population and the survey results would be more accurate.

The combined results for the 26 counties should not be interpreted as estimates for the entire state population but rather as estimates for only the counties that participated in the survey that year.

Indicator #: 3

Indicator: Decrease the retail access of alcohol to underage youth in South Carolina

Baseline Measurement: 10.4% (alcohol compliance check buy rate for FY22- SC Prevention Outcomes Annual Report)

First-year target/outcome measurement: 10% or below

Second-year target/outcome measurement: 10% or below

Data Source:

Local law enforcement data reported via the Environmental Prevention Reporting System (web-based)

Description of Data:

All alcohol compliance checks done by local law enforcement are reported to DAODAS via the Alcohol Enforcement Team/Environmental Prevention Reporting System network.

Data issues/caveats that affect outcome measures:

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

Priority #: 2

Priority Area: To reduce alcohol-related car crashes across South Carolina.

Priority Type: SUP

Population(s): PP

Goal of the priority area:

To reduce alcohol-related car crashes across South Carolina.

Strategies to attain the goal:

Local prevention providers in South Carolina will disseminate information to driving-age youth and adults about the dangers, law, and consequences of impaired driving through presentation, health fairs, media campaigns, distribution of printed materials, newspaper articles, and other media outreach.

Prevention providers in South Carolina will work in collaboration with local law enforcement through the South Carolina Alcohol Enforcement Team (AET) program. The AETs will focus on environmental prevention activities to reduce alcohol-related car crashes through public safety checkpoints, saturation patrols, and merchant education to prevent over-service and intoxicated driving.

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Key stakeholders will be trained on evidence-based practices reducing alcohol-related car crashes.

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: 30% (2020 FARS)

First-year target/outcome measurement: 29% or below

Second-year target/outcome measurement: 28% or below

Data Source:

Fatal Accident Reporting System (FARS)

Description of Data:

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

Data issues/caveats that affect outcome measures:

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

Priority #: 3

Priority Area: Youth Tobacco Use

Priority Type: SUP

Population(s): PP

Goal of the priority area:

To reduce tobacco/nicotine use among youth in South Carolina.

Strategies to attain the goal:

County prevention providers will provide information to youth and adults in South Carolina about the dangers, laws, consequences and harmfulness of underage tobacco/nicotine use through the dissemination of information.

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/nicotine through retails sources. Specific environmental prevention activities could include tobacco compliance checks and merchant education.

County prevention providers will work in collaboration with community coalitions to create and/or revise local policies that may positively impact youth tobacco/nicotine use.

Training will be provided to all key stakeholders on evidence-based practices to reduce youth tobacco/nicotine use.

Local prevention providers will continue to assist the State in implementing the annual Youth Access to Tobacco Study to measure the retailer violation rate (RVR) in South Carolina.

Local prevention providers will deliver the South Carolina Tobacco Education Program (TEP) for youth identified as having violated South Carolina law prohibiting youth under 18 from attempting to possess or purchase tobacco/nicotine products. The referral of youth to this program can come from the courts, schools, parents/guardians, and/or from the youth themselves.

Annual Performance Indicators to measure goal success

Indicator #: 1

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Indicator: To reduce the state Retailer Violation Rate (RVR) to 10% or less.

Baseline Measurement: 6.9% (SC Prevention Outcomes Report) for FFY22

First-year target/outcome measurement: 10% or below

Second-year target/outcome measurement: 10% or below

Data Source:

Synar Study

Description of Data:

The Federal Synar regulation requires that South Carolina conduct annual, unannounced inspections of a valid probability sample of tobacco outlets that are accessible to minors. The study is designed to determine the extent to which people younger than 21 can successfully buy cigarettes from retail outlets.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Decrease past-month (30-day use) of cigarettes, cigars, smokeless tobacco or electronic vapor product among South Carolina high school students as measured by the YRBS.

Baseline Measurement: 17.4% (SC YRBS) and 18.2% (US YRBS) 2021

First-year target/outcome measurement: 18% or below

Second-year target/outcome measurement: 18% or below

Data Source:

Youth Risk Behavior Survey (YRBS)

Description of Data:

Question on the YRBS includes all tobacco/nicotine products. The YRBS is conducted every two years (odd years) in South Carolina. A representative sample of high school students is attempted.

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Decrease the retail access of tobacco/nicotine to underage youth in South Carolina.

Baseline Measurement: 10.6% (SC Prevention Outcomes Report) FY2022

First-year target/outcome measurement: 10% or below

Second-year target/outcome measurement: 10% or below

Data Source:

Local law enforcement data reported via the Environmental Prevention Reporting System (web-based)

Description of Data:

All tobacco compliance checks done by local law enforcement are reported to DAODAS via the Alcohol Enforcement Team/Environmental Prevention Reporting System network.

Data issues/caveats that affect outcome measures:

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

NOT FINAL

Indicator #:	4
Indicator:	Decrease past month tobacco-cigarette use (30 day use) among South Carolina high school students as measured by the SC Communities that Care (CTC) Survey
Baseline Measurement:	1.3% (SC CTC 2022)
First-year target/outcome measurement:	5% or less
Second-year target/outcome measurement:	5% or less

Data Source:

South Carolina Communities that Care (CTC) survey

Description of Data:

The CTC is offered every two years (even years) for local counties to coordinate administration of the survey through the local school districts.

Data issues/caveats that affect outcome measures:

Participation is not required. In 2022, 26 of the 46 counties in South Carolina participated in the survey administration. The statewide report prepared by DAODAS is based on weighted data. The purpose of weighting the data is to better represent the larger student population in each county from which the student survey samples were drawn. The data was weighted according to characteristics that are known to be associated with substance use. For example, substance use is known to vary by grade and race/ethnicity. For this reason, we weighted the survey data by grade level and race/ethnicity (white, non-white) so that the students who were surveyed would better reflect the county's student population and the survey results would be more accurate.

The combined results for the 26 counties should not be interpreted as estimates for the entire state population but rather as estimates for only the counties that participated in the survey that year.

Indicator #:	5
Indicator:	Decrease past month tobacco use-smokeless (30 day use) among South Carolina high school students as measured by the SC Communities that Care (CTC) Survey
Baseline Measurement:	
First-year target/outcome measurement:	
Second-year target/outcome measurement:	

Data Source:

South Carolina Communities that Care (CTC) survey

Description of Data:

The CTC is offered every two years (even years) for local counties to coordinate administration of the survey through the local school districts.

Data issues/caveats that affect outcome measures:

Participation is not required. In 2022, 26 of the 46 counties in South Carolina participated in the survey administration. The statewide report prepared by DAODAS is based on weighted data. The purpose of weighting the data is to better represent the larger student population in each county from which the student survey samples were drawn. The data was weighted according to characteristics that are known to be associated with substance use. For example, substance use is known to vary by grade and race/ethnicity. For this reason, we weighted the survey data by grade level and race/ethnicity (white, non-white) so that the students who were surveyed would better reflect the county's student population and the survey results would be more accurate.

The combined results for the 26 counties should not be interpreted as estimates for the entire state population but rather as estimates for only the counties that participated in the survey that year.

Indicator #:	6
Indicator:	Decrease past month tobacco use-vaping (30 day use) among South Carolina high school

NOT FINAL

students as measured by the SC Communities that Care (CTC) Survey

Baseline Measurement: 13.4% (2022 CTC)

First-year target/outcome measurement: 12% or less

Second-year target/outcome measurement: 12% or less

Data Source:

South Carolina Communities That Care (CTC) Survey

Description of Data:

The CTC is offered every two years (even years) for local counties to coordinate administration of the survey through the local school districts.

Data issues/caveats that affect outcome measures:

Participation is not required. In 2022, 26 of the 46 counties in South Carolina participated in the survey administration. The statewide report prepared by DAODAS is based on weighted data. The purpose of weighting the data is to better represent the larger student population in each county from which the student survey samples were drawn. The data was weighted according to characteristics that are known to be associated with substance use. For example, substance use is known to vary by grade and race/ethnicity. For this reason, we weighted the survey data by grade level and race/ethnicity (white, non-white) so that the students who were surveyed would better reflect the county's student population and the survey results would be more accurate.

The combined results for the 26 counties should not be interpreted as estimates for the entire state population but rather as estimates for only the counties that participated in the survey that year.

Priority #: 4

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

Priority Type: SUP

Population(s): PP

Goal of the priority area:

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

Strategies to attain the goal:

County prevention providers will provide information to youth and adults in South Carolina about the dangers, laws, consequences and harmfulness of substance use and substance abuse through the dissemination of information.

County prevention providers in South Carolina will deliver evidence-based universal, selected, and/or indicated educational primary prevention programs to youth, adults, and/or families throughout the state based on the needs of individual communities.

