2012 SAPT Behavioral Health Assessment and Plan

Substance Abuse Prevention and Treatment (SAPT) Block Grant

Introduction

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

The South Carolina 2012 SAPT Behavioral Health Assessment and Plan is the State Plan portion of South Carolina's FY2011 Application for the SAPT BG and as such must be developed with key stakeholders and made available for public comment both before and after submission to SAMHSA.

The federal requirements for the SAPT Block Grant have changed considerably:

- Instead of looking ahead only one year, the State Plan now covers two years, with this first multi-year State Plan covering a transitional 21-month period, from October 1, 2011, to March 31, 2013.
- The Reports Section of the SAPT BG Application has been moved to December 1, 2011.
- The Block Grant application's planning and reporting periods will be aligned with state fiscal years. Thus, the next State Plan will be submitted by April 1, 2013, for the period July 1, 2013, to June 30, 2015.
- The content of the State Plan has also changed to reflect a renewed emphasis on needs assessment, strategic planning, effective model programs, performance management, and collaboration with providers of mental health, primary health, and recovery support services.
- SAMHSA is allowing the applicants to complete the various aspects of the State Plan over time, through September 30, 2012, although the initial draft will be submitted no later than October 1, 2011.

We ask the reader to review the South Carolina Block Grant application as various sections of it are completed over the course of the next year and to provide input. The intent is for anyone to have the opportunity to provide comments to DAODAS as the application is being developed. The current draft will remain on the DAODAS web site (www.daodas.state.sc.us) and will be updated as sections near completion. As a convenience, we are also attaching a Quick Reference Table that indicates the estimated availability dates for public comment on each section. Please visit our site often to review the latest drafts and to take advantage of the information that is available on South Carolina's outstanding substance abuse prevention, intervention and treatment system.

Quick Reference Table

Behavioral Health Assessment and Plan (State Plan)			
Section	**Subsection Title/Description**	**Final Public Comment Date**	**Final Submission Date**
I: State Information	State information, assurances, certifications and funding agreements	08/31/11	10/01/11
II: Planning Steps (Needs Assessment)	Introduction	08/31/11	10/01/11
	Framework	08/31/11	10/01/11
	Step 1: Assess the strengths and needs of the service system to address the specific populations	03/01/11	04/01/12
	Step 2: Identify the unmet service needs and critical gaps within the current system	04/01/12	05/01/12
	Step 3: Prioritize State Planning Activities (Table 2)	05/01/12	06/01/12
	Step 4: Develop Objectives, Strategies and Performance Indicator (Table 3)	06/01/12	07/01/12
III: Use of Block Grant Dollars for Block Grant Activities	Table 4. Services Purchased Using Reimbursement Strategy	11/01/11	12/01/11
	Table 5. Projected Expenditures for Treatment and Recovery Supports	11/01/11	12/01/11
	Table 6. Primary Prevention Planned Expenditures Checklist	11/01/11	12/01/11
	Table 7. Projected State Agency Expenditure Report	11/01/11	12/01/11
	Table 8. Resource Development Planned Expenditure Checklist	11/01/11	12/01/11
IV: Narrative Plan	Activities That Support Individuals in Directing Their Services	03/01/11	04/01/12
	Data and Information Technology	03/01/11	04/01/12
	Quality Improvement Reporting	03/01/11	04/01/12
	Consultation with Tribes	06/01/12	07/01/12
	Service Management Strategies	03/01/11	04/01/12

IV: Narrative Plan (continued)	State Dashboards	03/01/11	04/01/12
	Suicide Prevention	03/01/11	04/01/12
	Technical Assistance Needs	06/01/12	07/01/12
	Involvement of Individuals and Families	03/01/11	04/01/12
	Support of State Partners	03/01/11	04/01/12
	State Behavioral Health Advisory Council	06/01/12	07/01/12
	Comment on State Plan	08/31/11	10/01/11
	Combined Plans to Address:		
	• Bi-directional integration of behavioral health and primary care services	06/01/12	07/01/12
	• Provision of recovery support services for individuals with mental or substance use disorders	06/01/12	07/01/12
	• Provision of services for individuals with co-occurring mental and substance use disorders	06/01/12	07/01/12
Attachments	S.C. Strategic Prevention Framework State Incentive Grant (SPF SIG) Strategic Plan	08/31/11	10/01/11
	South Carolina FASD Collaborative Strategic Plan, FY 2011-2013	08/31/11	10/01/11
	DAODAS Block Grant Governing Terms	08/31/11	10/01/11
	S.C. Suicide Prevention Plan	08/31/11	10/01/11
	S.C. State Profile, S.C. State Epidemiological Outcomes Workgroup (SEOW)	08/31/11	10/01/11
	2009 State Profile — South Carolina National Survey of Substance Abuse Treatment Services (N-SSATS)	08/31/11	10/01/11
2012 SAPT Report	Submitted Separately	11/30/11	12/31/11
2012 SYNAR Report	Submitted Separately	11/30/11	12/31/11

Section II: Needs Assessment – *Substance Abuse Prevention and Treatment*

Framework for Planning

Federal Guidance: *States should identify and analyze the strengths, needs, and priorities of the State's behavioral health system. The strengths, needs, and priorities should take into consideration specific populations that are the current focus of the Block Grants, the changing health care environment and SAMHSA's strategic initiatives. The plan should address the following populations:*

Services for persons with or at risk of having substance use and/or mental health disorders:

- *Persons who are intravenous drug users (IDU)**
- *Adolescents with substance abuse and/or a mental health problems*
- *Children and youth who are at risk for mental, emotional and behavioral disorders, including, but not limited to addiction, conduct disorder and depression*
- *Women who are pregnant and have a substance use and/or mental disorder**
- *Parents with substance use and/or mental disorders who have dependent children**
- *Military personnel (active, guard, reserve, and veteran) and their families*
- *American Indians/Alaska Natives*

Services for persons with or at risk of contracting communicable diseases:

- *Individuals with tuberculosis* *
- *Persons with or at risk for HIV/AIDS and who are in treatment for substance abuse**

Targeted services:

- *Individuals with mental and/or substance use disorders who are homeless or involved in the criminal or juvenile justice systems*
- *Individuals with mental and/or substance use disorders who live in rural areas.*
- *Underserved racial and ethnic minority and LGBTQ populations*
- *Persons with disabilities*
- *Community populations for environmental prevention activities, including policy changing activities, and behavior change activities to change community, school, family and business norms through laws, policy and guidelines and enforcement.*
- *Community settings for universal, selective and indicated prevention interventions, including hard-to-reach communities and "late" adopters of prevention strategies.*

Populations that are marked with an asterisk are required to be included in the State's needs assessment. To the extent that the other listed populations fall within any of the statutorily covered populations, States must include them in the plan.

States should undertake a broader approach to their assessment and planning process and include other individuals who are in need of behavioral health services. In particular, States should begin planning now for individuals with low-incomes who currently are uninsured but will be covered by Medicaid or private insurance in FY 2014 and will present new opportunities for public behavioral health systems to expand access and capacity. In addition, States should identify who will not be covered after FY 2014 and how Federal funds will be used to support these individuals who may need treatment and supports (SAMHSA will provide each state with information regarding the projected number and demographics of potentially uninsured individuals).

MHPAEA, other legislation that enhances access to Medicaid, and SAMHSA's Strategic Initiatives place an emphasis on identifying the health, behavioral health and long-term care needs of individuals with mental and substance use disorders. These laws and initiatives also present significant opportunities for States to include in their benefit design recovery support services for adults, youth and families who have behavioral health needs. In addition, policy drivers place a heavy emphasis on wellness and the prevention of mental, emotional, and behavioral disorders. These major themes are relevant for State substance abuse and mental health authorities. SAMHSA is encouraging SMHAs and SSAs to develop and submit a combined plan to address the common areas below:

- *Bi-directional integration of behavioral health and primary care services;*
- *Provision of recovery support services for individuals with mental or substance use disorders.*

In addition, SAMHSA is also requesting a combined plan for any expenditure of funds for the provision of services for individuals with co-occurring mental and substance use disorders. For States that have separate mental health and substance abuse agencies, the combined plan for these activities should be included in both the State MHBG and SABG applications. These combined plans should be included in a State's application (for those states submitting one Block Grant application). For States that submit separate Block Grant applications, the combined plan for these activities should be included in both the State MHBG and SABG applications. In addition, states should also consider linking their Olmstead planning work in the Block Grant application, identifying individuals who are needlessly institutionalized or at risk of institutionalization.

SAMHSA is encouraging states to undertake each of the following planning steps in a timely manner. The FY 2011 Block Grant application and Addendum indicated that some States have already undertaken a needs assessment of the populations identified in the FY 2012/2103 Block Grant application. Other States are designing needs assessment processes that will be completed after the 9/1/2011 submission date. In the Block Grant application, States should either provide information on the unmet need or the critical gaps within the service system or provide the timeframe within FY 2012 that the assessment and analysis will be completed.

State's Response:

The table below lists the populations addressed in the 2012 South Carolina State Plan Needs Assessment, as well as the combined plans that are developed in collaboration with the South Carolina Department of Mental Health and other key stakeholders.

Population
Services for persons with or at risk of having substance use and/or mental health disorders
• Persons who are intravenous drug users (IDUs)*
• Adolescents with substance abuse and/or mental health problems
• Children and adolescents who are at risk for mental, emotional, and behavioral disorders, including – but not limited to – addiction, conduct disorder, and depression
• Women who are pregnant and have a substance use and/or mental disorder*
• Parents with substance use and/or mental disorders who have dependent children*
• Military personnel (active, Guard, reserve, and veteran) and their families
• American Indians / Alaska Natives
Services for persons with or at risk of contracting communicable diseases
• Individuals with tuberculosis*
• Persons with or at risk for HIV/AIDS and who are in treatment for substance abuse*
Targeted services
• Individuals with mental and/or substance use disorders who are homeless or involved in the criminal or juvenile justice systems
• Individuals with mental and/or substance use disorders who live in rural areas
• Underserved racial and ethnic minority and LGBTQ populations
• Persons with disabilities
• Community populations for environmental prevention activities, including policy-changing activities, and behavior-change activities to impact community, school, family, and business norms through laws, policy and guidelines, and enforcement
• Community settings for universal, selective, and indicated prevention interventions, including hard-to-reach communities and "late" adopters of prevention strategies
Combined Plans
• Bi-directional integration of behavioral health and primary care services
• Provision of recovery support services for individuals with mental or substance use disorders
• Provision of services for individuals with co-occurring mental and substance use disorders

DAODAS has started planning now for low-income individuals who currently are uninsured but will be covered by Medicaid or private insurance in FY2014 and will present new opportunities for public behavioral health systems to expand access and capacity. We hope to use the information that SAMHSA will provide regarding the projected number and demographics of potentially uninsured individuals who should continue to be covered by the SAPT Block Grant.

DAODAS is committed to a "no wrong door" approach to the provision of physical, behavioral, and recovery-support services for South Carolina residents. This "no wrong door" approach is bringing down silos and changing the mindset of provider agencies – both public and private. The department has joined state agencies, organizations, providers, consumers, and families in the establishment of statewide organizations and initiatives that are discussed elsewhere in the State Plan. We concur with the emphasis on a holistic approach to caring for our residents, with an emphasis on wellness and prevention. On the other side of the coin, we must continue to provide better services to individuals and families who are ravaged by addiction.

Finally, the framework for planning must include the facts about the negative consequences of addiction and the benefits of addiction treatment.

Studies have continued to show the costs imposed on individuals, families, our healthcare system, victims of crime, schools, businesses, and various governmental systems:

- A 1994 national study conducted by Columbia University researchers showed that substance abuse was associated with 19% of total Medicaid hospital costs, particularly in newborn/neonate complications, cardiovascular disease, and respiratory disease.

- The Centers for Disease Control and Prevention have shown that – during the transition from childhood to adulthood – adolescents establish patterns of behavior and make lifestyle choices that affect both their current and future health. Serious health and safety issues such as motor vehicle crashes, violence, substance use, and risky sexual behaviors can adversely affect adolescent and young adults.
  - Some adolescents also struggle to adopt behaviors that could decrease their risk of developing chronic diseases in adulthood, such as eating nutritiously, engaging in physical activity, and choosing not to use tobacco. Environmental factors such as family, peer group, school, and community characteristics also contribute to adolescents' health and risk behaviors.
  - These issues usually are established during childhood, persist into adulthood, are inter-related, and are mostly preventable. The potential consequences impact all aspects of society and governmental agencies:
    - ✓ Increased deaths and injuries to children (under the age of 10), adolescents (ages 10-25), and young adults due to car crashes, violence, and suicide;
    - ✓ Increased morbidity in mental health, disabilities, diabetes, cardiovascular diseases, maternal and neonatal conditions (among other mental and physical co-morbidities), and corresponding increases in healthcare costs;
    - ✓ Increased underachievement in education, truancy, and delinquency;
    - ✓ Decreased loss of productivity and income;
    - ✓ Increased violence and crime, with associated increased costs to victims and juvenile and adult justice systems; and
    - ✓ Increased social service costs.

