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

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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 (selected) / No

b) Ethnicity — Yes (selected) / No

c) Gender — Yes (selected) / No

d) Sexual orientation — Yes (selected) / No

e) Gender identity — Yes (selected) / No

f) Age — Yes (selected) / 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 (selected) / No

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

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

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? — Yes (selected) / 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

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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:

NOT FINAL

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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Footnotes:

NOT FINAL

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.

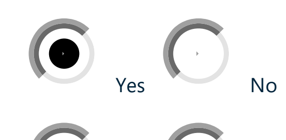
While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x-31, including cash payments to 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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Footnotes:

NOT FINAL

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.

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

Footnotes:

NOT FINAL

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)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ 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) ☑ Youth (ages 12-17)

c) ☑ Young adults/college age (ages 18-26)

d) ☑ Adults (ages 27-54)

e) ☑ 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) ☑ Archival indicators (Please list)

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

b) ☑ National survey on Drug Use and Health (NSDUH)

c) ☑ Behavioral Risk Factor Surveillance System (BRFSS)

d) ☑ Youth Risk Behavioral Surveillance System (YRBS)

e) ☐ Monitoring the Future

f) ☐ Communities that Care

g) ☑ 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.

NOT FINAL

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.

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;
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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

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.

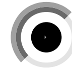
South Carolina Association of Prevention Professionals and Advocates (SCAPPA) certifies the substance use disorder workforce in South Carolina. The SCAPPA certification system is designed to certify the competency of two (2) classifications of prevention professionals: 1. Certified Prevention Specialist, 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.

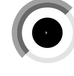
3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?

 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

Narratve Question

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

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

NOT FINAL

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

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

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.

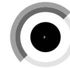
Alcohol Enforcement Teams in seven counties recorded 52 party dispersals in FY '22. A party dispersal is conducted when officers receive a complaint from a source and investigate that complaint. In some cases, officers observe a social gathering involving individuals under the legal alcohol drinking 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

Environmental Factors and Plan

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

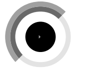
Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

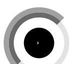
a) 90 percent capacity reporting requirement

Yes No

b) 14-120 day performance requirement with provision of interim services

 Yes No

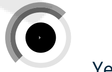
c) Outreach activities

 Yes No

d) Syringe services programs, if applicable

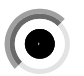
Yes No

e) Monitoring requirements as outlined in the authorizing statute and implementing regulation

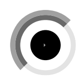
 Yes No

2. Has your state identified a need for any of the following:

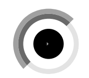
a) Electronic system with alert when 90 percent capacity is reached

 Yes No

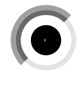
b) Automatic reminder system associated with 14-120 day performance requirement

 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.

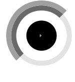
Tuberculosis (TB)

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)

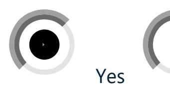
Yes No

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

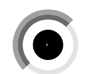


Yes No

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 (selected) / No

b) An organized referral system to identify alternative providers? — Yes (selected) / No

c) A system to maintain a list of referrals made by religious organizations? — Yes (selected) / 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 (selected) / No

2. Has your state identified a need for any of the following:

   a) Review and update of screening and assessment instruments — Yes (selected) / No

   b) Review of current levels of care to determine changes or additions — Yes (selected) / No

   c) Identify workforce needs to expand service capabilities — Yes (selected) / No

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

Patient Records

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

2. Has your state identified a need for any of the following:

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

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

   c) Updating written procedures which regulate and control access to records — Yes (selected) / 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 (selected) / 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 (selected) / 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

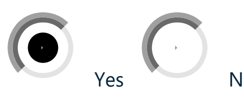
NOT FINAL

Facilities or The Joint Commission.

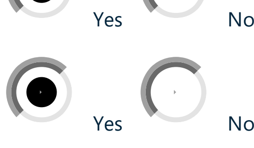
3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan

b) Establishment of policies and procedures related to independent peer review



c) Development of long-term planning for service revision and expansion to meet the needs of specific populations



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?

If Yes, please identify the accreditation organization(s)

i) ☑ Commission on the Accreditation of Rehabilitation Facilities

ii) ☑ The Joint Commission

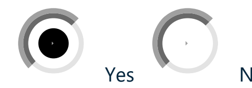
iii) ☐ Other (please specify)

NOT FINAL

Criterion 7&11

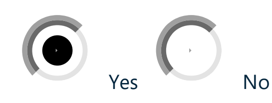
Group Homes

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

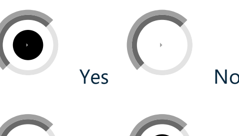
Yes No

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: ● No: ○

Waivers

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

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

a) Allocations regarding women — Yes: ○ No: ●

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis — Yes: ○ No: ●

b) Early Intervention Services Regarding HIV — Yes: ○ No: ●

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment — Yes: ○ No: ●

b) Professional Development — Yes: ○ No: ●

c) Coordination of Various Activities and Services — Yes: ○ No: ●

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

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?

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

No areas are needed at this time.

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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.

[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.