DAODAS prevention consultants and regional capacity coaches will provide technical assistance and training to local prevention professionals throughout the state to develop and implement strategic plans to address substance abuse in South Carolina.

DAODAS will train local prevention providers in South Carolina on evidence-based primary prevention programs and practices to reduce substance use and abuse and to promote healthier communities throughout the state.

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

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

NOT FINAL

Baseline Measurement: 100% in FY2022 SC Prevention Outcomes Report

First-year target/outcome measurement: 95% or higher

Second-year target/outcome measurement: 95% or higher

Data Source:

DAODAS funded provider electronic data collection and management through Grants Management System (GMS)

Description of Data:

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

Data issues/caveats that affect outcome measures:

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

Indicator #: 2

Indicator: To reduce the percentage of South Carolina high school youth who used marijuana in the past 30 days.

Baseline Measurement: 14.7% -SC YRBS 2021 and 15.5% US YRBS 2021

First-year target/outcome measurement: 15% or below

Second-year target/outcome measurement: 15% or below

Data Source:

Youth Risk Behavior Survey (YRBS)

Description of Data:

The YRBS is conducted every two years (odd years) in South Carolina. A representative sample of high school students is attempted.

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: To reduce the percentage of South Carolina high school students who reported they ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it.

Baseline Measurement: 6.0% US YRBS 2021

First-year target/outcome measurement: 10% or below

Second-year target/outcome measurement: 10% or below

Data Source:

Youth Risk Behavior Survey (YRBS)

Description of Data:

The YRBS is conducted every two years (odd years) in South Carolina. A representative sample of high school students is attempted.

Data issues/caveats that affect outcome measures:

None

NOT FINAL

Indicator #:	4
Indicator:	Decrease past month marijuana use (30 day use) among South Carolina high school students as measured by the SC Communities That Care (CTC) Survey
Baseline Measurement:	8.9% 2022 SC CTC
First-year target/outcome measurement:	10% or below
Second-year target/outcome measurement:	10% or below

Data Source:

South Carolina Communities That Care (CTC) Survey

Description of Data:

The CTC is offered every two years (even years) for local counties to coordinate administration of the survey through the local school districts.

Data issues/caveats that affect outcome measures:

Participation is not required. In 2022, 26 of the 46 counties in South Carolina participated in the survey administration. The statewide report prepared by DAODAS is based on weighted data. The purpose of weighting the data is to better represent the larger student population in each county from which the student survey samples were drawn. The data was weighted according to characteristics that are known to be associated with substance use. For example, substance use is known to vary by grade and race/ethnicity. For this reason, we weighted the survey data by grade level and race/ethnicity (white, non-white) so that the students who were surveyed would better reflect the county's student population and the survey results would be more accurate.

The combined results for the 26 counties should not be interpreted as estimates for the entire state population but rather as estimates for only the counties that participated in the survey that year.

Indicator #:	5
Indicator:	Decrease past month prescription drug use (30 day use) without a prescription among South Carolina high school students as measured by the SC Communities That Care (CTC) Survey
Baseline Measurement:	2.8% 2022 SC CTC Survey
First-year target/outcome measurement:	5 % or less
Second-year target/outcome measurement:	5% or less

Data Source:

South Carolina Communities That Care (CTC) Survey

Description of Data:

The CTC is offered every two years (even years) for local counties to coordinate administration of the survey through the local school districts.

Data issues/caveats that affect outcome measures:

Participation is not required. In 2022, 26 of the 46 counties in South Carolina participated in the survey administration. The statewide report prepared by DAODAS is based on weighted data. The purpose of weighting the data is to better represent the larger student population in each county from which the student survey samples were drawn. The data was weighted according to characteristics that are known to be associated with substance use. For example, substance use is known to vary by grade and race/ethnicity. For this reason, we weighted the survey data by grade level and race/ethnicity (white, non-white) so that the students who were surveyed would better reflect the county's student population and the survey results would be more accurate.

The combined results for the 26 counties should not be interpreted as estimates for the entire state population but rather as estimates for only the counties that participated in the survey that year.

Priority #: 5

NOT FINAL

Priority Area: Pregnant women and women with dependent children

Priority Type: SUT

Population(s): PWWDC

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Successful completion of treatment episodes for pregnant women.

Baseline Measurement: In 2022, 38% or pregnant women had a successful completion of a treatment episode

First-year target/outcome measurement: 40.5% (up 2.5% from baseline)

Second-year target/outcome measurement: 43% (Up 5% from baseline)

Data Source:

Provider clinical electronic health record

Description of Data:

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

Data issues/caveats that affect outcome measures:

None at this time.

Indicator #: 2

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

Baseline Measurement: In 2020, 183 pregnant women diagnosed with an Opioid Use Disorder began using MAT Services

First-year target/outcome measurement: 188 (a 2.5% increase from the baseline number)

Second-year target/outcome measurement: 193 (a 5% increase from the baseline number)

Data Source:

DAODAS provider electronic health record

Description of Data:

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

Data issues/caveats that affect outcome measures:

None at this time.

NOT FINAL

Indicator #:	3
Indicator:	Number of women with dependent children who are admitted into services.
Baseline Measurement:	In FY2022, 6,212 women with dependent children were admitted into services
First-year target/outcome measurement:	6,367 (this is a 2.5% increase from the baseline)
Second-year target/outcome measurement:	6523 (this is a 5% increase from the baseline)

Data Source:

DAODAS provider electronic health record.

Description of Data:

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

Data issues/caveats that affect outcome measures:

None at this time.

NOT FINAL

Priority #:	6
Priority Area:	Service Delivery to Uninsured Populations
Priority Type:	SUT
Population(s):	Other

Goal of the priority area:

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

Strategies to attain the goal:

1. Continue to expand fee for service block grant reimbursement strategies.
2. Work with provider network to expand service menus eligible for reimbursement

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Uninsured individuals receiving SABG funding for their treatment services.
Baseline Measurement:	In FY2022, 5205 uninsured individuals received a funded treatment service.
First-year target/outcome measurement:	5335 (this is a 2.5% increase from the baseline)
Second-year target/outcome measurement:	5465 (this is a 5% increase from the baseline)

Data Source:

DAODAS funder electronic health record.

Description of Data:

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

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 7

Priority Area: Adolescents with a Substance Use Disorder

Priority Type: SUT

Population(s): Other

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of adolescents admitted to treatment services.

Baseline Measurement: In FY2022, 3172 adolescents were admitted to treatment services.

First-year target/outcome measurement: 3251 (this is a 2.5% increase from the baseline)

Second-year target/outcome measurement: 3331 (this is a 5% increase from the baseline)

Data Source:

DAODAS provider electronic health record.

Description of Data:

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

Data issues/caveats that affect outcome measures:

None at this time.

NOT FINAL

Priority #: 8

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

Priority Type: SUT

Population(s): Other

Goal of the priority area:

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

Strategies to attain the goal:

1.Increase collaboration with the South Carolina Department of Corrections (SCDOC) to incorporate substance use disorder treatment services for offender re-entry programming.
2. Continue to coordinate treatment planning and service provision efforts for youth clients involved with the state's juvenile justice agency.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Criminal justice system referred treatment admission totals.

Baseline Measurement: In FY2022, 12,878 criminal justice referrals were admitted to treatment.

First-year target/outcome measurement: 13,200 (this is a 2.5% increase from the baseline)

Second-year target/outcome measurement: 13,522 (this is a 5% increase from the baseline)

Data Source:

DAODAS provider electronic health record.

Description of Data:

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

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 9

Priority Area: Persons Who Inject Drugs

Priority Type: SUT

Population(s): PWID

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: In FY2022, 2,169 persons who report injecting drugs were admitted to treatment services

First-year target/outcome measurement: 2,223 (this is a 2.5% increase from the baseline)

Second-year target/outcome measurement: 2277 (this is a 5% increase from the baseline)

Data Source:

DAODAS provider electronic health record.

Description of Data:

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

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 10

Priority Area: Individuals with Tuberculosis and Other Communicable Diseases

Priority Type: SUT

Population(s): TB

Goal of the priority area:

NOT FINAL

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Patients at risk for TB screened at time of assessment.

Baseline Measurement: 100%

First-year target/outcome measurement: 100%

Second-year target/outcome measurement: 100%

Data Source:

DAODAS provider electronic health record.

Description of Data:

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

Data issues/caveats that affect outcome measures:

None at this time.