- The 2011 South Carolina Epidemiological Profile has confirmed the following consequences:
    - Mortality from causes associated with alcohol use, including chronic liver disease, homicide, and suicide, is generally higher in South Carolina than in the United States as a whole.
    - Alcohol-related motor vehicle crash rates in South Carolina are also higher than national rates. In several years since 2001, more than half of fatal motor vehicle crashes in our state have involved alcohol.
    - Risky sexual behavior and teenage pregnancies are other potential consequences of alcohol use. South Carolina has higher rates of teen pregnancy compared to the United States as a whole. In 2007, there were 53.6 live births per 1,000 women ages 15 to 19 in South Carolina, compared to 42.5 per 1,000 women in the nation as a whole.
    - The mortality rates from lung cancer and ischemic cerebrovascular disease are higher in South Carolina than in the United States overall.

Fortunately, studies have also shown the benefits of substance abuse treatment:

- A study by University of Washington researchers on the cost effectiveness of the Screening, Brief Intervention and Referral to Treatment (SBIRT) project in the State of Washington (2004-2006) concluded that:
    - Screening and brief intervention services provided to the intervention group (working-age, disabled Medicaid patients) were associated with an estimated reduction in Medicaid costs per month per patient of $273, as opposed to $12 spent per patient per intervention.
    - The SBI program was also associated with a significant increase in the odds of being admitted to substance abuse treatment within a year following the intervention.

- A study conducted by University of California – Los Angeles researchers in 2002-2003 showed that each dollar invested in substance abuse treatment saved more than $7, primarily in reduced costs associated with crime and increased employment earnings.

- The S.C. Office of Research and Statistics data for 2009 shows that substance abuse is a major contributor to healthcare costs in hospitals. DAODAS post-treatment outcome surveys of clients indicated a steep decline in emergency room use in 2009, resulting in considerable savings.

Of course, all of these statistics pale in comparison to the real life tragedies that are caused by addiction that start even before birth. For example:

- Alcohol consumption during pregnancy may cause Fetal Alcohol Spectrum Disorders that affect babies with serious complications for the rest of their lives.
- One night of prom night drinking and driving takes the life of a proud graduate.
- An addicted mother's children are taken away from her.
- An addicted father's career and family fall apart.
- After having lost job, family, and future, an addict is driven to crime to support his habit.

This State Plan is put together to ensure that taxpayer funds are spent efficiently and effectively. Critical as that is, however, the true measure of success is one changed life at a time through prevention, intervention, treatment, and recovery support.

The State's Approach to Developing the Substance Abuse Needs Assessment

The existing treatment needs assessment was based on the studies conducted during the second round of the State Treatment Needs Assessment Program (STNAP), funded by a grant from SAMHSA. The needs assessment was aimed at estimating the number of people with current alcohol and other drug abuse and dependence, thereby arriving at the number of individuals in need of treatment. By mid-FY2003, data analysis had been completed for all four studies that had been conducted as part of the second round of the STNAP. These included a telephone survey of adolescents, a survey of the Medicaid-eligible population, a telephone survey of the adult household population, and a Hospital-Mental Health-Alcohol-Drug Client Treatment Utilization Study. By the end of FY2003, all of the reports for the four studies had been completed, approved, and printed. The results of these studies had been used to develop estimates of need for each annual SAPT Block Grant application, but DAODAS realizes that it can no longer rely on those surveys.

Instead, the department is following SAMHSA guidance in using best available data, to include: the 2010 Census results; prevalence data derived from the latest National Survey on Drug Use and Health; in-state data from various databases; and limited prevalence studies. These data sources include: ATOD use surveys; ATOD treatment and mental health admission information; alcohol outlets; ATOD arrests; crime reports; traffic crashes; DUI license suspensions; deaths; hospital discharges; diseases, including HIV/AIDS and STDs; other health issues; and other demographic and social-indicator data.

DAODAS is using a deliberate planning approach to develop its needs-assessment study, determining prevalence, services provided, the treatment gap, gaps in data, and gaps in service provision for each of the identified populations. Once the needs assessment is completed, the department will determine which needs are of the greatest priority and develop corresponding goals, strategies, measurable indicators, and action plans. This effort will be accomplished in accordance with the coordination/collaboration approach recommended by SAMHSA, that is, by involving sister agencies, organizations, providers, consumers, and families.

DAODAS is determined to craft the best possible needs assessment and corresponding strategic plan during this State Plan cycle, so that when preparations start on October 2, 2012, for the next iteration that is due April 1, 2013, we will have everyone in place and need only to revise the existing plan in light of updated data and SAMHSA guidance.

Section II: Planning Steps (Needs Assessment)

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

Federal Guidelines: *Overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. How the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. The roles of the SSA, the SMH, and other State agencies with respect to the delivery of behavioral health services. Description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. How these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.*

State's Response:

South Carolina's substance abuse prevention, intervention and treatment system consists of a public system composed of the S.C. Department of Alcohol and Other Drug Abuse Services (DAODAS), which is the Single State Authority, and 33 county alcohol and drug abuse authorities that have organized themselves as Behavioral Health Services Association of South Carolina Inc. (BHSA). The 33 county authorities have offices in each of the state's 46 counties, thereby ensuring the availability of core substance abuse services that include crisis counseling, ASAM Level I outpatient treatment, prevention, intervention, the Alcohol and Drug Safety Action Program ("ADSAP," the state's DUI program), and gambling addiction services. As shown later in this section, treatment services above basic outpatient services are also provided throughout the state.

A brief history of South Carolina's public substance abuse system can help put the current system into perspective.

- DAODAS' earliest precursor was the South Carolina Alcoholic Center, which was founded with the passage of Act 309 by the South Carolina General Assembly in 1957. The Center's primary emphasis was reducing the stigma associated with alcoholism and educating policymakers and the general public about the need for treatment services.
- In 1966, the South Carolina Alcoholic Center was redesignated as the South Carolina Commission on Alcoholism, an independent governmental public health agency responsible for providing programs and services to prevent and control the state's alcohol-related problems.
- In 1969, the General Assembly created the South Carolina Office of the Commissioner of Narcotics and Controlled Substances, which was housed within the Governor's Office and was responsible for providing programs and services to prevent and control problems with drugs other than alcohol.
- In 1974, the two agencies were merged into the South Carolina Commission on Alcohol and Drug Abuse (SCCADA). Under the direction of an 11-member policymaking and governing board, this agency was charged with developing a statewide service-delivery system and with

planning, coordinating and evaluating all programs and services designed to prevent and treat the state's problems with both alcohol and other drugs.

- Although specialized alcohol and other drug abuse services began developing at the community level during the 1950s and 1960s, the initiation of a coordinated statewide planning and programming effort got a major boost with the passage of Act 1063 of 1972 and Act 301 of 1973.
    - Act 1063 provided for the distribution to counties of one-fourth of mini-bottle tax revenue to be used for education on the dangers of alcohol abuse and for the treatment of alcoholics and other drug users.
    - Passed a year later, Act 301 required each county to designate a single county authority on alcohol and other drug abuse to act as the sole agency for planning the programs funded by Act 1063. In addition, the act required each county authority to develop a county plan to be approved by the state authority as a condition for the release of Act 1063 funding.
    - By 1975, each of South Carolina's 46 counties had appointed a local authority on alcohol and other drug abuse and was operating under an approved county plan.
    - With the passage of Act 265 of 1993, the S.C. Commission on Alcohol and Drug Abuse was redesignated as the S.C. Department of Alcohol and Other Drug Abuse Services (DAODAS), a cabinet-level department that reports directly to the Governor.

The characteristics of South Carolina's public substance abuse system include:

- Each county authority is licensed by the S.C. Department of Health and Environmental Control and accredited by the Commission on Accreditation of Rehabilitation Facilities or the Joint Commission.
- Licensing and credentialing of substance abuse counselors is regulated by State statute. This includes the requirement for certification of treatment counselors by the S.C. Association of Alcoholism and Drug Abuse Counselors (SCAADAC) and of prevention professionals by the S.C. Association of Prevention Professionals and Advocates (SCAPPA).
- There are no financial intermediaries between DAODAS and the county authorities, nor are there separate child and adult systems.
- DAODAS and the leadership of BHSA work closely to optimize the efficiency and effectiveness of services.
- Collaboration is facilitated through the joint Accountability and Services committees, which are comprised of DAODAS staff and county authority leadership and staff.
- DAODAS reviews and approves the county authorities' strategic plans, which not only triggers the release of alcohol taxes earmarked for the county authorities but also serves to help guide the allocation of SAPT Block Grant and other available funding through subgrants, discretionary grants and subcontracts.
- Conversely, the county authorities develop their plans with local surveys, focus groups, advisory councils, and/or political entities that oversee them (either county governments or specially appointed commissions). Thus, strategic planning starts at the local level, then

issues are addressed through the joint committees, approved by the BHSA membership, and finalized by the approval of the Single State Authority's Director.

Other substance abuse service providers include:

- S.C. Department of Mental Health:
    - Earle E. Morris Jr. Alcohol and Drug Addiction Treatment Center ("Morris Village"), which is licensed by the State of South Carolina and is accredited by the Commission on Accreditation of Rehabilitation Facilities. Morris Village has 120 operational beds and provides inpatient treatment for adults affected by alcohol and/or other drug abuse or addiction, and – when indicated – addiction accompanied by psychiatric illness. Patients are admitted from throughout the state by referrals from community mental health centers and county alcohol and drug abuse authorities. Morris Village accepts both voluntary and involuntary admissions.
    - William S. Hall Psychiatric Institute / Child & Adolescent, which is also licensed by the State of South Carolina as a specialized hospital with a separately licensed 37-bed residential treatment facility for children and adolescents. The Institute provides inpatient psychiatric services, treatment for alcoholism and other drug abuse or addiction, and residential treatment for adolescents. Patients are admitted from throughout the state with referrals from community mental health centers, juvenile parole boards, the family court system, the S.C. Department of Social Services and the S.C. Department of Juvenile Justice. Outpatient services include the Assessment and Resource Center.
- The S.C. Vocational Rehabilitation Department:
    - Holmesview Center in Greenville and Palmetto Center in Florence, two voluntary residential treatment centers for clients who need inpatient therapy for the chronic abuse of alcohol and/or other drugs. Both facilities provide a full range of vocational and treatment services for people whose employment is prevented or jeopardized by substance abuse or dependence. Referred to the centers by their vocational rehabilitation counselors, these clients receive follow-up services once they return to their communities.

The National Survey of Substance Abuse Treatment Services (N-SSATS), conducted on March 31, 2009, contains the last available state profile for South Carolina. The survey indicated that there were 113 substance abuse treatment facilities in the state. The first table depicts the number of facilities by type of operation, while the second table shows the primary foci of interest. The full state profile may be found in Attachment 1.

Type of Operation	Number
Private non-profit	33
Private for-profit	34
Local government	31
State government	11
Federal government	4
Dept. of Veterans Affairs	2
Dept. of Defense	2
Total	**113**

Primary Focus of Facility	Number
Substance abuse treatment services	94
Mental health services	2
Mix of mental health and substance abuse treatment services	15
General health care	2
Other/unknown	0
Total	**113**

Note: The survey response rate in South Carolina was 94.4%.

All 33 county alcohol and drug abuse authorities continue to provide the following core services in each of the 46 counties:

- traditional group, individual, and family outpatient counseling, to include the post-discharge period;
- Alcohol and Drug Safety Action Program (ADSAP, which is the state's DUI program);
- youth and adolescent services; and
- primary prevention/education programs.