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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

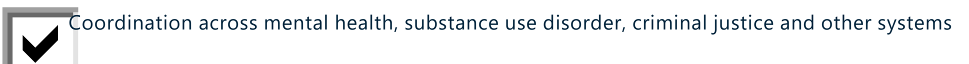
[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[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.

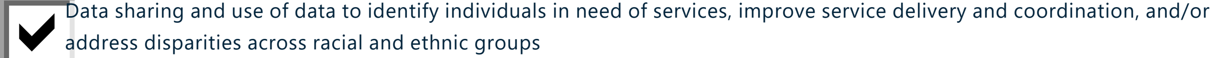
[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

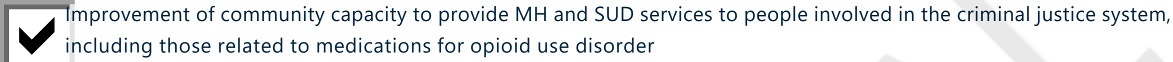
1. Does the state (SMHA and SSA) engage in any activities of the following activities:



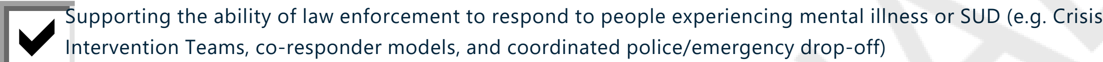
☑ Coordination across mental health, substance use disorder, criminal justice and other systems



☑ Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups

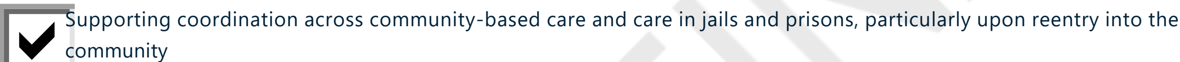


☑ Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder

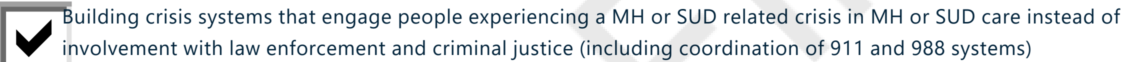


☑ Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)

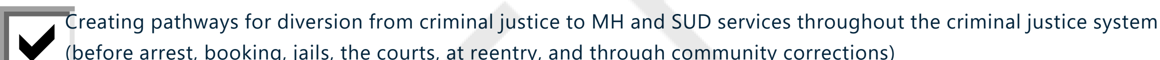
☑ Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;



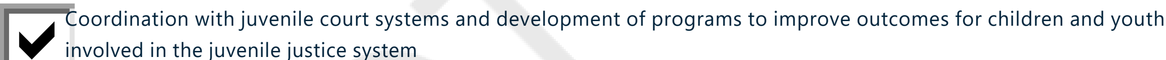
☑ Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community



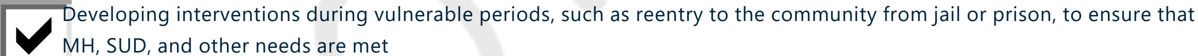
☑ Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)



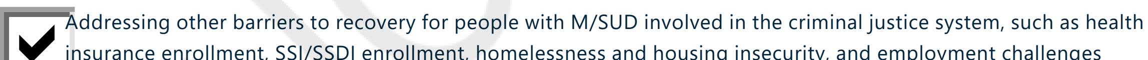
☑ Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)



☑ Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system



☑ Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met

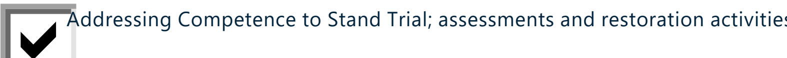


☑ Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges

☑ Partnering with the judicial system to engage in cross-system planning and development at the state and local levels

☑ Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system

☑ Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD



☑ Addressing Competence to Stand Trial; assessments and restoration activities.

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

◉ Yes ○ No

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.

NOT FINAL

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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Footnotes:

NOT FINAL

Environmental Factors and Plan

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.

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

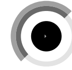
   d) ☑ Acamprosate

   e) ☑ Naltrexone (oral, IM)

   f) ☐ Naloxone

NOT FINAL

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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Footnotes:

NOT FINAL

Environmental Factors and Plan

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

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

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

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

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

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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Footnotes:

NOT FINAL

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders.

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

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

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

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

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

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

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

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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Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

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

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

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

1. Does the state's Olmstead plan include:

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

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

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

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

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Footnotes:

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Environmental Factors and Plan

18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[4].

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

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

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5].

According to data from the 2017 Report to Congress[6] on systems of care, services:

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

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

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

NOT FINAL

employment); and

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

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

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

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

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

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

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

Please respond to the following items:

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

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

b) The resilience of children and youth with SED? ● Yes ○ No

c) The recovery of children and youth with SUD? ● Yes ○ No

d) The resilience of children and youth with SUD? ● Yes ○ No

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

a) Child welfare? ● Yes ○ No

b) Health care? ● Yes ○ No

c) Juvenile justice? ● Yes ○ No

d) Education? ● Yes ○ No

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

a) Service utilization? ● Yes ○ No

b) Costs? ● Yes ○ No

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

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

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

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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Environmental Factors and Plan

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

NOT FINAL

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:

NOT FINAL