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Footnotes:

NOT FINAL

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 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

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

Activity (See instructions for using Row 1.)	Source of Funds									
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention[c] and Treatment	$37,382,258.61		$840,000.00	$33,294,311.83	$33,612,729.53	$0.00	$1,781,752.00		$951,728.00	$11,963,676.12
a. Pregnant Women and Women with Dependent Children[c]	$5,227,597.20		$420,000.00	$3,245,198.78	$0.00	$0.00	$495,920.00		$0.00	$959,969.00
b. Recovery Support Services	$4,228,598.36		$0.00	$6,967,360.05	$1,496,407.84	$0.00	$0.00		$132,933.00	$1,732,350.73
c. All Other	$27,926,063.05		$420,000.00	$23,081,753.00	$32,116,321.69	$0.00	$1,285,832.00		$818,795.00	$9,271,356.39
2. Primary Prevention[d]	$12,755,575.98		$0.00	$10,469,818.89	$5,737,721.01	$0.00	$0.00		$1,082,961.00	$3,335,641.93
a. Substance Use Primary Prevention	$12,755,575.98		$0.00	$10,469,818.89	$5,737,721.01	$0.00	$0.00		$1,082,961.00	$3,335,641.93
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
6. Early Intervention Services for HIV	$0.00		$0.00	$490,006.00	$1,132,236.00	$0.00	$0.00		$0.00	$0.00
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	$2,603,343.41		$560,000.00	$2,476,590.65	$3,437,595.55	$0.00	$87,768.00		$0.00	$942,936.49
11. Crisis Services (5 percent set-aside)										
12. Total	**$52,741,178.00**	**$0.00**	**$1,400,000.00**	**$46,730,727.37**	**$43,920,282.09**	**$0.00**	**$1,869,520.00**	**$0.00**	**$2,034,689.00**	**$16,242,254.54**

NOT FINAL

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

[c] Prevention other than primary prevention

[d] The 20 percent set-aside funds in the SUPTRS BG must be used for activities designed to prevent substance misuse.

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Footnotes:

Planning Tables

Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's National Survey on Drug Use and Health (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment column, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	5,000	720
2. Women with Dependent Children	26,000	6,811
3. Individuals with a co-occurring M/SUD	111,200	2,382
4. Persons who inject drugs	7,000	2,777
5. Persons experiencing homelessness	4,000	902

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

The following are data sources for the aggregate numbers estimated in need: 1) Based on total number of women that gave birth in SC in 2019 that had an accompanying diagnosis of maternal substance use at any time during pregnancy/child birth (data request from SC Revenue and Fiscal Affairs Office) 2) Based on statistics provided by the Annie E. Casey Foundation (https://www.aecf.org/resources/2021-kids-count-data-book) regarding number of children living in single-parent homes in SC coupled with a SAMHSA report (https://www.samhsa.gov/data/sites/default/files/report_3223/ShortReport-3223.html) indicating that 80% of those are single-mother households; additionally the report noted that 8% of those mothers had a past-year SUD 3) Based on NSDUH estimates (https://www.samhsa.gov/data/nsduh/state-reports-NSDUH-2019) that 278,000 South Carolinians have an SUD and NIDA estimates that 40% of those with an SUD have a co-occurring mental health condition (https://www.drugabuse.gov/drug-topics/trends-statistics/infographics/comorbidity-substance-use-other-mental-disorders) 4) Based on percentage of statewide County Alcohol and Drug Authority clients who report IDU at intake coupled with NSDUH estimates regarding number not in but needing treatment for illicit drug use ages 18 and older

NOT FINAL

(https://www.samhsa.gov/data/nsduh/state-reports-NSDUH-2019) 5) Statewide Estimate by the U.S. Interagency Council on Homelessness (https://www.usich.gov/homelessness-statistics/sc/)

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Footnotes:

NOT FINAL

Planning Tables

Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	FFY 2024		
Expenditure Category	**FFY 2024 SUPTRS BG Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[3]	$16,576,830.13	$818,795.00	$10,231,325.39
2 . Substance Use Primary Prevention	$6,377,787.99	$1,082,961.00	$3,335,641.93
3 . Early Intervention Services for HIV[4]			
4 . Tuberculosis Services			
5 . Recovery Support Services[5]	$2,114,299.18	$132,933.00	$1,732,350.73
6 . Administration (SSA Level Only)	$1,301,671.70		$942,936.49
7. Total	**$26,370,589.00**	**$2,034,689.00**	**$16,242,254.54**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

NOT FINAL

Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions 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 use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). The most recent AtlasPlus HIV data report 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 required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services 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 SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG funds for EIS/HIV even though the 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 SUPTRS BG 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 will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

[5]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

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Footnotes:

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Planning Tables

Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	A	B		
Strategy	IOM Target	FFY 2024		
		SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
1. Information Dissemination	Universal	$2,164,896	$343,185	$1,964,751
	Selected			
	Indicated			
	Unspecified			
	Total	**$2,164,896**	**$343,185**	**$1,964,751**
2. Education	Universal	$263,298		$360,294
	Selected	$65,825		$90,074
	Indicated	$197,474		$270,221
	Unspecified			
	Total	**$526,597**	**$0**	**$720,589**
3. Alternatives	Universal	$292,554	$24,148	$138,123
	Selected			
	Indicated			
	Unspecified			
	Total	**$292,554**	**$24,148**	**$138,123**
4. Problem Identification and Referral	Universal			
	Selected	$102,394		
	Indicated	$307,181		$7,996
	Unspecified			
	Total	**$409,575**	**$0**	**$7,996**
	Universal			$293,300

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5. Community-Based Processes	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$293,300**
6. Environmental	Universal			$135,884
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$135,884**
7. Section 1926 (Synar)-Tobacco	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
8. Other	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$3,393,622**	**$367,333**	**$3,260,643**
Total SUPTRS BG Award[3]		**$26,370,589**	**$2,034,689**	**$16,242,255**
Planned Primary Prevention Percentage		**12.87 %**	**18.05 %**	**20.08 %**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Footnotes:

SAPTBG: A total of $379,849.10 of prevention funds and a total of $96,868.54 of prevention from the combined column are accounted for in resource table 6. This brings the total for prevention from table 6 to $476,717.64.

COVID-19 Award: A total of $25,000 of prevention funds are accounted for in resource table 6

ARP Award: a total of $75,000.00 of prevention funds are accounted for in resource table 6.

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Planning Tables

Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023   Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award[1]	FFY 2024 ARP Award[2]
Universal Direct	$833,778		$882,671
Universal Indirect	$4,394,419	$632,961	$2,009,680
Selected	$168,218		$90,074
Indicated	$504,655	$425,000	$278,216
Column Total	**$5,901,070**	**$1,057,961**	**$3,260,642**
Total SUPTRS BG Award[3]	**$26,370,589**	**$2,034,689**	**$16,242,255**
Planned Primary Prevention Percentage	**22.38 %**	**52.00 %**	**20.08 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Footnotes:

SAPTBG: A total of $379,849.10 of prevention funds and a total of $96,868.54 of prevention from the combined column are accounted for in resource table 6. This brings the total for prevention from table 6 to $476,717.64.

COVID-19 Award: A total of $25,000 of prevention funds are accounted for in resource table 6

ARP Award: a total of $75,000.00 of prevention funds are accounted for in resource table 6.

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Planning Tables

Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
Prioritized Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☑
Marijuana	☑	☐	☐
Prescription Drugs	☑	☑	☑
Cocaine	☐	☐	☐
Heroin	☐	☐	☐
Inhalants	☐	☐	☐
Methamphetamine	☐	☐	☐
Fentanyl	☑	☑	☑
Prioritized Populations			
Students in College	☑	☑	☑
Military Families	☐	☐	☐
LGBTQI+	☐	☑	☑
American Indians/Alaska Natives	☐	☐	☐
African American	☑	☑	☑

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Hispanic	☑	☑	☑
Persons Experiencing Homelessness	☐	☐	☐
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☐	☐	☐
Rural	☑	☑	☑
Underserved Racial and Ethnic Minorities	☑	☑	☑

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

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Planning Tables

Table 6 Non-Direct-Services/System Development

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023   Planning Period End Date: 9/30/2024

Expenditure Category	FFY 2024				
	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems	$25,000.00	$25,000.00	$25,000.00	$196,800.00	
2. Infrastructure Support			$60,000.00		
3. Partnerships, community outreach, and needs assessment	$84,346.00	$121,081.29			
4. Planning Council Activities (MHBG required, SUPTRS BG optional)					
5. Quality Assurance and Improvement	$105,000.00	$15,000.00	$83,737.08		
6. Research and Evaluation		$138,465.00		$25,000.00	$75,000.00
7. Training and Education	$101,063.11	$80,302.81	$25,000.00		
8. Total	**$315,409.11**	**$379,849.10**	**$193,737.08**	**$221,800.00**	**$75,000.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