In spite of drastic cuts in funding, many county authorities also provide more intensive and specialized levels of care, such as intensive outpatient services (more than nine hours per week), day treatment, detoxification, adolescent inpatient treatment, and/or other residential services. Those county agencies that do not offer the non-core services are required by the DAODAS Block Grant Governing Terms to refer their clients to appropriate higher levels of care. The county authorities provide the following services beyond outpatient treatment. *(Changes from previous capabilities are noted.)*:

- **Intensive Outpatient Treatment** (by sub-state planning areas):
  - Area 1: Anderson/Oconee Behavioral Health Services; Behavioral Health Services of Pickens County; Cherokee County Commission on Alcohol and Drug Abuse; The Phoenix Center (Greenville); Spartanburg Alcohol and Drug Abuse Commission; and Union County Commission on Alcohol and Drug Abuse
  - Area 2: Cornerstone (Edgefield and Greenwood counties); Counseling Services of Lancaster; GateWay Counseling Center (Laurens County); Hazel Pittman Center

(Chester County); Keystone Substance Abuse Services (York County); LRADAC (Lexington and Richland counties); and Westview Behavioral Health Services (Newberry County)

  - Area 3: Circle Park Behavioral Health Services (Florence County); Clarendon Behavioral Health Services; Rubicon Inc. (Darlington County); Shoreline Behavioral Health Services (Horry County); Sumter Behavioral Health Services; and Trinity Behavioral Care – Marlboro
  - Area 4: Aiken Center; Beaufort County Alcohol and Drug Abuse Department; Charleston Center; Dawn Center (Orangeburg County); Dorchester Alcohol and Drug Commission; and Ernest E. Kennedy Center (Berkeley County)

- **Day Treatment** – Anderson/Oconee Behavioral Health Services (Area 1); Charleston Center (Area 4); Counseling Services of Lancaster (Area 2); and Keystone Substance Abuse Services (Area 2)
- **Social Detoxification** – Charleston Center (Area 4); Keystone Substance Abuse Services (Area 2); Shoreline Behavioral Health Services (Area 3); Sumter Behavioral Health Services (Area 3); and Westview Behavioral Health Services (Area 1). *(Note – The following were closed or suspended their operations during fiscal year 2010 [FY10]: Spartanburg Alcohol and Drug Abuse Commission [Area 1] and Trinity Behavioral Care [Dillon and Marion counties] [Area 3].)*
- **Medical Detoxification** – Charleston Center (Area 4); Keystone Substance Abuse Services (Area 2); LRADAC (Area 2); and The Phoenix Center (Area 1)
- **Halfway House** – Charleston Center (Area 4); Circle Park Behavioral Health Services (Area 3); LRADAC (Area 2); Sumter Behavioral Health Services (Area 3); and Trinity Behavioral Care (Area 3)
- **Residential Treatment Facilities** – Charleston Center (Area 4); Circle Park Behavioral Health Services (Area 3); Colleton County Commission on Alcohol and Drug Abuse (Area 4); The Phoenix Center (Area 1); Shoreline Behavioral Health Services (Area 3); and Westview Behavioral Health Services (Area 1). *(Note – The facility operated by Trinity Behavioral Care [Area 3] was closed in FY10.)*
- **Inpatient Treatment Facilities** – William J. McCord Adolescent Treatment Facility in Orangeburg (operated by the Dawn Center). On April 30, 2010, the state celebrated the opening of a second adolescent treatment facility, the White Horse Academy in Greenville (operated by The Phoenix Center).

State Prevention Partnerships

South Carolina is working toward a collaborative substance abuse prevention system that ensures the use of evidence-based programs, policies, and practices, as well as emphasizes cultural competency and demonstrates accountability among partners. In 2000, CSAP awarded South Carolina a State Incentive Grant (SIG), called the Governor's Cooperative Agreement for Prevention (G-CAP), which sparked the formation of the Governor's Council on Substance Abuse Prevention and Treatment, involving 13 state agencies committed to the prevention of ATOD abuse. The various agencies on the Governor's Council – many of which are cabinet-

level agencies like DAODAS – are committed to taking prevention to the next level over the next several years. At the Governor's request, cabinet member Robert C. Toomey, Director of DAODAS, serves as chair of the Council. The group has met quarterly since 2000, but its workgroups meet on a monthly to bi-monthly basis.

The Council's varied membership of state agencies and community and youth service organizations provides an ideal mix of perspectives to effectively guide substance abuse prevention services in South Carolina and to spread its impact into key agencies. Currently, the Council fulfills the following roles:

- serves as an advisory body to Governor Nikki Haley on substance abuse prevention and treatment;
- tracks substance abuse funding streams and seeks to identify opportunities to coordinate, leverage, or redirect funding;
- promotes effective prevention strategies and processes and encourages their implementation in key organizations;
- addresses important issues through standing or ad hoc committees (Underage Drinking Action Group, Methamphetamine Action Group);
- advocates for prevention and treatment and their increased funding;
- oversees major initiatives (e.g., SPF SIG, federal treatment grants); and
- informs Council members of ATOD information and important agency developments.

The Governor's Council has proven to be an effectively diverse group in terms of its concern for the state's various populations, its state and local perspectives, and its cross-agency input. Even so, cultural diversity is an issue of constant attention. The Council currently oversees the State Epidemiological Outcomes Workgroup (SEOW) and will continue translating its findings and recommendations into actionable policies. The Council will also continue to regularly produce a document tracking changes in key indicators as identified in the state strategic plan for prevention and assess agencies' contributions toward achieving outcomes identified in the strategic plan. Additionally, the Council – through its Evidence-Based Programs, Policies and Practices workgroup – will continue to monitor selection and implementation of culturally appropriate evidence-based policies and practices throughout South Carolina.

The entire membership of the Governor's Council has enhanced its collaboration and communication, but the value of the key stakeholders has been particularly influential in linking the integral state agencies listed below:

- Alcohol, Tobacco, and Other Drugs – DAODAS administers the SAPT BG, the Governor's portion of the SDFSC program, and the EUDL block grant. The department and its provider system of 33 county authorities, along with other community and faith-based organizations, provide prevention, intervention, treatment, and recovery-support services throughout the state. *Resources:* DAODAS will continue to spearhead substance abuse prevention for the Governor and will dovetail grant decision-making efforts with other grants administered by

the agency and its partners (i.e., Departments of Public Safety and Education) that are also awarding state grants to local communities.

- Education – The State Department of Education (SDE) provides SDFSC funding for every school district. The SDE's strong policies for the use of these funds substantially influence evidence-based practices in prevention and collaboration between local school districts and local county prevention agencies when serving the school-based population throughout the state. *Resources:* The SDE will support the implementation of student surveys throughout the state to help create the local data included in county epidemiological profiles. Joint planning with this initiative will result in maximizing scarce grant resources across agency lines.
- Public Health / Tobacco – The South Carolina Department of Health and Environmental Control (DHEC) manages Centers for Disease Control and Prevention and tobacco-settlement funds directed toward the prevention of tobacco use. DHEC's policy-change and environmental emphases mesh strongly with the values of the original SIG. *Resources:* DHEC will continue to serve as a valuable partner in the SEOW as it collects vast amounts of data throughout the state on tobacco consumption/consequences.
- Law Enforcement – The South Carolina Department of Public Safety (DPS) distributes competitive and block grants to law enforcement agencies. Existing partnerships from the SIG between law enforcement and local prevention professionals spread rapidly to implement effective environmental strategies within various communities throughout the state. Continuing existing partnerships and building new partnerships through the South Carolina SPF SIG will enhance the dissemination of effective environmental strategies. *Resources:* DPS will continue collaborating with the efforts of the SEOW. DAODAS will continue to work with the state's Criminal Justice Academy to seek approval of officer-recertification hours for intensive training that has been developed in South Carolina to address the capacity of local law enforcement agencies to implement environmental strategies (e.g., alcohol compliance checks, third-party transactions, controlled party dispersals, public safety checkpoints).
- Budget & Control Board (BCB) Office of Research and Statistics (ORS) – The State Integrated Data System (IDS) is being developed by ORS. The State IDS is a data warehouse that will ultimately include all relevant individual-service data streams related to substance use and its consequences. *Resources:* The State IDS links data files on a de-identified basis across agencies and programs to show concurrent risks and can longitudinally identify subsequent outcomes. The partnership with ORS and the State IDS will continue to strengthen the SEOW.
- Department of Transportation (DOT) – This state agency explores and implements innovative ways to serve citizens and promote safe and efficient transportation in keeping with the National Highway Traffic Safety Administration's mission to save lives, prevent injuries, and reduce motor vehicle crashes. *Resources:* DOT recognizes the value in partnering with DAODAS. Most recently, the two agencies came together to discuss the problem of intoxicated pedestrians and how prevention could be part of the solution. DOT will be a vital partner in reducing alcohol-related car crashes, as well as continuing to explore other areas involving the abuse of alcohol.

South Carolina partners will work together to develop a state prevention strategic plan based on the work of the SEOW. The plan will include goals and objectives that will result in key stakeholders leveraging resources to work together as a state to implement a prevention strategic plan that will be created in accordance with the Strategic Prevention Framework's six guiding principles and five steps to achieve positive outcomes for the state.

Funding for the county system is required in legislation and has a historical basis. The amount of funds currently allocated to each county to provide primary prevention services is based on population and specific need factors, although there is a base amount to ensure that prevention services are provided in each county area throughout the state. The SSA will be actively looking to enhance this structure over the next several years to support a more data-driven process of allocating funds to address service needs/gaps.

While South Carolina certainly touts a highly effective prevention system, there is acknowledgement of areas in which further work to develop a plan for the state will enhance our ability to develop a more comprehensive and effective substance abuse prevention system. Such areas include addressing the issue of underserved counties based on needs-assessment data, and the development of capacity such as training, technical assistance, and the ability to offer more in-depth support to help counties build productive community-level epidemiological workgroups.

The South Carolina provider system has an opportunity to strengthen its infrastructure through improved vision; greater collaboration with partners; increased use of the SPF model; more data-driven planning; increased use of evidence-based programs, policies, and practices; improved evaluation practices; heightened cultural competence; and increased focus on sustainability. These improvements will lead to better targeted services across the lifespan, higher-quality implementation, improved outcomes, reduced community ills from substance abuse, and more quality contributions from other key prevention partners.

The challenges for DAODAS in developing the Needs Assessment (indeed, the entire State Plan) are many and will necessitate a deliberate planning approach that will rely on technical assistance and other support from SAMHSA, careful analysis, and close collaboration with the S.C. Department of Mental Health (DMH), key stakeholders, consumers, and families. Therefore, at the end of each section, an action plan is provided that describes which agencies have been and will be involved, and when the section will be finalized. The "action table" for this section is:

Section	Section II: Planning Steps (Needs Assessment). *Step 1: Assess the strengths and needs of the service system to address the specific populations.*	
Key Stakeholders	DMH, BHSA, S.C. Vocational Rehabilitation Department, SC FAVOR, Federation of Families of South Carolina. Others will be included in workgroups that address specific populations.	
Subsections to be Completed	**Final Public Comment Due**	**Finalized with SAMHSA**
Overview of the State's behavioral health prevention, early-identification, treatment, and recovery-support systems	03/01/11	04/01/12
How the public behavioral health system is currently organized at the state, intermediate, and local levels differentiating between child and adult systems	03/01/11	04/01/12
Description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services	03/01/11	04/01/12
How these systems address the needs of diverse racial, ethnic, and sexual gender minorities as well as youth, who are often underserved	03/01/11	04/01/12

Section II. Planning Steps (Needs Assessment)

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

Federal Guidance: *This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.*

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

State's Response:

In the following pages are found a needs assessment for each of the populations that is identified in the *Framework for Planning (Step 1)*. Using a template format and a deliberate and consultative planning process, DAODAS hopes that its needs-assessment efforts will result in a revised Strategic Plan that will be the blueprint for meeting the challenges faced by the state's behavioral health system. Using the best available data and in conjunction with key stakeholders, the needs-assessment process consists of the following steps:

1. Prevalence is estimated and evaluated for quality.
2. Treatment need is estimated and evaluated for quality.
3. Treatment gap is calculated (when possible).
4. Data gaps are identified.
5. Service gaps are identified.
6. Recommendation is made regarding inclusion in the State Plan as a priority (Step 3).
7. If a priority, goals, strategies, and measurable outcomes are developed (Step 4).

This section will provide a brief overview of the magnitude of substance abuse problems facing South Carolina. It also attempts to employ this strategy for each of the populations highlighted by SAMHSA in the Block Grant application. The section specifically provides an estimate of the number of South Carolinians in need of substance abuse treatment. It also depicts how that need estimate relates to the current capacity of the state's resources for providing substance abuse treatment. Providing an accurate depiction of the true volume of substance abuse in our state, however, is extremely difficult. Discussing the problem in terms of prevalence, or the number of individuals reporting problems associated with the use of alcohol or other illegal drugs, is difficult due to the stigma and likely repercussions associated with disclosing these types of behaviors. For this reason, much of the data used to describe South Carolina's substance abuse problems comes from sources that only partially address questions related to the magnitude of such problems facing South Carolina.

One of the best sources currently available for describing substance abuse problems at the state level is the National Survey on Drug Use and Health (NSDUH). This survey provides state-level estimates by combining multiple years of data-collection efforts. Data from the most recent report covers the survey years 2008 and 2009. Despite the difficulties discussed above relating to gathering accurate data about drug use, the report indicates that approximately 9% of South Carolinians age 12 or older reported the use of an illicit drug during the past month. The report also claims that approximately 9.5% of South Carolinians were estimated to have a substance abuse or dependence diagnosis at some point during the previous year. That's one out of every 10 people in the state.