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Environmental Factors and Plan

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

Narrative Question

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

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

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

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

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

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

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

f) Persons with substance use disorders in the justice system

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

h) Other adults with substance use disorders

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

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

NOT FINAL

Behavioral health services in our state are delivered through a complex array of fragmented systems with varying policies and resources. As we recognize the significant gaps in services and funding the Governor and Legislature have appropriated a significant amount of funding to the SC Dept. of Health and Human Services, (our Medicaid agency) for the purpose of improving infrastructure of the current system. The agency has established an advisory committee and consultants to evaluate local needs and conceptualize innovative service models to address adults and adolescents in mental, addiction, and co-occurring crisis, and before crisis along a continuum of care through community-based services. One year into the planning for South Carolina Behavioral System Redesign is underway considering how with a pilot in one of the four regions of the state will develop acute, crisis, outpatient, residential, community-based, and prevention services will address children and youth with serious emotional disturbances and substance use issues, as well as adults with mental and substance use disorders. The plans are considering how services will be accessible, cost-effective, sustainable, and most importantly, patient-centered. As state leadership,(with local and patient input) determines how integrated accessible care will be developed robustly, grants to hospitals have gone out across the state for the development of EmPATH units within hospitals to ease the overcrowding of emergency departments and to better serve individuals in psychiatric need. When built, these units will be an important alternative to incarceration for people who are better served with clinical assessment and services. Next, lower-levels of care for step-down are being conceptualized and existing care is being coordinated to the units to ensure a cascade of availability based on need. Psychiatric Residential Treatment Facilities are desperately needed in the state, particularly for children and youth. The Medicaid agency has worked to identify reimbursement opportunities and mishaps to develop incentives for PRTF development.
The Department of Mental Health has worked to build out the 988 services, and in partnership with the SSA developed and deployed an online interactive screening program for individuals to self-screen and connect with services. Over 3,000 citizens have taken the screener, most of whom score with severe depression and immediate needs. Qualitative and quantitative data analysis are underway with the screening results to inform service and program improvement as well as outreach and connection.
Substance use service providers have been strongly encouraged by the SSA to engage in outreach. A few have done very well at partnering with other organizations to make services available in outlying areas of need or near overdose hotpots. Recovery community organizations are still being supported to conduct HIV screening with State funds.
The Women's Services Coordinator and NTN have been working closely with a Quality Manager to review women's services and women and children's residential services. Capacity is still being build back after partial closures from COVID in these residential settings as well as in withdrawal management settings. Some providers are only now opening all available beds. Yet, censuses have been low and without waitlists as fewer individuals are seeking or being referred to this level of care.
Overdose prevention efforts are robust and always aiming to engage individuals in accessing care.

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

Parity is essentially not enforced in South Carolina. The SSA has suggested that the state conduct a Parity Compliance Market Survey to better understand how parity is or is not being honored. The market however may not be interested in engaging in this and stakeholder buy-in would be essential to success outside of a mandate.

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

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

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

c) Efforts to integrate primary care into behavioral health settings

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. 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.
The SSA works closely with our SC Office of Rural Health and in partnership the agencies will be educating rural primary care clinics on the importance of treating with MOUD. Resources and support will be offered to those practices willing to begin MOUD services. Stigma and reimbursement continue to be primary challenges expanding practice in primary care settings.
Addiction care in acute settings is also desperately needed as buprenorphine stabilization has not been widely adopted as a standard of care.
The SSA has opened SOR grant funds to health systems to plan and seed implementation of MOUD in primary and acute care settings.
In 2024 the South Carolina Center of Excellence in Addiction, (which the SSA is a founding member of) will analyze Medicaid and SSA payer claims from 2020 to 2023 to understand with the Opioid Cascade of care where service gaps in care are occurring in our public and private settings. This information will allow for targeted investments to build capacity in future years.
Additionally, the Center of Excellence is also conducting a statewide environmental scan of psychiatric mental health nurse

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practitoners to understand where they are practicing and how we can leverage those professionals to expand access to mental health and addiction services in safety net settings. 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.

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

a) Adults with serious mental illness

b) Adults with substance use disorders

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

The state's service delivery systems for adults with serious mental illness and adults with substance use disorder have historically been and continue to be deeply bifurcated. Coordination of care for these populations in the public systems is largely dependent upon local relationships and local capacity, (ability/willingness) to treat people with co-occurring disorders. Though targeted case management and other case management billing options are available for coordination. However, there is a severe scarcity of providers that are able and willing to treat individuals with both serious mental illness and substance use disorders. The state has invested in a new referral platform, UniteUs to support care coordination and referrals to care and also to resources for social and medical needs. As the General Assembly studies and contemplates restructuring the state's health services agencies, there is opportunity to improve care coordination and develop services for more complex needs.

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

The 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 31 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.

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

Should the state undergo health service agency restructuring technical assistance will be needed to support redesign of service delivery for improved access, integration, and coordination.

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Footnotes:

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Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

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

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

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

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

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

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

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

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

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

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

Please respond to the following items:

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

NOT FINAL

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?

South Carolina strives to ensure equity in access, services provided, and substance use disorders outcomes among individuals of all cultures, sexual/gender minorities, orientation, and ethnicities. The S.C. Department of Alcohol and Other Drug Abuse Services (DAODAS) has implemented strategic goals, objectives, and performance measures for all its county subgrantees to reduce health disparities and promote equity.

Our providers use the Strategic Prevention Framework model to conduct needs assessments using quantitative and qualitative data to identify and improve the capacity and availability of equitable services for underserved populations and communities, and to reduce racial and ethnic health disparities.

Examples of strategies that DAODAS has put in place to assist the county providers in reducing health disparities among the underserved populations and communities are:
• Training provider staff on culturally and linguistically appropriate services.
• Increasing the use of electronic health records to improve treatment services and increase coordination of care.
• Training in evidence-based models for clinical, peer support, and administrative staff to promote high-quality services to reduce racial and ethnic health disparities.
• Addressing the physical, mental, and social determinants of health of individuals with substance use and co-occurring disorders, with a focus on cultural competence and inclusion of experts from such fields as medicine, psychiatry, housing, transportation, employment, and education.

DAODAS, through the SUPTRBG, funds the following initiatives to increase equity in access and high quality of service delivery outcomes for all cultures, sexual/gender minorities and orientation, and ethnicities:
• Training of nationally recognized Catawba Nation members who are in recovery as Certified Peer Support Specialists, ensuring that other tribal members have access to evidence-based services without having to leave their land.
• Providing a safe and welcoming space in community providers for LGBTIQQ+ individuals and their allies.
• The Mom's IMPACTT (Improving Access to Maternal Mental Health and Substance Use Disorder Care Through Telemedicine and

NOT FINAL

Tele-Mentoring) program for pregnant women and women within 12 months postpartum who have dependent children.
• Use of Master Word to provide interpretive services for individuals seeking substance use disorders.
• Faith-based organizations.

Please indicate areas of technical assistance needed related to this section

Not at this time.

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Footnotes:

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Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[6] http://psychiatryonline.org/

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

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

Please respond to the following items:

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

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

- **a)** [x] Leadership support, including investment of human and financial resources.
- **b)** [x] Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** [x] Use of financial and non-financial incentives for providers or consumers.
- **d)** [ ] Provider involvement in planning value-based purchasing.
- **e)** [x] Use of accurate and reliable measures of quality in payment arrangements.
- **f)** [x] Quality measures focused on consumer outcomes rather than care processes.
- **g)** [x] 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?

After 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 incentivized to see patients.

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

None at this time.

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Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

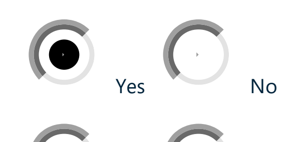
While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

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

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

Please respond to the following:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?



Yes No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

Yes No

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

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 through desk reviews and site visits. DAODAS has also implemented a new Grants Management System to provide continued oversight for subgrantees, and increased transparency for the agency.

Please indicate areas of technical assistance needed related to this section

DAODAS is a past recipient of technical assistance regarding this section. No additional assistance is needed at this time.

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Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

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

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

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

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

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

Please respond to the following items:

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

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

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

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

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Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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 Processes*** 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.

NOT FINAL

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)

a) [ ] Children (under age 12)

b) [x] Youth (ages 12-17)

c) [x] Young adults/college age (ages 18-26)

d) [x] Adults (ages 27-54)

e) [x] Older adults (age 55 and above)

f) [ ] Cultural/ethnic minorities

g) [ ] Sexual/gender minorities

h) [ ] Rural communities

i) [ ] Others (please list)

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

a) [x] Archival indicators (Please list)

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

b) [x] National survey on Drug Use and Health (NSDUH)

c) [x] Behavioral Risk Factor Surveillance System (BRFSS)

d) [x] Youth Risk Behavioral Surveillance System (YRBS)

e) [ ] Monitoring the Future

f) [ ] Communities that Care

g) [x] State - developed survey instrument

h) [ ] Others (please list)

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds?

( ) Yes (•) No

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

b) If no, (please explain) how SUPTRS BG funds are allocated:

A funding formula was established by DAODAS in July 2013, 2019 and most recently in 2023 for the FY2024 state fiscal year. DAODAS provides SAPT BG primary prevention set aside dollars to 31 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 $70,000 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 their total base funds for primary prevention service implementation is $115,000.

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. Currently the revised population-based data from the 2020 Census is being used. The percentages did not change from Fiscal Year 2023. These range from 0.40% to 13.87%. The funding range for FY24 increased and is currently an additional $7,223.66 for the least populated county to $249,152.33 for the greatest populated county. 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.

6. Does your state integrate the National CLAS standards into the assessment step?

Yes No

a) If yes, please explain in the box below.

One of DAODAS's core principles is to serve the residents South Carolina regardless their race, ethnic background, or sexual orientation. Since cultural competency is interwoven in the Strategic Planning Framework, it is also addressed in the county plans to ensure programs, policies, and practices are appropriate and effective for populations served throughout county. The needs assessment process reflects gathering data demonstrated in various populations, including racial, ethnic, sexual-gender
minorities.

b) If no, please explain in the box below.

7. Does your state integrate sustainability into the assessment step?

Yes No

a) If yes, please explain in the box below.

Sustainability is integrated into the county plan process as this process is built on the Strategic Prevention Framework (SPF).

b) If no, please explain in the box below.

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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 Processes*** 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.

NOT FINAL

Capacity Planning

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce?

Yes No

a) 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 primary prevention workforce?

Yes No

a) If yes, please describe mechanism used.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?

Yes No

a) If yes, please describe mechanism used.

Since FY2016, DAODAS has coordinated an annual training survey to help determine capacity needs of the prevention workforce in South Carolina. Subsequently, DAODAS, PIRE and SCAPPA work to coordinate trainings provided throughout the year. DAODAS and SCAPPA host four meetings/trainings a year on the first Thursday of the month for the prevention field (one each quarter-August, November, February and May). The meetings are held in-person in Columbia. SCAPPA also hosts an annual meeting that includes training yearly in December. Throughout the year, DAODAS also offers the SPF Application for Prevention Success Training (SAPST) and Prevention Ethics to ensure needs are met.

4. Does your state integrate the National CLAS Standards into the capacity building step?

Yes No

a) If yes, please explain in the box below.

One of DAODAS's core principles is to serve the residents South Carolina regardless their race, ethnic background, or

sexual orientation. Since cultural competency is interwoven in the Strategic Planning Framework, it is also included in the county plans. Agencies are to ensure programs, policies, and practices are appropriate and effective for the various populations served throughout county. The capacity process reflects identifying internal and external capacity that the agency has or needs to build in order to provide services for various populations, including racial, ethnic, sexual-gender minorities.

5. Does your state integrate sustainability into the capacity building step?

Yes No

a) If yes, please explain in the box below.

Sustainability is integrated into the county plan process as this process is built on the Strategic Prevention Framework (SPF).

b) If no, please explain in the box below.

NOT FINAL

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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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 Processes*** 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.

NOT FINAL

Planning

1. Does your state have a strategic plan that addresses substance use primary 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 SUPTRS BG?

( ) 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 SUPTRS BG primary prevention funds
- **b)** [ ] Timelines
- **c)** [ ] Roles and responsibilities
- **d)** [ ] Process indicators
- **e)** [ ] Outcome indicators
- **f)** [ ] Cultural competence component (i.e., National CLAS Standards)
- **g)** [ ] Sustainability component

h) ☐ Other (please list):

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

i) ☑ Not applicable/no prevention strategic plan

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

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

N/A

6. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? ○ Yes ● No

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

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

N/A

8. Does your state integrate the National CLAS Standards into the planning step? ● Yes ○ No

a) If yes, please explain in the box below.

One of DAODAS's core principles is to serve the residents South Carolina regardless their race, ethnic background, or sexual orientation. Since cultural competency is interwoven in the Strategic Planning Framework, it is also addressed in the county plans. Providers are to demonstrate that programs, policies, and practices selected to implement are appropriate and effective for populations identified to serve throughout county.

b) If no, please explain in the box below.

N/A

9. Does your state integrate sustainability into the planning step? ● Yes ○ No

a) If yes, please explain in the box below.

Sustainability is integrated into the county plan process as this process is built on the Strategic Prevention Framework (SPF).

b) If no, please explain in the box below.

N/A

NOT FINAL

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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 Processes*** 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 SUPTRS BG 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 31 local agencies-some are county government, and some are local non-profits- that provide prevention, intervention,

NOT FINAL

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 SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

Prevention staff in local county alcohol and drug abuse authorities 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. Due to the COVID-19 pandemic, local county prevention staff developed virtual prevention services, drive-thru health fairs and increased the use of social media platforms to provide information to the public. Although the effects of the pandemic have diminished, many agencies are continuing to utilize the virtual activities in collaboration with the traditional "in-person" prevention activities in their communities.

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. 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. Previously funded education programs that have been successfully implemented and can also be provided moving forward are the following:

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. In FY2022, the program was implemented with 298 matched middle school youth at two sites. There was a statistically significant positive change in perceived risk.

All Stars is a comprehensive ATOD prevention curriculum. In FY2022, this program was used by one middle school site with a total of 94 matched participants. There was a statistically significant positive change in perceived risk.

Class Action is a comprehensive ATOD prevention curriculum. This program was used in FY2022 by two high school sites with a total of 34 matched (high school) participants. There was a statistically significant positive change in perceived risk.

Keepin' It Real is a video-enhanced intervention for youth 10 to 17 that uses a culturally grounded resiliency model that incorporates traditional ethnic values and practices to protect against drug use. It was used by three sites in FY2022 with a total of 71 matched middle school participants. There was a statistically significant positive change in perceived risk.

Life Skills Training is a skill based ATOD prevention curriculum and was the most widely implemented program in FY2022 with eight sites and 882 matched middle and 95 high school participants. For middle school, there were statistically significant positive changes in perceived risk, disapproval of use, and perceived peer norms. For substance use, there was a statistically significant decrease in e-cigarette or vape use. For high school, there were statistically significant positive changes in perceived risk and perceived peer norms. Additionally, there was a significant decrease in e-cigs or vape use.

Operation Prevention: Rx, is an evidenced-based program. Operation Prevention's mission is to educate students about the true impacts of opioids and kick-start lifesaving conversations in the home and classroom. It was used by one middle school site in FY2022 with a total of 110 matched participants. There was a statistically significant undesired change in perceived parental attitudes. There were no statistically significant changes in substance use.

Prime for Life: Exploring is an evidence-based motivational prevention, intervention and pretreatment program specifically designed for people who might be making high-risk choices, was used by one high school site in FY2022 with a total of 28 matched participants. There were statistically significant desired changes in three of the five risk factors (perceived risk, disapproval of use and perceived peer norms). There were no significant changes in substance use.

Project Alert, a comprehensive ATOD prevention curriculum for middle school students, was delivered at one site in FY2022 with a total of 55 matched participants. There were statistically significant desired changes in all five risk factors. There were no significant changes in substance use.

NOT FINAL

Why Try is a comprehensive ATOD prevention curriculum, implemented at one middle school site with 23 matched participants in FY2022. There was a significant desired change in perceived peer norms and no changes in substance use.

County authorities are not required to use evidence-based interventions exclusively, though most do. Nine different curriculum-based programs were implemented, with 100% of participants being in evidence-based programs in FY2022. Providers were instructed to administer the pre-test within two weeks prior to the start of the program content and administer the post-test within two weeks following the end of the content. In March 2020, the coronavirus pandemic forced the physical closure of most South Carolina schools. Providers asked DAODAS and PIRE to assist with developing an online survey. Consequently, four online surveys were developed to accommodate the request: pre & post-middle school online surveys and pre & post-high school online surveys. Prevention personnel used the online surveys with the delivery of online or remote curriculum-based prevention education programs. Regardless of whether paper or online surveys, providers were instructed on participant protection procedures that would ensure confidentiality.

There were 1,547 middle school participants with matched pre- and post-tests. Most (60.1%) participants were in 6th grade. By sex, the distribution was females (45.9%) and males (50.6%). Most participants identified as White (44.8%) or Black/African American (34.9%).