Another problem associated with the use of the NSDUH concerns its strategy of excluding those individuals who are most likely to have substance abuse problems. The survey excludes institutionalized settings (e.g., prisons, jails) and the non-sheltered homeless population. The exclusion of these groups probably works to drastically under-represent the true volume of substance abuse in the state. Data from the South Carolina Department of Public Safety points out that approximately 20% of inmates in our state's prison system during fiscal year 2009 (FY09) were incarcerated for a drug offense. Taking that figure as a rough estimate of treatment need would imply that one out of every five incarcerated offenders had a substance abuse problem. That's double the non-institutionalized estimate provided by the NSDUH.

Unfortunately, this process is hampered by the large knowledge gap concerning the state's substance-abusing population. While we know, for example, that there were 35,000 drug-law arrests and 17,000 DUI arrests in FY09, we do not know exactly how many of these behaviors went undetected by the criminal justice system. Resource-allocation strategies based on incomplete information (such as the criminal justice system detection example) can lead to misguided funding strategies. For this reason, this section will also attempt to highlight the critical knowledge gaps that, if remedied, would greatly assist our state's decision-making process as it relates to prioritizing South Carolina's response to substance abuse problems.

The following data sources have been used to identify the state's unmet service needs and critical gaps within the current system.

Source	Location
National Survey on Drug Use and Health (NSDUH), Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies. (October 29, 2009)	http://oas.samhsa.gov/nsduhLatest.htm
Treatment Episode Data Set, SAMHSA	http://oas.samhsa.gov/dasis.htm#teds2
National Facilities Surveys on Drug Abuse and Mental Health Services, SAMHSA	http://oas.samhsa.gov/dasis.htm#nssats2
U.S. Census Bureau, 2010 Census Summary	http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t
S.C. State Profile, S.C. State Epidemiological Outcomes Workgroup (SEOW)	http://www.daodas.state.sc.us/SC%20Profile%202009.pdf
DAODAS Client Management Information System (SAAMIS)	(Reports available from DAODAS)
S.C. Budget and Control Board – Office of Research and Statistics, Health and Demographics	http://ors.sc.gov/hd/default.php

The action plan for this section is:

Section	Section II: Planning Steps (Needs Assessment). *Step 2: Identify the unmet service needs and critical gaps within the current system.*	
Key Stakeholders	S.C. Department of Mental Health, Behavioral Health Services Association of South Carolina Inc., S.C. Vocational Rehabilitation Department, Faces and Voices of Recovery South Carolina, Federation of Families of South Carolina. Others to be included in workgroups that address specific populations.	
Subsections to be Completed	**Final Public Comment Due**	**Finalized with SAMHSA**
Data sources used to identify the needs and gaps of the populations relevant to the SAPT Block Grant	04/01/12	05/01/12
State Epidemiological Outcomes Workgroup (SEOW) composition and contribution to the process for primary prevention and treatment planning	04/01/12	05/01/12
States should obtain and include in their data sources information from other state agencies that provide or purchase behavioral health services.	04/01/12	05/01/12

Persons who are intravenous drug users (IDUs)*	
DAODAS Points of Contact	Long, Walker
Estimated Completion Date	To be determined (TBD)
Recommended Priority	TBD

Prevalence

Data available from the 2006-2008 NSDUH report indicate that an annual average of 425,000 persons nationwide age 12 or older (0.17%) used a needle to inject heroin, cocaine, methamphetamine, or other stimulants during the past year. There were some differences by age group, with the rate of past-year injection drug use higher for the 18- to 25- and 26- to 34-year-old age group (0.28% and 0.26%, respectively) compared to those ages 12 to 17 and 50 years or older (0.09% and 0.11%, respectively). Applying an interpolated national average of 0.20% to South Carolina's 2009 Census estimate for the 18-and-older population would indicate a gross prevalence figure of 7,000 individuals.

Data from the most recently completed fiscal year indicates that approximately 4% of agency clients admitted to non-intervention level services – and 11.5% admitted to any bedded service – reported intravenous drug use at some point during their drug use history.

Using the national estimates above may, due to the predominately rural composition of the state, exaggerate the extent of injection drug use in South Carolina. Data from our client management system indicates that – of the clients admitted during the latest fiscal year whose method of administering their primary problem drug was injection – 70% were admitted to agencies covering the three largest and most metropolitan areas of the state (Charleston County, Greenville County, and the Midlands area). An analysis of clients' county of residence for the same group indicates that seven areas comprised 70% of these admissions (Charleston County, Greenville County, Horry County, Pickens County, Spartanburg County, and the Midlands area). Taking the .17% figure as a possible estimate of injection drug use for these counties would imply that roughly 3,600 individuals were injection drug users during the past year. While the present data do not allow for any way to substantiate these crude estimates, it does provide the state and local providers with some clues and priority geographic areas that could benefit from a more focused analysis of service-related needs.

Data sources:

- Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (October 29, 2009). The NSDUH Report: Injection Drug Use and Related Risk Behaviors. Rockville, Md.
- Data available from the DAODAS Substance Abuse Agencies Management Information System (SAAMIS)

Methodology: Synthesis of available data points

Data gaps: Local data-collection efforts could substantiate or refute the national estimates utilized here. Information from private facilities offering methadone maintenance, other specialized opiate treatment services, as well as other agencies that typically come in contact with drug-using populations (e.g., criminal justice or social service agencies) could further increase our ability to come up with valid and reliable estimates of injection drug use.

Services Provided

Data sources: DAODAS Substance Abuse Agencies Management Information System (SAAMIS)

Methodology: Extraction

Data gaps: TBD

Analysis

Who provides the services: 33 county authorities and other TBD providers

***Gaps in service provision*:** TBD

***Related Goals and Objectives*:**

Work to date: Initial prevalence and Services Provided figures
Work to be done: Identify other providers. Determine gaps in data and service provision. Determine needed technical assistance and/or funding resources. Decide priority (Step 3) and, as required, develop goals, strategies ad measurable objectives (Step 4).
Resources needed: TBD
Stakeholders: Behavioral Health Services Association of South Carolina Inc., S.C. Department of Mental Health, S.C Department of Health and Environmental Control, Faces and Voices of Recovery South Carolina, Federation of Families of South Carolina

Note: This is a preliminary analysis and requires additional data sources and analyses. The data used for the needs assessment section were designed to provide a brief snapshot of substance use prevalence and treatment need. Several estimates were derived from national- or state-level sources, and thus fail to consider local variations. The reader should exercise extreme caution before making assumptions about the applicability of these estimates.

Adolescents with substance abuse and/or a mental health problem	
DAODAS Points of Contact	Long, Walker
Estimated Completion Date	To be determined (TBD)
Recommended Priority	TBD

Prevalence

Data from the 2008 to 2009 NSDUH indicate that 4% of adolescents ages 12 to 17 met the criteria for abuse or dependence on alcohol at some point during the previous year. The same data indicate that 4.05% of adolescents met the criteria for abuse or dependence on any illicit drug during the past year. In total, the report estimates that 6.18% of adolescents met the abuse/dependence criteria for alcohol or some other drug during the past year. The same report notes that 3.87% of adolescents in need of treatment for illicit drug use and 3.98% adolescents in need of treatment for alcohol use did not receive any form of specialized treatment.

Applying those estimates to the number of South Carolina's 18-or-younger population reported during the 2010 Census would indicate that approximately 43,200 young people will likely need – but not receive – treatment for a substance abuse problem at some point during adolescence.

Data sources:

- NSDUH Series H-40, HHS Publication No. (SMA) 11-4641. Rockville, Md.: Substance Abuse and Mental Health Services Administration, 2011.
- U.S. Census Bureau, 2010 Census Summary File 1.

Methodology: Synthesis of available data points

Data gaps: Local data-collection efforts could substantiate or refute the national estimates utilized here.

Services Provided

Data sources: DAODAS Substance Abuse Agencies Management Information System (SAAMIS)

Methodology: Extraction

Data gaps: Partner agencies working with adolescents are currently participating in a screening program designed to detect substance abuse and other behavioral health issues. The system, while improving, continues to perform less than adequately due to sporadic participation and referral follow-through in several areas throughout the state. Available data do tend to indicate that several agencies come into contact with substance abusing adolescents, but the data-collection process would likely benefit from some quality-improvement strategies. The variation between communities across the state (rural vs. suburban or racial composition differences) also implies that a state-level estimate might artificially inflate or under-report the true extent of substance abuse. Some level of local data-collection process would likely assist communities in focusing their limited resources on strategies that have the biggest potential for reducing substance abuse problems in this age group. A special emphasis on the variation across schools or districts could potentially work to inform local communities about substance abuse and other behavioral health issues across the state.

Analysis

Who provides the services: 33 county authorities plus other TBD providers

***Gaps in service provision*:** Comparing the prevalence estimates to the number of adolescents actually served by South Carolina's public substance abuse agencies during the most recent year would confirm that there is a substantial treatment gap. During fiscal year 2011, 6,253 adolescents ages 12 to 17 received one or more services during the year. This would imply that approximately 37,000 adolescents in need of treatment likely received some sort of care elsewhere, or none at all.

Related Goals and Objectives:

Work to date: Initial prevalence and Services Provided figure

Work to be done: Identify other providers. Determine gaps in data and service provision. Determine

needed technical assistance and/or funding resources. Decide priority (Step 3) and, as required, develop goals, strategies, and measurable objectives (Step 4).
Resources needed: TBD
Stakeholders: Behavioral Health Services Association of South Carolina Inc., S.C. Department of Mental Health, S.C Department of Health and Environmental Control, Faces and Voices of Recovery South Carolina, Federation of Families of South Carolina

Note: This is a preliminary analysis and requires additional data sources and analyses. The data used for the needs assessment section were designed to provide a brief snapshot of substance use prevalence and treatment need. Several estimates were derived from national- or state-level sources, and thus fail to consider local variations. The reader should exercise extreme caution before making assumptions about the applicability of these estimates.

Children and youth who are at risk for mental, emotional and behavioral disorders, including, but not limited to addiction, conduct disorder and depression	
DAODAS Points of Contact	Nienhius, Long, Williams-Manning, Walker
Estimated Completion Date	To be determined (TBD)
Recommended Priority	TBD
Prevalence	
Data from the 2008-2009 NSDUH (SC Estimate) indicate that 34% of 12- to 17-year-olds believe that there is a “great risk” associated with using marijuana once a month. Data from the same report indicate that 41% of the same age group believe that there is a “great risk” associated with consuming five or more alcoholic beverages once or twice a week. Applying those estimates to the number of South Carolina’s 18-or-younger population reported during the 2010 Census would indicate that approximately 700,000 minors do not believe that use of alcohol or drugs poses any substantial risk to their long-term health. Additional analysis is needed to flesh out this estimate. In particular, there is a need to use data from the SEOW State Profile in conjunction with the NSDUH. Also, there is a need for additional guidance/clarity regarding the scope of this analysis in light of the Center for Disease Control and Prevention’s findings that risky health behaviors of adolescents are interrelated and persist into adulthood. How exactly is the substance abuse field to relate to the other systems that address such critical health behaviors as bullying, risky sexual behavior, obesity, school absenteeism, etc.?	
Data sources: o Substance Abuse and Mental Health Services Administration, State Estimates of Substance Use and Mental Disorders from the 2008-2009 National Surveys on Drug Use and Health, NSDUH Series H-40, HHS Publication No. (SMA) 11-4641. Rockville, Md.: Substance Abuse and Mental Health Services Administration, 2011. o U.S. Census Bureau, 2010 Census Summary File 1.	
Methodology: Applying census figures to latest state-level NSDUH estimates	
Data gaps: Local data-collection efforts could substantiate or refute the national estimates utilized here.	
Services Provided	
Data sources:	
Methodology:	
Data gaps:	
Analysis	
Who provides the services: 33 county authorities plus other TBD providers	
Gaps in service provision:	
Related Goals and Objectives:	
Work to date: Initial prevalence figures	
Work to be done: Identify other providers. Determine gaps in data and service provision. Determine needed technical assistance and/or funding resources. Decide priority (Step 3) and, as required, develop goals, strategies, and measurable objectives (Step 4).	
Resources needed: TBD	
Stakeholders: S.C. Joint Council on Children and Adolescents, Behavioral Health Services Association of South Carolina Inc., S.C. Department of Mental Health, S.C Department of Health and Environmental Control, Faces and Voices of Recovery South Carolina, Federation of Families of South Carolina	

Note: This is a preliminary analysis and requires additional data sources and analyses. The data used for the needs assessment section were designed to provide a brief snapshot of substance use prevalence and treatment need. Several estimates were derived from national- or state-level sources, and thus fail to consider local variations. The reader should exercise extreme caution before making assumptions about the applicability of these estimates.