There were 166 high school participants with matched pre- and post- tests. Most (48.2%) participants were in the 9th grade. By sex, the distribution was females (47.9%) and males (50.9%). Most participants identified as Black (45.5%) or White 46.1%).

For middle school, the results showed statistically significant positive changes on three of the five risk factor measures: perceived risk, disapproval of use and perceived peer norms. For high school, the results showed statistically significant positive changes on three of the five risk factor measures: perceived risk, disapproval of use and perceived peer norms.

For middle school substance use, there were statistically significant reductions in e-cigarette or vapes, marijuana and binge drinking use. For high school substance use, there were no statistically significant reductions.

For all eight substances measured, more than 95.3% of middle school participants who were non-users at pre-test remained non-users at post-test for each substance.

For all eight substances measured, more than 92% of high school participants who were non-users at pre-test remained non-users at post-test for each substance.

For all eight substances measured, at least 26.2% of middle school participants who used it at pre-test reported reducing their use for that substance at post-test. For all eight substances measured, at least 33.3% of high school participants who used it at pre-test reported reducing their use for that substance at post-test.

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

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. These types of activities will continue to be funded.

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 to be funded activities. County authorities often play a role in the post-arrest process for youth violators of alcohol or tobacco laws. The COVID-19 pandemic affected enforcement efforts for both underage alcohol and tobacco. Related to alcohol, county providers often offer programming as part of their solicitor's Alcohol Education Program (AEP), a program many first-time offenders will be offered in lieu of a conviction. Two hundred two (202) youth were served in AEP in FY '22, up from FY'21 (178 youth). For tobacco, county agencies offer the Tobacco Education Program (TEP) for youth as a program they can complete when charged with underage tobacco possession in lieu of paying a fine. In FY'22, 147 youth participated in TEP, up from FY '21 when 110 youth participated.

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 to receive funding.

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.

NOT FINAL

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.

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 to receive funding. 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, 31 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 offered 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 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 2022 include:

In FY'22, there were 4,495 alcohol compliance checks and 601 tobacco compliance checks entered in the online reporting system. In FY '22, 41 counties submitted alcohol compliance checks and 18 counties submitted tobacco forms, compared to 34 counties and 13 counties, respectively, in FY '21. There may have been additional compliance checks for which a form was
not entered in the online system, so the data received may not reflect every compliance check during the year, though it should contain most of the enforcement activity. The data suggested that both alcohol and tobacco buy rates increased from FY'21 from 9.8% to 10.4% for alcohol and from 5.9% to 10.6% for tobacco. The buy-rate for alcohol is the highest level reported since 2016 and the buy-rate for tobacco is at the highest level since 2011.

Most FY'22 alcohol compliance checks were conducted at convenience stores (60.8%). The next most common type of location was liquor stores (11.6%), then large grocery stores (7.9%), small grocery stores (6.2%), restaurants (6%), drug stores (5%), other outlets (1.4%), bars (1%), and hotels (0.2%). In most cases, the youth attempted to buy beer (77.8%) although a substantial number attempted to buy liquor (10.7%) or alcopop drinks (5.8%). Wine or wine coolers were attempted 3.1% of the time. Most youth volunteers were between the ages of 16 and 19 (97.2%). More purchase attempts were made by males (52.3%) than females. Most alcohol checks were conducted by White youth (89.7%), followed by Black or African American youth (5.9%).

For tobacco compliance checks, 74.2% were conducted at convenience stores, followed by other tobacco outlets (11%), large grocery stores (6.8%), small grocery stores (5%), drug stores (2.8%) and liquor stores (0.2%). In most cases, youth attempted to buy cigarettes (42.6%). The remaining attempts were made for e-cigarettes or vaping products (juice, cartridges) (35.8%),
cigarillos or little cigars (1.5%) and cigars (1.5%). To place this in context, in FY '08, only 5% of attempts were for these non-cigarette tobacco products. In FY '22, the most common age for youth volunteers was 16 (50.1%) and 17 (18.2%). More

NOT FINAL

purchase attempts were made by females (72.2%) than males. White youth conducted 75.7% of tobacco compliance checks, and more than one race youth conducted 17% of the checks.

The other primary enforcement activity aimed at retailers is the use of bar checks. The intent of bar checks can vary between (1) doing a sweep of patrons in a bar/restaurant to look for those who are underage or have fake IDs, (2) looking for retailer violations such as selling to underage customers or some other violation of an alcohol license, or (3) building rapport with retailers or reminding them to be mindful of relevant laws during a “walk through” or “casual contact.” One “bar check” or visit to an establishment could serve multiple purposes.

Bar Checks are conducted at on-premises alcohol establishments. The operation is not a compliance check in the sense that an undercover youth is sent into an establishment to attempt to purchase alcohol. In contrast, the operation occurs when law enforcement officers “walk through” an establishment checking for fake IDs, observing for retailer violations, and
conducting casual contacts with alcohol outlet personnel and patrons. There were 318 operations recorded in FY ’22 in nine counties, up from 284 operations in FY ’21. The officers issued 54 tickets for fake IDs, 7 verbal or written warnings, and 51 various retailer violations. Shoulder tap operations involve an underage volunteer standing outside of an off-premises
establishment and asking adults going in to purchase alcohol for them. Those who do are ticketed. In FY’22, three counties representing three circuits conducted shoulder taps a total of four different times, up from two in FY ’21 and down from five in FY ’20. Altogether, 68 individuals were approached in FY ’22 compared to 22 in FY ’21. No one purchased alcohol for
the youth. In FY ’21 the rate was 0%, and it was 6.2% in FY ’20. Twenty-eight (28) other charges were written during these operations.

In FY’22, AETs across South Carolina recorded 685 public safety checkpoints in 27 counties. The checkpoints expended more than 916 hours (about 1 and a half months). Officers recorded contact with approximately 40,214 vehicles resulting in 3,875 citations and arrests. Highlights of those citations and arrests were 315 tickets for drug possession, 97 DUI arrests (.08 or greater BAC [Blood Alcohol Concentration]) among adults, 8 fugitives apprehended, 136 tickets for open container, and 42 felony arrests. Thirty-eight (38) underage individuals were ticketed for alcohol possession/consumption at the checkpoints.

Saturation patrols, also called directed patrol, are sometimes described as “roving checkpoints.” Public safety checkpoints are stationary while saturation patrols are conducted by officers patrolling in vehicles. Both enforcement operations concentrate on areas where vehicle crashes and traffic violations occur. These focus areas are determined by data analysis and officers’
knowledge about the areas. In FY 2022, there were 208 saturation patrols that expended a total of 582 hours and involved 621 officers. This type of operation was recorded in 19 counties. The patrols resulted in 2,200 citations and arrests. In those violations, there were 88 tickets for drug possession, 15 DUI arrests, 3 fugitives apprehended, 51 tickets for open container, and 19 felony arrests.

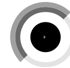
Alcohol Enforcement Teams in seven counties recorded 52 party dispersals in FY ‘22. A party dispersal is conducted when officers receive a complaint from a source and investigate that complaint. In some cases, officers observe a social gathering involving individuals under the legal alcohol drinking age of 21 years old while on duty and investigating the gathering. In FY
’22, the predominant source for the party investigation was reported party dispersal/noise complaint. There was a total of 139 officer hours recorded at the gatherings involving 832 people. Officers recorded 224 tickets and arrests at the gatherings.

Efforts to enforce laws regarding underage purchases of alcohol or tobacco are strengthened by efforts to help educate and train those who sell alcohol or tobacco products with appropriate information and proper techniques. Several merchant education curricula are in use nationally and in South Carolina, though the county authorities are now exclusively using the PREP (Palmetto Retailer Education Program) curriculum. County authorities were each required to implement merchant education programming in FY ’22 and collectively served 858 retail staff, which is up from 515 in FY ’21. Thirty-five of the 46 counties served at least one retailer in PREP.

There is a standardized PREP post-test used across the system that allows standardization of outcomes. Primarily, the test is graded for a pass or fail. Among those who passed in FY ’22, the average score was 95.0%.

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

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means?

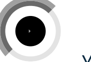
 Yes No

a) If yes, please describe.

NOT FINAL

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 can conduct site visits and desk reviews of the local county providers to review the prevention program/services provided throughout the state to ensure adherence to all state and federal guidelines.

4. Does your state integrate National CLAS Standards into the implementation step?

 Yes No

a) If yes, please describe in the box below.