Women who are pregnant and have a substance use and/or mental disorder*	
DAODAS Points of Contact	Long, Walker
Estimated Completion Date	To be determined (TBD)
Recommended Priority	TBD

Prevalence

Number of Newborns Discharged from SC Hospitals during FFY 2010

Payor Source	# of Newborn Hospital Discharges	National NSDUH Substance Use Estimate for Pregnant Women			# in Need of Treatment		
		Illicit Drug Use	Binge Drinking	Tobacco Use	Drug Use	Binge Drinking	Tobacco Use
Medicaid	24,693	**4.5%**	**11.9%**	**15.3%**	1,110	2,963	3,704
Self-Pay	2,651				119	318	398
Private Insurance	26,897				1,210	3,227	4,035
Medicare	235				11	28	35
TOTAL	54,479				2,451	6,537	8,172

Data sources:

- NSDUH Series H-40, HHS Publication No. (SMA) 11-4641. Rockville, Md.: Substance Abuse and Mental Health Services Administration, 2011.
- U.S. Census Bureau, 2010 Census Summary File 1.
- S.C. Budget and Control Board – Office of Research and Statistics, Health and Demographics, Newborn Inpatient Database Query Tool (accessed 8/16/2011)

Methodology: Recent national estimates quantifying the number of pregnant women who reported using any substance during pregnancy were used to develop general estimates for the possible number of pregnant substance-using females in South Carolina. In order to describe the gap between treatment need and receipt of specialized treatment services, the estimated number of pregnant substance users was then compared to the number of clients seen by local providers who reported being pregnant at any point during the treatment episode.

Data gaps: Local or state-level data regarding the prevalence of substance use detected by general or specialized healthcare providers, as well as the Department of Social Services, has historically been unavailable to Single State Authority staff. A lack of emphasis on correctly recording the referral source at the time of entry has also led to increased suspicion about the quality of this extremely important field.

Services Provided
Data sources: DAODAS Substance Abuse Agencies Management Information System (SAAMIS)
Methodology: Extraction
Data gaps: Services provided by entities other than county authorities
Analysis
Who provides the services: 33 county authorities plus other TBD providers
Gaps in service provision:
Related Goals and Objectives:
Work to date: Initial prevalence and Services Provided figures
Work to be done: Identify other providers. Determine gaps in data and service provision. Determine needed technical assistance and/or funding resources. Decide priority (Step 3) and, as required, develop goals, strategies, and measurable objectives (Step 4).
Resources needed: TBD
Stakeholders: Behavioral Health Services Association of South Carolina Inc., S.C. Department of Mental Health, S.C Department Social Services (DSS), S.C. Department of Health and Human Services (DHHS), S.C. Department of Health and Environmental Control, Faces and Voices of Recovery South Carolina, Federation of Families of South Carolina

Note: This is a preliminary analysis and requires additional data sources and analyses. The data used for the needs assessment section were designed to provide a brief snapshot of substance use prevalence and treatment need. Several estimates were derived from national- or state-level sources, and thus fail to consider local variations. The reader should exercise extreme caution before making assumptions about the applicability of these estimates.

Parents with substance use and/or mental disorders who have dependent children*	
DAODAS Points of Contact	Long, Walker
Estimated Completion Date	To be determined (TBD)
Recommended Priority	TBD
Prevalence	
A recent report from SAMHSA's NSDUH indicates that approximately 8.3 million children under 18 years of age (11.9%) lived with at least one parent who was dependent on or abused alcohol or an illicit drug during the past year. Applying that estimate to the number of South Carolina's 18-or-younger population reported during the 2010 Census would indicate that 118,852 children lived with parents that had an alcohol or other drug problem.	
Data sources: o NSDUH Series H-40, HHS Publication No. (SMA) 11-4641. Rockville, Md.: Substance Abuse and Mental Health Services Administration, 2011. o U.S. Census Bureau, 2010 Census Summary File 1.	
Methodology: Synthesis of available data points.	
Data gaps: State prevalence-data collection efforts could substantiate or refute the national estimates utilized here. County-level prevalence surveys would further narrow the data to aid in programming and funding allocations.	
Services Provided	
Data from public substance abuse treatment agencies indicate that roughly 35% of adult client intakes ages 18 to 44 reported living most of the time with one or more dependent children during the most recently completed fiscal year (N=9,017). ***Data sources:*** DAODAS Substance Abuse Agencies Management Information System (SAAMIS)	
Methodology: Extraction	
Data gaps: Our data system is does not currently contain the sophistication necessary to link family members. This hinders staff from assessing what dependent children or other family members receive in terms of support or other treatment services. We also have not historically coded referral source or reason for entry information in a way that allows us to assess how many youth clients are participating in services due to parental substance abuse problems. Finally, we are also at a loss to fully describe the volume of contact that other agencies have with families impacted by substance abuse. For example, we are routinely given information from criminal justice entities about the number of arrests for alcohol- or other drug-related crimes, but we receive minimal information at the state level regarding the total number of children who were impacted by problems related to their parent's substance abuse.	
Analysis	
Who provides the services: 33 county authorities plus other TBD providers	
Gaps in service provision: Comparing the prevalence estimates to the number of adolescents actually served by South Carolina's public substance abuse agencies during the most recent year would confirm that there is a substantial treatment gap. During fiscal year 2011, 6,253 adolescents ages 12 to 17 received one or more services during the year. This would imply that approximately 37,000 adolescents in need of treatment likely received some sort of care elsewhere, or none at all.	
Related Goals and Objectives:	
Work to date: Initial prevalence and Services Provided figures	
Work to be done: Identify other providers. Determine gaps in data and service provision. Determine needed technical assistance and/or funding resources. Decide priority (Step 3) and, as required, develop goals, strategies, and measurable objectives (Step 4).	

Resources needed: TBD
Stakeholders: Behavioral Health Services Association of South Carolina Inc., S.C. Department of Mental Health, S.C Department of Health and Environmental Control, Faces and Voices of Recovery South Carolina, Federation of Families of South Carolina

Note: This is a preliminary analysis and requires additional data sources and analyses. The data used for the needs assessment section were designed to provide a brief snapshot of substance use prevalence and treatment need. Several estimates were derived from national- or state-level sources, and thus fail to consider local variations. The reader should exercise extreme caution before making assumptions about the applicability of these estimates.

Military personnel (active, Guard, reserve, veteran) and their families UNDER DEVELOPMENT	
DAODAS Points of Contact	Prim, Bonsu, Walker
Estimated Completion Date	To be determined (TBD)
Recommended Priority	TBD
Prevalence	
Data sources:	
Methodology:	
Data gaps:	
Services Provided	
Data sources:	
Methodology:	
Data gaps:	
Analysis	
Who provides the services: 33 county authorities plus other TBD providers	
Gaps in service provision:	
Related Goals and Objectives:	
Work to date:	
Work to be done:	
Resources needed:	
Stakeholders:	

<table>
<tr><th colspan="2">American Indians/Alaska Natives</th></tr>
<tr><td>DAODAS Points of Contact</td><td>Bonsu, Walker</td></tr>
<tr><td>Estimated Completion Date</td><td>To be determined (TBD)</td></tr>
<tr><td>Recommended Priority</td><td>TBD</td></tr>
<tr><th colspan="2">Prevalence</th></tr>
<tr><td colspan="2">U.S. Census count was 19,524. The NSDUH estimated that the treatment need among this population was 18% for any substance abuse problem, or 3,514 individuals.</td></tr>
<tr><td colspan="2">Data sources:
o Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (June 24, 2010). The NSDUH Report: Substance Use among American Indian or Alaska Native Adults, Rockville, Md., provides national treatment need estimate for Native American Populations based on NSDUH data collected from 2004 to 2008.
o U.S. Census Bureau, 2010 Census Summary File 1.</td></tr>
<tr><td colspan="2">Methodology: Synthesis of available data points</td></tr>
<tr><td colspan="2">Data gaps: State prevalence-data collection efforts could substantiate or refute the national estimates utilized here. County-level prevalence surveys would further narrow the data to aid in programming and funding allocations.</td></tr>
<tr><th colspan="2">Services Provided</th></tr>
<tr><td colspan="2">Data sources: DAODAS Substance Abuse Agencies Management Information System (SAAMIS)</td></tr>
<tr><td colspan="2">Methodology: Extraction</td></tr>
<tr><td colspan="2">Data gaps: No data on services provided by entities other than the 33 county authorities</td></tr>
<tr><th colspan="2">Analysis</th></tr>
<tr><td colspan="2">Who provides the services: 33 county authorities plus other TBD providers</td></tr>
<tr><td colspan="2">Gaps in service provision: Comparing the prevalence estimates to the number of clients actually served by South Carolina’s public substance abuse agencies during the most recent year would confirm that there is a substantial treatment gap.</td></tr>
<tr><td colspan="2">Related Goals and Objectives: None</td></tr>
<tr><td colspan="2">Work to date: Initial prevalence and Services Provided figures</td></tr>
<tr><td colspan="2">Work to be done: Identify other providers. Determine gaps in data and service provision. Determine needed technical assistance and/or funding resources. Decide priority (Step 3) and, as required, develop goals, strategies, and measurable objectives (Step 4).</td></tr>
<tr><td colspan="2">Resources needed: TBD</td></tr>
<tr><td colspan="2">Stakeholders: Behavioral Health Services Association of South Carolina Inc., S.C. Department of Mental Health, Faces and Voices of Recovery South Carolina, Federation of Families of South Carolina, Catawba Nation, S.C. Commission for Minority Affairs</td></tr>
</table>

Note: This is a preliminary analysis and requires additional data sources and analyses. The data used for the needs assessment section were designed to provide a brief snapshot of substance use prevalence and treatment need. Several estimates were derived from national- or state-level sources, and thus fail to consider local variations. The reader should exercise extreme caution before making assumptions about the applicability of these estimates.

Individuals with tuberculosis*	
DAODAS Points of Contact	Prim, Walker
Estimated Completion Date	To be determined (TBD)
Recommended Priority	TBD

Prevalence

Health Care providers in South Carolina are required to report detected cases of tuberculosis (TB) to the state's Health Agency. This data-collection standard has provided the state with a useful trend measure that can be used to track the incidence of TB. For CY 2010, there were 153 newly reported cases of TB infection in the state. That's a decrease of almost 7% from the previous calendar year.

Hospital inpatient and emergency room (ER) discharge data can also be helpful in describing the volume of individuals infected with TB seeking healthcare services in the state. Data provided by the state's Budget and Control Board from 2008 indicate that there were 717 ER episodes and 738 inpatient episodes with any mention of a TB diagnosis. These figures help speak to the potential volume of individuals infected with TB currently living and accessing various healthcare services within the state (approximately 1,400+ individuals).

Data from the state's publicly funded treatment providers indicates that screening services have drastically declined across the state over the past two years. There were 559 screenings conducted at treatment provider sites during fiscal year 2011 compared to 1,181 conducted during fiscal year 2010. That's a 50% decline. Staff are currently investigating the reasons behind the decline to establish whether any part of the decline is due to data-reporting lapses.

Data sources:

- S.C. Department of Health and Environmental Control – South Carolina's STD/HIV/AIDS Data Surveillance Report. (December 31, 2010).
- State statistics from HCUP State Inpatient Databases and State Emergency Department Databases 2008, Agency for Healthcare Research and Quality (AHRQ), based on data collected by the South Carolina Budget and Control Board and provided to AHRQ
- Data available from DAODAS Substance Abuse Agencies Management Information System (SAAMIS)

Methodology: Synthesis of available data points

Data gaps: The data collected around TB has typically been limited to the screening process. No information is currently collected regarding the post-screening process. In other words, we have no information on how many clients have initial screenings that return positive. We also appear to have experienced a substantial decline in the testing process during the past couple of years. It is unclear, however, whether that process is due to a decline in the availability of testing services or some other data-collection issue. As mentioned above, state staff will continue to investigate the reasons behind this decline.

Services Provided

Data sources: DAODAS Substance Abuse Agencies Management Information System (SAAMIS)

Methodology: Extraction

Data gaps: Data is not available on post-screening process. Limited data-collection protocol in public health system (i.e., S.C. Department of Health and Environmental Control).

Analysis

Who provides the services: County alcohol and drug abuse authorities that have access to medical staff are able to provide TB screening (i.e., in-house PPD tests). All other county authorities have to refer the client elsewhere for screening and treatment. There is a need for alternative TB service providers in conjunction with local health departments.