One of DAODAS's core principles is to serve the residents South Carolina regardless their race, ethnic background, or sexual orientation. Since cultural competency is interwoven in the Strategic Planning Framework, it is also addressed in the county plans developed by the local providers. The plans are to ensure services planned to be implemented are programs, policies, and practices that are a good cultural fit and appropriate for populations identified to be served throughout county.

b) If no, please explain in the box below.

5. Does your state integrate sustainability into the implementation step?

Yes No

a) If yes, please describe in the box below.

Sustainability is integrated into the county plan process as this process is built on the Strategic Prevention Framework (SPF).

b) If no, please explain in the box below

NOT FINAL

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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 Processes*** 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 primary 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 SUPTRS BG funded prevention services:

a) ☑ Numbers served

NOT FINAL

b) [x] Implementation fidelity

c) [ ] Participant satisfaction

d) [x] Number of evidence based programs/practices/policies implemented

e) [x] Attendance

f) [x] Demographic information

g) [ ] Other (please describe):

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

a) [x] 30-day use of alcohol, tobacco, prescription drugs, etc

b) [x] Heavy use

c) [x] Binge use

d) [x] Perception of harm

e) [x] Disapproval of use

f) [x] Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

g) [ ] Other (please describe):

5. Does your state integrate the National CLAS Standards into the evaluation step? (•) Yes ( ) No

a) If yes, please explain in the box below.

One of DAODAS's core principles is to serve the residents South Carolina regardless their race, ethnic background, or sexual orientation. Since cultural competency is interwoven in the Strategic Planning Framework, it is also addressed in the evaluation of county plans to ensure programs, policies, and practices are appropriate effective for populations served throughout county.

b) If no, please explain in the box below.

6. Does your state integrate sustainability into the evaluation step? (•) Yes ( ) No

a) If yes, please describe in the box below.

Sustainability is integrated into the county plan process as this process is built on the Strategic Prevention Framework (SPF).

b) If no, please explain in the box below.

NOT FINAL

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 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.

NOT FINAL

10. Substance Use Disorder Treatment - Required SUPTRS BG

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

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

b) Services for special populations:

		Yes	No
i)	Prioritized services for veterans?	●	○
ii)	Adolescents?	●	○
iii)	Older Adults?	●	○

NOT FINAL

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 onsite visits. Additionally, county agencies are required to provide DAODAS with monthly reports detailing the current capacity for PWWDC,. 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 Improvement Program (MIP) is imposed. If the MIP is not successful, DAODAS may take a number of measures, ranging from withholding reimbursements to assigning the county's catchment area to another county authority.

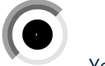
NOT FINAL

Criterion 4,5&6

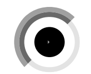
Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

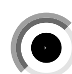
a) 90 percent capacity reporting requirement

 Yes No

b) 14-120 day performance requirement with provision of interim services

 Yes No

c) Outreach activities

 Yes No

d) Syringe services programs, if applicable

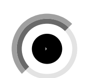
Yes No

e) Monitoring requirements as outlined in the authorizing statute and implementing regulation

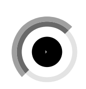
Yes No

2. Has your state identified a need for any of the following:

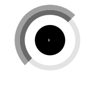
a) Electronic system with alert when 90 percent capacity is reached

 Yes No

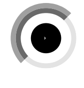
b) Automatic reminder system associated with 14-120 day performance requirement

 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, LGBTQI+, 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 onsite visits. Additionally, county agencies are required to provide DAODAS with monthly reports detailing the current capacity for PWID. 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 Improvement Program (MIP) is imposed. If the MIP is not successful, DAODAS may take a number of measures, ranging from withholding reimbursements to assigning the county's catchment area to another county authority.

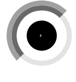
Tuberculosis (TB)

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

NOT FINAL

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 by desk reviews and onsite visits. The Federal requirements for tuberculosis 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 Improvement Program (MIP) is imposed. If the MIP is not successful, DAODAS may take a number of measures, ranging from withholding 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 such 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 SUPTRS BG 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 SUPTRS BG funds to support elements of a Syringe Services Program?

( ) Yes (●) No

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

NOT FINAL

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

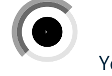
Yes No

   f) Explore expansion of services for:

      i) MOUD

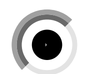
Yes No

      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:

NOT FINAL

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 including 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.

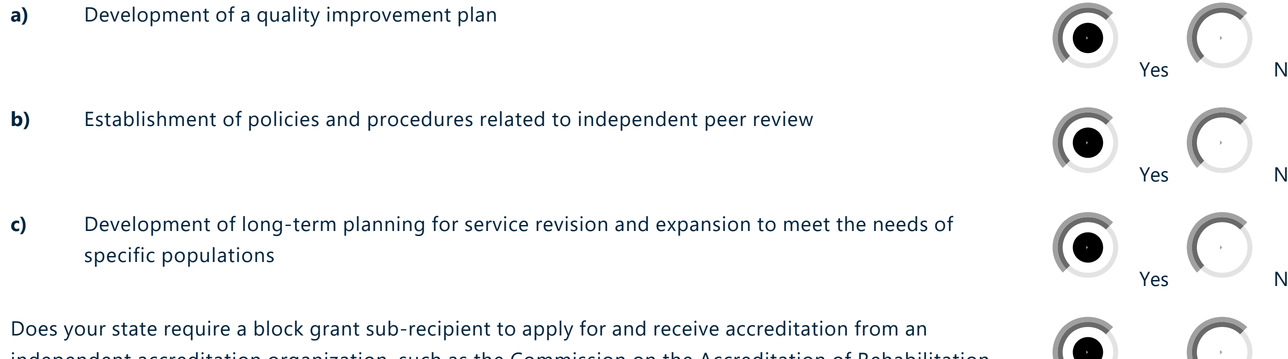
   a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

   Based on correspondence received during the DAODAS FY2021 Compliance Monitoring Review regarding the Independent Peer Review requirement, policy language was shared allowing for accreditation in lieu of independent peer review. The DAODAS Funding and Compliance Contract (see attached) requires that all the County Alcohol and Drug Abuse Authorities maintain national accreditation either through the Commission on the Accreditation of Rehabilitation

NOT FINAL

Facilities or The Joint Commission.

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) ☑ Commission on the Accreditation of Rehabilitation Facilities

ii) ☑ The Joint Commission

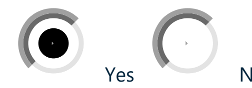
iii) ☐ Other (please specify)

NOT FINAL

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 opportunity 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) Performance-based accountability:

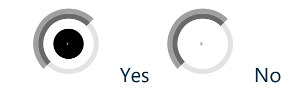
Yes No

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

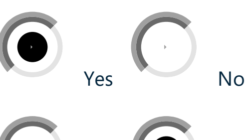
Yes No

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

NOT FINAL

d) State Targeted Response TTC? — Yes: (selected) / 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: (selected)

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis — Yes: ( ) / No: (selected)

b) Early Intervention Services Regarding HIV — Yes: ( ) / No: (selected)

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment — Yes: ( ) / No: (selected)

b) Professional Development — Yes: ( ) / No: (selected)

c) Coordination of Various Activities and Services — Yes: ( ) / No: (selected)

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

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

If the answer is No to any of the above, please explain the reason.

NOT FINAL

Footnotes:

NOT FINAL

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

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

Please respond to the following items:

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

Yes No

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

No areas are needed at this time.

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

Footnotes:

NOT FINAL

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

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

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

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

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

[2] *Ibid*

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

		Yes	No
1.	Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues?	●	○
2.	Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?	●	○
3.	Does the state provide training on trauma-specific treatment and interventions for M/SUD providers?	●	○
4.	Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?	●	○
5.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	●	○
6.	Does the state use an evidence-based intervention to treat trauma?	●	○

NOT FINAL

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

DAODAS has trained all our county provider clinical counselors on the principles of trauma informed care to increase awareness and understanding of the impact traumatic experiences may have on patients using the Trauma Recovery and Empowerment Mode l (TREM) model. The model offers skills and strategies to assist patients in better understanding, coping with processing emotions and memories tied to their traumatic experiences.
In addition, trauma screening has been incorporated into our bio-psychosocial assessments, to ensure that patients seeking substance use disorders treatment are assessed, treated, or refer to services that will help them understand and recover from their trauma and other mental health conditions.

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

No at this time.

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

Footnotes:

NOT FINAL

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

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

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

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

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

NOT FINAL

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

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

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

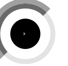
Please respond to the following items

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

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

NOT FINAL

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

 Yes ○ No

DAODAS provides programs that advocates for equal treatment for individuals who have been criminalized and marginalized in the criminal Justice system. We have an MOA with SCDC to promote a better outcome for inmates with substance use disorder and co-occurring disorder by providing, opioid use disorders and stimulant use disorders services to inmates, peer support services and vivitrol shots prior to re-entering back to the community.