Gaps in service provision: Due to funding losses, local health departments have been forced to curtail, if not stop, traditional TB screening tests (i.e., PPD and/or chest x-rays. There is a lack of public

access to health care around the state.
Related Goals and Objectives: Increase the number of clients screened for TB. Increase provision of TB services among clients who are at high risk for TB or who have latent TB infection.
Work to date: Initial prevalence and Services Provided figures. An established TB screening methodology has been developed that is appended to the Uniform Clinical Record Manual. Continuing to develop a working relationship with the state TB control folks housed at DHEC. Continuing to work with S.C. Primary Healthcare Association as they look at improving access to TB/HEP/HIV services through their member clinics.
Work to be done: Need to strengthen the relationship with the state TB control staff. Establish a TB training protocol that can be implemented with the county authorities. Establish a uniform TB reporting protocol among the county authorities. Identify other providers. Determine gaps in data and service provision. Determine needed technical assistance and/or funding resources. Decide priority (Step 3) and, as required, develop goals, strategies, and measurable objectives (Step 4).
Resources needed: TBD
Stakeholders: Behavioral Health Services Association of South Carolina Inc., S.C. Department of Mental Health, S.C Department of Health and Environmental Control, Faces and Voices of Recovery South Carolina, Federation of Families of South Carolina, S.C. Primary Health Care Association

Note: This is a preliminary analysis and requires additional data sources and analyses. The data used for the needs assessment section were designed to provide a brief snapshot of substance use prevalence and treatment need. Several estimates were derived from national- or state-level sources, and thus fail to consider local variations. The reader should exercise extreme caution before making assumptions about the applicability of these estimates.

Persons with or at risk for HIV/AIDS and who are in treatment for substance abuse*	
DAODAS Points of Contact	Prim, Walker
Estimated Completion Date	To be determined (TBD)
Recommended Priority	TBD

Prevalence

Healthcare providers in South Carolina are required to report detected cases of HIV/AIDS to the state's Health Agency. This data-collection standard has provided the state with a useful trend measure that can be used to track the incidence of HIV/AIDS. For CY 2010, there were 800 newly reported cases of HIV infection in the state. That's an increase of almost 2.5% from the previous calendar year. This brings the cumulative count of reported infections to 24,964 individuals. Of these, DHEC reports that there are 9,994 individuals living in South Carolina who were HIV/AIDS positive as of December 2010.

Additional information reported to the S.C. Department of Health and Environmental Control indicated that 22 of the newly reported cases were exposed to HIV/AIDS through injection drug use or having sex with someone who was an injection drug user. Data from a recent SAMHSA publication utilizing NSDUH data suggest that a substantially larger group of HIV-positive individuals are in need of alcohol and other drug treatment services. That report estimates that almost 23.4% of all HIV-positive individuals were in need of these services at some point during the previous year.

Hospital inpatient and emergency room (ER) discharge data can also be helpful in describing the volume of HIV/AIDS-positive individuals seeking healthcare services in the state. Data provided by the state Budget and Control Board from 2008 indicate that there were 8,674 ER episodes and 3,924 inpatient episodes with any mention of an HIV diagnosis. These figures help speak to the potential volume of HIV-positive individuals currently living and accessing various healthcare services within the state.

While not conducive to providing an exact estimate of the number of individuals in South Carolina with HIV/AIDS who are in need of substance abuse treatment, the available data can provide an indication as to the size of the population that local providers could possibly serve. Taking the total population of individuals living with HIV/AIDS as the only data point that provides a unique count of potential clients, along with a national treatment-need estimate provided by a recent NSDUH report, would indicate that approximately 3,000 HIV/AIDS-positive clients were in need of treatment services at some point during 2010.

Data sources:

- Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (December 1, 2010). *The NSDUH Report: HIV/AIDS and Substance Use*. Rockville, Md.
- S.C. Department of Health and Environmental Control – South Carolina's STD/HIV/AIDS Data Surveillance Report. (December 31, 2010).
- State statistics from HCUP State Inpatient Databases and State Emergency Department Databases 2008, Agency for Healthcare Research and Quality (AHRQ), based on data collected by the South Carolina Budget and Control Board and provided to AHRQ
- Data available from DAODAS Substance Abuse Agencies Management Information System (SAAMIS)
- Screening and early-intervention data hand coded by county authorities

Methodology: Synthesis of available data points

Data gaps: Unfortunately, there has been a great deal of resistance to any attempt to collect more information on HIV/AIDS status. There has also been a similar level of resistance to the collection of information regarding risk-taking behaviors that increase the possibility of exposure to HIV. We currently do not have a reliable way to tell who or how many clients are at risk for HIV infection or other sexually transmitted diseases. Currently, client HIV-positive status is recorded in a fashion that does not allow for

any additional analyses, since the information is recorded in a way that does not identify the client in any fashion (paper or electronic). Screening data or other data points that might highlight the quantity or type of risk-taking behaviors in which our clients engage is also excluded from both the paper and electronic health data collected during an episode. Having these data points linked to a client record could provide agencies with information on strategies that could potentially reduce the harms associated with these types of behaviors and/or medical conditions. Unfortunately, fears over privacy concerns have prevented thoughtful consideration of expanding our current data-collection efforts to include this information.

Services Provided

Data from the state's publicly funded treatment providers yield the following. First, the data provided demonstrated that 7,406 clients were assessed to determine the need for HIV early-intervention services. Second, other provided data indicated that screening and intervention services have accounted for 1,241 clients being screened and provided the HIV rapid test across the state. Data available from the DAODAS Substance Abuse Agencies Management Information System also indicates that 44 individuals received treatment during FY2011 who were identified as being HIV positive during their treatment episode.

Data sources:

- DAODAS Substance Abuse Agencies Management Information System (SAAMIS)
- Year-end reports submitted by DHEC and the 33 county authorities to DAODAS
- PEMS data collected by DHEC

Methodology: Extraction

Data gaps: Lack of a universal HIV risk-assessment protocol. Need for standardized screening tool. Inability to include HIV risk-behavior data points that can be gathered through both the client paper and electronic health-data clinical record.

Analysis

Who provides the services: HIV Early Intervention Services (HIV EIS) provided by 16 county alcohol and drug abuse authorities under the direction of a partnership between DAODAS and DHEC that consists of assessment for high-risk behaviors associated with HIV infection. Screening for HIV risk behaviors. Making available the HIV rapid test along with risk-reduction education.

Gaps in service provision: Need to expand the number of trained personnel locally who are able to assess, screen, and provide the HIV Rapid Test

Related Goals and Objectives: Increase the number of admitted clients who are assessed, screened, and provided the HIV rapid test. Increase the number of clients who have access to and receive risk-reduction education.

Work to date: Figures on initial prevalence and services provided. Maintenance of a strong collaborative relationship with our state health department through the Statewide HIV Planning Council. Have a comprehensive quality assurance / quality improvement process in place that is overseen by DAODAS and DHEC. Provide training on a semi-regular basis that includes the mechanics of providing the HIV rapid test, as well as collateral issues related to state statutes and policies associated with HIV infection and AIDS.

Work to be done: Identify other providers. Determine gaps in data and service provision. Determine needed technical assistance and/or funding resources. Clarify data-collection policies and procedures associated with HIV EIS. Decide priority (Step 3) and, as required, develop goals, strategies, and measurable objectives (Step 4).

***Resources needed*:** Development of a universal HIV-assessment protocol. Development of a standardized screening tool that is linked to an electronic data-collection system. Improve training process linked to starting provision of HIV EIS.

Stakeholders: Behavioral Health Services Association of South Carolina Inc., S.C. Department of Mental Health, S.C Department of Health and Environmental Control, Faces and Voices of Recovery South Carolina, Federation of Families of South Carolina, S.C. HIV Planning Council members

Note: This is a preliminary analysis and requires additional data sources and analyses. The data used for the needs assessment section were designed to provide a brief snapshot of substance use prevalence and treatment need. Several estimates were derived from national- or state-level sources, and thus fail to consider local variations. The reader should exercise extreme caution before making assumptions about the applicability of these estimates.

Individuals with mental and/or substance use disorders who are homeless	
DAODAS Points of Contact	Bonsu, Walker
Estimated Completion Date	To be determined (TBD)
Recommended Priority	TBD
Prevalence	
Data from the snapshot homelessness count indicate that there was a total of 4,701 homeless individuals living in South Carolina. Approximately 10% reported having ever received treatment for substance abuse problems. This is likely a substantial underestimate of both the true count of homelessness in the state as well as the true proportion of the homeless population that are in need of treatment services. First, the survey methodology undercounts individuals due to the recruitment strategies utilized. Briefly, the effort is based on a volunteer staff that varies in terms of their ability to adequately cover the entire state. The effort also fails to take into account periodic homelessness due to its administration being confined to one day during the year. Finally, the substance abuse question only asks if the person has ever received treatment for a substance abuse problem. It does not assess current use patterns. Data from our FY2011 admissions counts indicate that approximately 1,000 clients reported being homeless for most of the past 30 days. While this is far less than the approximately 5,000 individuals located in the snapshot survey, it is greater than the substance abuse problem indicator reported from the same project. Again, this is probably due to the methodology issues highlighted above. Data-collection measures that employ more sophisticated strategies would likely improve the quantity and quality of the information on homeless in the state.	
Data sources: Data from the latest South Carolina Homeless Count was collected on January 27, 2011. www.schomeless.org/scch_2011.php	
Methodology: Synthesis of available data points	
Data gaps: More work needs to be done to locate the homeless and serve them in the areas that they occupy. Partnering with the state and local homeless coalitions would likely improve the amount of information we have about the treatment need for this population. County-level prevalence surveys would further narrow down the data to aid in programming and funding allocations.	
Services Provided	
Data sources: DAODAS Substance Abuse Agencies Management Information System (SAAMIS)	
Methodology: Extraction	
Data gaps: Services by providers other than the county authorities	
Analysis	
Who provides the services: 33 county authorities, other providers, S.C Homeless Coalition, S.C Veteran Affairs homeless program	
Gaps in service provision: TBD	
Related Goals and Objectives:	
Work to date: Initial prevalence and Services Provided estimates. Through funding from the S.C. Housing Finance and Development Authority, DAODAS established two transitional houses in Columbia and Florence.	
Work to be done: Identify other providers. Determine gaps in data and service provision. Determine needed technical assistance and/or funding resources. Decide priority (Step 3) and, as required, develop goals, strategies, and measurable objectives (Step 4).	
Resources needed: TBD	
Stakeholders: Behavioral Health Services Association of South Carolina Inc., S.C. Department of	

Mental Health, S.C Department of Health and Environmental Control, Faces and Voices of Recovery South Carolina, Federation of Families of South Carolina, S.C. Homeless Coalition, S.C. Veteran Affairs homeless program, United Way of South Carolina

Note: This is a preliminary analysis and requires additional data sources and analyses. The data used for the needs assessment section were designed to provide a brief snapshot of substance use prevalence and treatment need. Several estimates were derived from national- or state-level sources, and thus fail to consider local variations. The reader should exercise extreme caution before making assumptions about the applicability of these estimates.

Individuals with mental and/or substance use disorders who are involved in the criminal or juvenile justice systems	
DAODAS Points of Contact	Bonsu, Walker
Estimated Completion Date	To be determined (TBD)
Recommended Priority	TBD

Prevalence

The criminal justice system has traditionally been the largest referral source for the state's public substance abuse treatment system. During FY2011, approximately 43% (N=4,000) of intakes under the age of 17 were referred through the criminal justice system. In South Carolina, minors under the age of 17 are typically handled through the family court system. Anyone 17 or older, or minors accused of certain crimes, are processed through the adult criminal justice system. This system is also a very large referral source. The inclusion of referrals recorded as coming from the Department of Motor Vehicles – which are likely due to DUI convictions – lifts the percentage of all 17-and-older intakes referred from the criminal justice system to 54% of all adult intakes (N=18,750).

The criminal justice system can also provide data concerning its population's need for substance abuse services. One way to discuss treatment need for offenders currently served through community supervision programs is the occurrence of positive drug tests that would indicate a violation of probationary rules. Of the 18,188 drug tests performed by the Department of Probation, Parole and Pardon Services during FY2010, 34.4%, or 6,262, screened positive for one or more drugs. Another way to classify treatment need is to consider the volume of drug specific arrests. In FY2009, the latest year for which arrest data is available, there were 32,880 drug arrests. An analysis of the past few years indicates that personal-use offenses accounted for approximately 75% of all drug arrests occurring between FY2005 and FY2009. Alcohol-related substance abuse treatment needs can also be assessed through DUI and drunkenness arrest charges. In 2009, there were 17,248 DUI and 12,328 drunkenness arrests in South Carolina. Finally, a count of the number of offenders entering community supervision or correctional facilities for drug-related charges can be used to provide a crude estimate of the substance abuse treatment needs of this population. During FY2010, 3,888 offenders were admitted to community supervision programs, and 2,569 offenders were admitted to correctional facilities for drug-related offenses.

Taking any of these data points as a *yearly* indicator of the quantity of treatment need indicates that the public substance abuse system could reasonably expand the number of clients seen through criminal justice referral sources. For the most recent year, the state's public substance abuse treatment system received 20,468 intakes from the criminal justice or Department of Motor Vehicles referral sources. Limiting our focus to the 32,880 drug arrests, 6,262 positive drug tests recorded by probation officials, the 17,248 DUI arrests, and the 12,328 drunkenness arrests would result in 68,718 individuals in the criminal justice system who can be readily identified as needing treatment. This crude estimate could benefit substantially from more sophisticated analyses, but it does provide a snapshot in terms of the substance abuse problems detected by the criminal justice system during the most recent one-year time frame.

Data sources:

- South Carolina Criminal and Juvenile Justice Trends 2010. S.C. Department of Public Safety, Office of Justice Programs.
- Indicators of Illegal Drug Activity in South Carolina FY05-10. S.C. Department of Public Safety, Office of Justice Programs. June 2011. www.scdps.org/ojp/stats/index.html

Methodology: Synthesis of available data points

Data gaps: Unfortunately, the state's judicial system lacks a coordinated information system that could be used to report on the number of convictions and the associated sanctions associated with alcohol or other drug criminal convictions. Due to this data gap, we're often left to wonder what "drop off" exists between arrest and conviction, especially for the lower magistrate or municipal court settings. County-level prevalence information would further narrow the data to aid in programming and funding

allocations.
Services Provided
Data sources: DAODAS Substance Abuse Agencies Management Information System (SAAMIS)
Methodology: Extraction
Data gaps: Services by providers other than the county authorities
Analysis
Who provides the services: 33 county authorities, other providers, S.C Department of Juvenile Justice, S.C. Department of Corrections
***Gaps in service provision*:** Comparing the prevalence estimates to the number actually served by South Carolina's public substance abuse agencies during the most recent year would confirm that there is a substantial treatment gap.
Related Goals and Objectives:
Work to date: Initial prevalence and Services Provided estimates
Work to be done: Identify other providers. Determine gaps in data and service provision. Determine needed technical assistance and/or funding resources. Decide priority (Step 3) and, as required, develop goals, strategies, and measurable objectives (Step 4).
Resources needed: TBD
Stakeholders: Behavioral Health Services Association of South Carolina Inc., S.C. Department of Mental Health, S.C Department of Health and Environmental Control, Faces and Voices of Recovery South Carolina, Federation of Families of South Carolina, S.C. Department of Probation, Parole and Pardon Services (DPPPS), S.C. Department of Motor Vehicles (DMV), S.C. Department of Juvenile Justice (DJJ), S.C. Department of Corrections (SCDC), S.C. Department of Public Safety (DPS)

Note: This is a preliminary analysis and requires additional data sources and analyses. The data used for the needs assessment section were designed to provide a brief snapshot of substance use prevalence and treatment need. Several estimates were derived from national- or state-level sources, and thus fail to consider local variations. The reader should exercise extreme caution before making assumptions about the applicability of these estimates.

Individuals with mental and/or substance use disorders who live in rural areas	
DAODAS Points of Contact	Wilson, Walker
Estimated Completion Date	To be determined (TBD)
Recommended Priority	TBD

Prevalence

The South Carolina Office of Rural Health indicates that in South Carolina, 36 of the state's 46 counties fall outside of a metropolitan area and nearly 75% of the state is designated as rural. Special consideration of healthcare delivery systems and the populations that they seek to serve must be considered, given much of the state's predominantly rural status. A recent NSDUH report provides some indication that treatment need in rural areas, while lower than metropolitan areas, still poses a formidable issue for these communities. The report found that 4.6% of individuals age 12 or older reported current use of illicit drugs in counties designated as completely rural. That's roughly half the rate noted for large metropolitan areas (9%). Binge drinking, on the other hand, appears to be similar regardless of population density. The same report notes that the rate for metropolitan and non-metropolitan counties was 24% for large metropolitan areas versus 22.7% for non-metropolitan areas.

The difficulty in labeling an area as rural versus metropolitan can be complicated by a host of factors. What's key for South Carolina to recognize is that it is a predominantly rural state. Assuming that the rural designation would apply to any county with fewer than 100,000 residents would imply that 31 out of 46 counties could be classified as rural. Using data from the 2010 census, this classification system would put the rural population for the state at 1,209,943. This would imply that roughly 56,000 rural residents are current illicit drug users and that 266,000 recently engaged in binge drinking behaviors. Since some likely used drugs as well as indulged in binge drinking, a rough prevalence estimate would be 300,000. Overlapping this designation strategy with the reported number of clients served during the most recent year would indicate that roughly 11,000 clients were seen in these counties. This would imply that a substantial amount of work remains for any efforts designed to meet the substance abuse treatment needs for these areas.

Data sources:

- U.S. Census Bureau, Census of Population and Housing 2010
- Data available from DAODAS Substance Abuse Agencies Management Information System (SAAMIS)
- Substance Abuse and Mental Health Services Administration. (2010). Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings (Office of Applied Studies, NSDUH Series H-38A, HHS Publication No. SMA 10-4586Findings). Rockville, Md.
- South Carolina Office of Rural Health. Accessed on 8/19/2011. www.scorh.net

Methodology: Synthesis of available data points

Data gaps: State prevalence-data collection efforts could substantiate or refute the national estimates utilized here. County-level prevalence surveys would further narrow the data to aid in programming and funding allocations.

Services Provided

Data sources: DAODAS Substance Abuse Agencies Management Information System (SAAMIS)

Methodology: Extraction

Data gaps: Variation between communities in terms of the available services and unique treatment needs of their populations would likely benefit the state's ability to plan for service provision to rural-based services. Information designed to address transportation and other client barriers that could prevent treatment engagement must be included in an in-depth analysis of rural area needs. Partnerships and stakeholders should also be engaged to assess the degree to which resource sharing could help address the treatment gap estimated here.

Analysis
Who provides the services: 33 county authorities plus other TBD providers
***Gaps in service provision*:** Comparing the prevalence estimates to the number of clients actually served by South Carolina's public substance abuse agencies during the most recent year would confirm that there is a substantial treatment gap.
Related Goals and Objectives:
Work to date: Initial prevalence and Services Provided figures
Work to be done: Identify other providers. Determine gaps in data and service provision. Determine needed technical assistance and/or funding resources. Decide priority (Step 3) and, as required, develop goals, strategies, and measurable objectives (Step 4).
***Resources needed*:** TBD
***Stakeholders*:** Behavioral Health Services Association of South Carolina Inc., S.C. Department of Mental Health, S.C Department Health and Environmental Control, Faces and Voices of Recovery South Carolina, Federation of Families of South Carolina, S.C. Office of Rural Health

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Underserved racial and ethnic minority and LGBTQ populations	
DAODAS Points of Contact	Bonsu, Walker
Estimated Completion Date	To be determined (TBD)
Recommended Priority	TBD

Prevalence

Demographic Category	2010 Census Population	Estimated Treatment Need	# in Need of Treatment Based Upon Estimate	TX Provided During FY 2011 (SAAMIS)
African American	1,290,684	8.8% classified as Abuse or Dependent in 2009 NSDUH	103,255	12,497
Hispanic Ethnicity	235,682	8.3% for Alcohol Use 3.4% for Drug Use	19,561 8,014	All Hispanic Clients N = 1,090
Asian	59,051	3.5% classified as Abuse or Dependent in 2009 NSDUH	2,067	171
LGBTQ	?????	?????	?????	?????

Data sources:

- Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (July 16, 2009). The NSDUH Report: Substance Use Treatment Need and Receipt among Hispanics. Rockville, Md., provides national treatment-need estimate for Hispanic Population based on NSDUH data collected from 2002 to 2007.
- Substance Abuse and Mental Health Services Administration. (2010). *Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings* (Office of Applied Studies, NSDUH Series H-38A, HHS Publication No. SMA 10-4586Findings). Rockville, Md.
- U.S. Census Bureau, 2010 Census Summary File 1.

Methodology: Synthesis of available data points

Data gaps: The needs assessment data, where available, provide an indication of treatment need for these populations at a national level. Unfortunately, these figures fail to take into account the local variation in both substance abuse issues and minority group population composition factors. County-level prevalence surveys would further narrow the data to aid in programming and funding allocations.

Services Provided

Data sources: DAODAS Substance Abuse Agencies Management Information System (SAAMIS)

Methodology: Extraction

Data gaps: Data on services provided by entities other than county authorities

Analysis

Who provides the services: 33 county authorities plus other TBD providers

***Gaps in service provision*:** Comparing the prevalence estimates to the number of clients actually served by South Carolina's public substance abuse agencies during the most recent year would confirm that there is a substantial treatment gap. Most county authorities do not have an on-site interpreter to immediately work with Hispanic or Asian clients when they come in for services.
Related Goals and Objectives:
Work to date: Initial prevalence and Services Provided figures. DAODAS funds interpretive services in Region II, which has a high population of Hispanic/Latino residents, by having a staff member on board to provide the services (Alpha Center). The department also provides funding for contract staff to provide interpretive services in Region IV.
Work to be done: Identify other providers. Determine gaps in data and service provision. Determine needed technical assistance and/or funding resources. Decide priority (Step 3) and, as required, develop goals, strategies, and measurable objectives (Step 4).
Resources needed: TBD
Stakeholders: Behavioral Health Services Association of South Carolina Inc., S.C. Department of Mental Health, S.C Department Health and Environmental Control, Faces and Voices of Recovery South Carolina, Federation of Families of South Carolina, S.C. Commission for Minority Affairs

Note: This is a preliminary analysis and requires additional data sources and analyses. The data used for the needs assessment section were designed to provide a brief snapshot of substance use prevalence and treatment need. Several estimates were derived from national- or state-level sources, and thus fail to consider local variations. The reader should exercise extreme caution before making assumptions about the applicability of these estimates.

Persons with disabilities	
DAODAS Points of Contact	Bonsu, Walker
Estimated Completion Date	To be determined (TBD)
Recommended Priority	TBD
Prevalence	
Data sources:	
Methodology:	
Data gaps:	
Services Provided	
Data sources:	
Methodology:	
Data gaps:	
Analysis	
Who provides the services: 33 county authorities, other providers, S.C School for the Deaf and the Blind (SCDB)	
***Gaps in service provision*:**	
Related Goals and Objectives:	
Work to date:	
Work to be done: Develop prevalence estimate, services provided, and unmet service need. Identify other providers. Determine gaps in data and service provision. Determine needed technical assistance and/or funding resources. Decide priority (Step 3) and, as required, develop goals, strategies, and measurable objectives (Step 4).	
***Resources needed*:** TBD	
Stakeholders: Behavioral Health Services Association of South Carolina Inc., S.C. Department of Mental Health, S.C Department Health and Environmental Control, Faces and Voices of Recovery South Carolina, Federation of Families of South Carolina, S.C School for the Deaf and the Blind (SCDB)	

Note: This is a preliminary analysis and requires additional data sources and analyses. The data used for the needs assessment section were designed to provide a brief snapshot of substance use prevalence and treatment need. Several estimates were derived from national- or state-level sources, and thus fail to consider local variations. The reader should exercise extreme caution before making assumptions about the applicability of these estimates.