DAODAS has been assisting South Carolina department of Juvenile justice to moved from a system that attempts to force children into programs that happens to be available to a system that provides services based on an individualized assessment of needs of individual children and their families. Using The Bridge program comprehensive, individualized, family -centered services for adolescents who are preparing to leave an Alcohol and Drug inpatient facility, a juvenile justice residential institution, or other residential setting within the community. The program aims to improve treatment outcomes while reducing re-entry into residential systems of care.

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

Yes No

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

The Joint Citizens and legislative Committee on Children: Is a consortium of appointed citizens, legislators, and agency directors, charged with the critical responssibility of identifying and studing key issues facing South Carolina's children, then promoting sound strategies for the development of children's policy. The Committee makes recommendations to the Governor and General Assembly, to use in consideration of policy, funding, and legislation to benefit our children's future.

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

No at this time

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14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

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 offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

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. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

SAMHSA is asking for input from states to inform SAMHSA's activities.

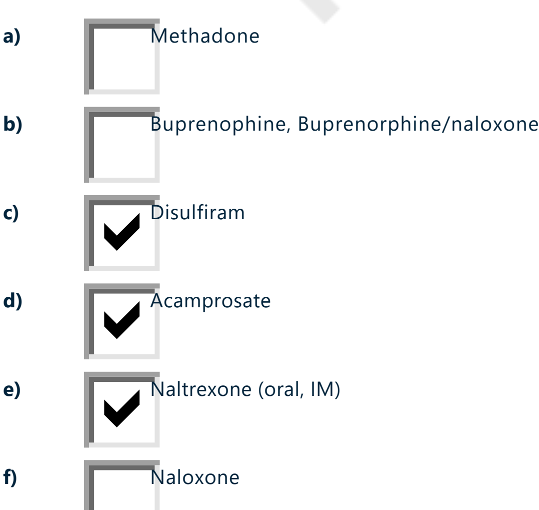
NOT FINAL

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding the use of medications for substance use disorders? ◉ Yes ○ No

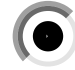
2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women? ◉ Yes ○ No

3. Does the state purchase any of the following medication with block grant funds?



- 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 treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs?

 Yes No

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

The state purchases a large quantity of methadone, buprenorphine, and naloxone with SOR grant funds and State funds for the ease of budgeting. All sub grantees are required by contract to make all FDA-Approved medications for treatment available for individuals they serve.

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

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

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

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

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

   The state's Department of Mental Health has led crisis service planning and implementation opening a division of suicide prevention in 2019 and then supporting the build out of the 988 services. The Mental Health America Greenville affiliate has supported the National Suicide Lifeline historically, and now supports the primary 988 call center. The Department of Mental Health opened an additional call center this year to keep more calls from routing outside of the state. Mobile Crisis is also available through the Department of Mental Health in all regions. While one licensed crisis stabilization center exists in the state, exploration and development of others, in particular - EmPATH units in hospitals is underway.

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

   *a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
   *b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
   *c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA*

NOT FINAL

guidelines.

d) ***Full Implementation*** *stage: occurs once staffing is complete, services are provided, and funding streams are in place.*

e) ***Program Sustainability*** *stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis Call Capacity

a. Number of locally based crisis call Centers in state

i. In the 988 Suicide and Crisis lifeline network

ii. Not in the suicide lifeline network

b. Number of Crisis Call Centers with follow up protocols in place

c. Percent of 911 calls that are coded as BH related

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

a. Independent of first responder structures (police, paramedic, fire)

b. Integrated with first responder structures (police, paramedic, fire)

c. Number that employs peers

3. Safe place to go or to be:

a. Number of Emergency Departments

b. Number of Emergency Departments that operate a specialized behavioral health component

c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)

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

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to	☐	☐	☐	☐	☑	☐
Someone to respond	☐	☐	☐	☑	☐	☐
Safe place to go or to be	☐	☐	☑	☐	☐	☐

b. Briefly explain your stages of implementation selections here.

The 988 suicide and crisis lifeline is live to all citizens, with more than 50% but less than 100% of calls being answered in South Carolina.

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

As the SC Dept. of Health and Human Services, (our Medicaid agency) is leading the South Carolina Behavioral System Redesign that is underway, planning is routed in the core principles and concepts of SAMHSA's National Guidelines for Behavioral Health Crisis Care which is routinely being referenced for planning purposes.

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

This is under the purview of the Department of Mental Health.

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

NOT FINAL

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

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16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders.

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

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

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

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

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

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

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

NOT FINAL

Please respond to the following:

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

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

   b) Required peer accreditation or certification? ◉ Yes ○ No

   c) Use Block grant funding of recovery support services? ◉ Yes ○ No

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

2. Does the state measure the impact of your consumer and recovery community outreach activity? ◉ Yes ○ No

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

   South Carolina peers work closely with local mental health providers. South Carolina offers a mental health peer support designation through an organization called SC Share. Peers housed in both Recovery Community Organizations as well as county alcohol and drug abuse authorities provide warm handoffs and care coordination for patients to address their cooccurring needs.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations

   South Carolina currently funds twelve (12) Recovery Community Organizations (RCO) and three (3) Collegiate Recovery Programs. Peer support specialists are housed in each of our 31-county alcohol and drug abuse authorities to provide ongoing recovery support services to individuals prior to engaging in treatment services, during the treatment experience as well as to those individuals that have completed or discontinued treatment services. DAODAS provides funding for peers to work in seven (7) hospitals as part of SBIRT programs as well as in various harm reduction and community outreach settings. DAODAS also supports the state IC&RC certification board, Addiction Professionals of South Carolina (APSC), who provide statewide training to ensure the efficacy and safety of each peer as they deliver services to the citizens of South Carolina.

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

   South Carolina consistently looks to expand and help create additional recovery support opportunities. Of particular note are the formation of three (3) new RCOs whose primary goal is to provide RSS to underserved populations in rural communities. In addition, three (3) first of their kind faith based RCOs have been launched in South Carolina with a twelve (12) county reach. Of the three (3) stated funded and three (3) privately funded Collegiate Recovery Programs (CRP), DAODAS supports A.U.R.I.S.E. which is housed at Allen University. As an HBCU, A.U.R.I.S.E. has begun to engage other HBCUs in hopes of being an ally in their desires to build a CRP of their own. Governor Henry McMaster declared April 13, 2023, Collegiate Recovery Day in South Carolina. The day was capped off with a celebration of RSS on the State House Steps.

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

   Not at this time.

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17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

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

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

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

1. Does the state's Olmstead plan include:

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

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

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

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

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18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[4].

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

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

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5].

According to data from the 2017 Report to Congress[6] on systems of care, services:

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

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

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

NOT FINAL

employment); and

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

---

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

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

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

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

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

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

Please respond to the following items:

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

a) The recovery of children and youth with SED? ◉ Yes ○ No

b) The resilience of children and youth with SED? ◉ Yes ○ No

c) The recovery of children and youth with SUD? ◉ Yes ○ No

d) The resilience of children and youth with SUD? ◉ Yes ○ No

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

a) Child welfare? ◉ Yes ○ No

b) Health care? ◉ Yes ○ No

c) Juvenile justice? ◉ Yes ○ No

d) Education? ◉ Yes ○ No

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

a) Service utilization? ◉ Yes ○ No

b) Costs? ◉ Yes ○ No

c) Outcomes for children and youth services? ◉ Yes ○ No

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

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

NOT FINAL

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

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

a) to the adult M/SUD system? (x) Yes ( ) No

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

c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems? (x) Yes ( ) No

d) Does the state have an established FEP program? (x) Yes ( ) No

Does the state have an established CHRP program? (x) Yes ( ) No

e) Is the state providing trauma informed care? (x) 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, comprised of 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 use 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 of Excellence in Evidence-Based Intervention 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 in Evidence-Based Intervention 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.

None at this time.

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Footnotes:

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22. Public Comment on the State Plan - Required

Narrative Question

Please respond to the following items:

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

   a) Public meetings or hearings? ○ Yes ○ No

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

      If yes, provide URL:

      If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

   c) Other (e.g. public service announcements, print media) ○ Yes ○ No

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

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Footnotes:

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Environmental Factors and Plan

23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf** ,
2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf**,
3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs** **http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf** ,

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

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Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and

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HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

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DAODAS will follow the federal guidance provided in Section 520. South Carolina Code of Laws, Section 44-53-110(33) prohibits. implementation of these services.

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Environmental Factors and Plan

Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
No Data Available					

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Footnotes:

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