Community populations for environmental prevention activities, including policy-changing activities and behavior-change activities to alter community, school, family and business norms through laws, policies and guidelines, and enforcement	
DAODAS Points of Contact	Nienhius, Walker
Estimated Completion Date	To be determined (TBD)
Recommended Priority	TBD
Prevalence	
See S.C. State Profile, S.C. State Epidemiological Outcomes Workgroup (SEOW)	
Data sources: S.C. State Profile, S.C. State Epidemiological Outcomes Workgroup (SEOW)	
Methodology: Synthesis of available data points	
Data gaps: See S.C. State Profile, S.C. State Epidemiological Outcomes Workgroup (SEOW)	
Services Provided	
Data sources: See S.C. State Profile, S.C. State Epidemiological Outcomes Workgroup (SEOW)	
Methodology: Extraction	
Data gaps: See S.C. State Profile, S.C. State Epidemiological Outcomes Workgroup (SEOW)	
Analysis	
Who provides the services: 33 county authorities plus other TBD community organizations and governmental agencies	
Gaps in service provision: See S.C. State Profile, S.C. State Epidemiological Outcomes Workgroup (SEOW)	
Related Goals and Objectives:	
Work to date: The S.C. State Profile is being updated under the aegis of the SPF-SIG program.	
Work to be done: Identify other providers. Determine gaps in data and service provision. Determine needed technical assistance and/or funding resources. Decide priority (Step 3) and, as required, develop goals, strategies, and measurable objectives (Step 4).	
Resources needed: TBD	
Stakeholders: S.C. Governor's Council on Substance Abuse Prevention and Treatment, Behavioral Health Services Association of South Carolina Inc., S.C. Department of Mental Health, S.C. Department of Health and Environmental Control, Faces and Voices of Recovery South Carolina, Federation of Families of South Carolina	

Community settings for universal, selective, and indicated prevention interventions, including hard-to-reach communities and "late" adopters of prevention strategies	
DAODAS Points of Contact	Nienhius, Walker
Estimated Completion Date	To be determined (TBD)
Recommended Priority	TBD
Prevalence	
See S.C. State Profile, S.C. State Epidemiological Outcomes Workgroup (SEOW)	
Data sources: S.C. State Profile, S.C. State Epidemiological Outcomes Workgroup (SEOW)	
Methodology: Synthesis of available data points	
Data gaps: See S.C. State Profile, S.C. State Epidemiological Outcomes Workgroup (SEOW)	
Services Provided	
Data sources: See S.C. State Profile, S.C. State Epidemiological Outcomes Workgroup (SEOW)	
Methodology: Extraction	
Data gaps: See S.C. State Profile, S.C. State Epidemiological Outcomes Workgroup (SEOW)	
Analysis	
Who provides the services: 33 county authorities plus other TBD community organizations and governmental agencies	
***Gaps in service provision*:** See S.C. State Profile, S.C. State Epidemiological Outcomes Workgroup (SEOW)	
Related Goals and Objectives:	
Work to date: The S.C. State Profile is being updated under the aegis of the SPF-SIG program.	
Work to be done: Identify other providers. Determine gaps in data and service provision. Determine needed technical assistance and/or funding resources. Decide priority (Step 3) and, as required, develop goals, strategies, and measurable objectives (Step 4).	
Resources needed: TBD	
Stakeholders: S.C. Governor's Council on Substance Abuse Prevention and Treatment, Behavioral Health Services Association of South Carolina Inc., S.C. Department of Mental Health, S.C. Department of Health and Environmental Control, Faces and Voices of Recovery South Carolina, Federation of Families of South Carolina	

Federal Guidance. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning.

State's Response:

The South Carolina State Epidemiological Outcomes Workgroup (SEOW) is tasked with examining alcohol-, tobacco-, and other substance-related data to determine the scope and magnitude of substance abuse and its related consequences in South Carolina, and with supporting ongoing state-level monitoring and evaluation through its data collection, assimilation, and reporting across the state. The SEOW updates the state profile annually, and the most recent edition of the state profile is located on the DAODAS web site (www.daodas.state.sc.us). Data resources are available from various state agencies that are represented on the workgroup. Workgroup members are data managers and coordinators, an epidemiologist, substance abuse treatment and prevention consultants, and data analysts. The chairperson is a Senior Associate Dean and tenured Professor of Biostatistics for the University of South Carolina's School of Public Health.

The South Carolina SEOW identified four state prevention priorities in 2008, with the specific goal of identifying South Carolina's top alcohol, tobacco, and other drug (ATOD) priorities. Facilitation of the prioritization process required a comprehensive review of substance use-related indicators by the SEOW. Indicators were summarized by construct and presented by population and substance. Trend, rate, rate ratio, and high-risk groups were identified for each indicator to help demonstrate areas of concern. Of greatest concern were those indicators for which the state rate was higher than the national rate and/or those indicators that demonstrated an upward trend.

Prioritization of indicators was based on five criteria, two of which were data source and data quality. The source of indicators and data quality are directly related to criteria for selecting the consequence and consumption constructs and indicators (availability/accessibility, validity, timeliness, consistency, and sensitivity of the data) that were included in the state epidemiological profile. The remaining criteria for prioritization were political will (willingness of the population and politicians to address an issue), changeability (the likelihood that measurable change can take place), and existing resources (the abundance or lack of resources available to address an issue). The measurement used for each indicator was low (L), medium (M), and high (H). The top 10 potential indicators, as identified by the SEOW after a review of all the information in the state profile, are shown below, along with the criteria ratings assigned by the SEOW during a prioritization retreat.

Prioritization Chart of Top 10 Potential Indicators:

INDICATOR	Data Source	Data Quality	Political Will	Changeability	Existing Resources
Underage alcohol use	Youth Risk Behavior Survey	H	H	M	M+
Underage drinking and driving	Youth Risk Behavior Survey	H	H-	H	H
Alcohol-related car crash	Fatality Analysis Reporting System	H	H-	M	H
Smokeless tobacco use	Youth Risk Behavior Survey	H	L	M	M
Smoking during pregnancy	Pregnancy Risk Assessment Monitoring System	H	H	H	M
Youth tobacco use	Youth Risk Behavior Survey	H	M	H	M
Adult tobacco use	Behavior Risk Factor Survey	H	M	M	M
Marijuana use	National Survey on Drug Use and Health, Youth Risk Behavior Survey	H	L	M	L
HIV/AIDS	Centers for Disease Control and Prevention, Department of Health and Environmental Control	M	L	M	L
Teen pregnancy	National Vital Statistics System	H	M-	M	M-

After considerable discussion and analysis of the 10 potential priorities, the workgroup emerged with a final list of four state prevention ATOD priorities:

1. Underage alcohol use
2. Alcohol-related car crashes (with an emphasis on underage drinking and driving)
3. Substance abuse during pregnancy
4. Youth tobacco use (including smokeless tobacco use)

The four SEOW-identified state ATOD priorities were presented to and approved by the Governor's Council on Substance Abuse Prevention and Treatment on April 23, 2008. The priorities were not ranked in order of greatest priority, as they all pose significant risks to South Carolinians. The four priority areas were discussed and reconfirmed by the members of the Governor's Council at a meeting held on March 30, 2010. The South Carolina Strategic Prevention Framework State Incentive Grant (SPF SIG) is currently addressing the first two state priorities, underage drinking and DUI car crashes.

Under the direction of the SEOW, in 2008, DAODAS provided each of the state's 46 counties with a pre-filled template similar to the state epidemiological profile. County prevention professionals were responsible for developing or organizing local SEOW data teams that would conduct and analyze the results of local surveys, focus groups, and environmental scans. The teams were encouraged to use culturally appropriate instruments for their population when conducting the needs assessment for their SEOW profiles. They were also to include in their county profile any relevant data accessible to them that was not available at the state level. The final county profile was to include three priorities established by the county based on data presented in the plan. These county profiles have been used by the counties in 2009 and 2010 to plan their prevention programs and services offered in the county. During the spring of 2010, through the SPF SIG, the SEOW led the process – required by DAODAS of all 46 South Carolina counties – to update their local county profiles and use the updated profiles in their county strategic plans. The updated profiles were also to be used by the county to develop their plans for providing primary prevention services in 2011.

The SEOW continues to collaborate with the 33 county alcohol and drug abuse authorities (agencies) throughout the state to promote better appreciation and understanding of data. Ultimately, it is our goal that the data plans and products implemented, produced, and updated by the South Carolina SEOW will influence decisions made by key stakeholder agencies and organizations, policymakers, and the general public. The South Carolina SEOW continues to broaden its efforts to promote statewide data-driven prevention planning, policies, and programs.

State ATOD Prevention Priorities by Data Sources

PRIORITY	DATA SOURCE	INDICATOR
Underage alcohol use	National Institute of Alcohol Abuse and Alcoholism	Total sales of ethanol per capita age 14 and older
	Youth Risk Behavior Surveillance System	Current (past-30-day) alcohol use among youth in grades 9-12
	Youth Risk Behavior Surveillance System	Current (past-30-day) alcohol use among youth in grades 9-12 by gender, grade, and race/ethnicity
	National Survey on Drug Use and Health	Current (past-30-day) alcohol use among persons ages 12-17 and 18-25
	Youth Risk Behavior Surveillance System	First alcohol use before age 13
	Youth Risk Behavior Surveillance System	Binge alcohol use in the past 30 days among youth in grades 9-12
	Youth Risk Behavior Surveillance System	Binge alcohol use in the past 30 days among youth in grades 9-12 by gender, grade, and race/ethnicity
	National Survey on Drug Use and Health	Binge alcohol use in the past 30 days among persons ages 12-17 and 18-25
DUI car crashes (with an emphasis on underage drinking and driving)	Youth Risk Behavior Surveillance System	Drinking and driving among youth in grades 9-12
	Youth Risk Behavior Surveillance System	Drinking and driving among youth in grades 9-12 by gender, grade, and race/ethnicity
	Youth Risk Behavior Surveillance System	Youth in grades 9-12 reporting being a passenger in a car with a drinking driver
	Fatality Analysis Reporting System	Percent of fatal motor vehicle crashes in which at least one driver, pedestrian, or cyclist had been drinking
	Fatality Analysis Reporting System	Number of vehicle deaths in which at least one driver, pedestrian, or cyclist had been drinking
	Fatality Analysis Reporting System	Percent of drivers involved in fatal crashes who used alcohol
	S.C. Department of Public Safety	Number of nighttime single-vehicle crashes per 1,000 population age 16 and older

State ATOD Prevention Priorities by Data Sources (continued)

PRIORITY	DATA SOURCE	INDICATOR
Substance use during pregnancy	Pregnancy Risk Assessment Monitoring System	Percent of pregnant women reporting smoking during the last three months of pregnancy
	Pregnancy Risk Assessment Monitoring System	Percent of pregnant women reporting any use of alcohol during the last three months of pregnancy
	S.C. Community Assessment Network; National Vital Statistics System	Rate (per 1,000 live births) of women reporting smoking at any time during pregnancy
Youth tobacco use (including smokeless tobacco use)	Youth Risk Behavior Surveillance System	Current (past-30-day) cigarette use among youth in grades 9-12
	Youth Risk Behavior Surveillance System	Current (past-30-day) cigarette use among youth in grades 9-12 by gender, grade, and race/ethnicity
	National Survey on Drug Use and Health	Current (past-30-day) cigarette use among persons age 12 and older by age group
	Youth Risk Behavior Surveillance System	Daily cigarette use among youth in grades 9-12
	Youth Risk Behavior Surveillance System	Daily cigarette use among youth in grades 9-12 by gender, grade, and race/ethnicity
	Youth Risk Behavior Surveillance System	Youth in grades 9-12 reporting first cigarette use before age 13
	Youth Risk Behavior Surveillance System	Current (past-30-day) smokeless tobacco use among youth in grades 9-12
	Youth Risk Behavior Surveillance System	Current (past-30-day) smokeless tobacco use among youth in grades 9-12 by gender, grade, and race/ethnicity

Data gaps identified by the SEOW:

1. College-age drinking
2. Local county-level youth surveys
3. Substance use during pregnancy
4. Tobacco use among youth
5. Military families

The majority of data compiled and analyzed by the SEOW is derived from archival sources. This data is present in the state- and county-level epidemiological profiles and plays a vital role in the establishment of ATOD priorities across the state. Although archival data holds great value, the workgroup recognizes its duty to address data gaps that hinder the state prevention system's ability to advocate for and implement evidence-based ATOD policies, strategies, and programs.

College-Age Drinking – Although multiple gaps in data exist in South Carolina, college-age drinking was chosen for analysis due to an overwhelming lack of available college-age drinking data across the state. While state-level alcohol-consumption data for high school students is available from the Youth Risk Behavior Survey (YRBS), a system for promoting statewide collection of consumption data was essentially non-existent for college-age students. In response, an incentive-based statewide liaison-support system was established to encourage institutions of higher learning to participate in the Core Survey. (The Core Survey is a measurement tool of the Core Institute at Southern Illinois University - Carbondale that collects college-age drinking data that shows prevalence, attitudes, perception of risk, and social norms regarding substance use among college-age students.) The availability of good-quality data for alcohol and other substance use among both high school and college-age students could prove to be extremely useful as we further analyze alcohol consumption over a broad range of formative years. This abundance of data may increase South Carolina's ability to enact policies, strategies, and monitoring systems that possess the strength to radically shift the paradigm of alcohol use from adolescence through adulthood. The South Carolina SPF SIG is currently helping to address this data gap, and this effort will need to be sustained in order to provide county-level data for comprehensive prevention planning to address underage drinking and binge drinking among young adults.

The SEOW has previously utilized archival YRBS data in its monitoring and analysis of ATOD prevalence and trends, but that particular data set provides no county-level data. Currently, through the South Carolina SPF SIG, county-level school survey data is being collected with the implementation of the South Carolina Communities That Care Survey. This effort will need to be sustained in the future to provide county-level data for comprehensive prevention planning to address substance abuse, underage drinking, and binge drinking; prescription drug abuse; and tobacco use among children and adolescents in South Carolina.

The SEOW has also begun discussions regarding steps needed to reduce the data gap related to its remaining two priorities: tobacco use among youth (with an emphasis on smokeless tobacco use) and substance use during pregnancy. Finally, the SEOW has also begun discussions in

reference to existing data gaps surrounding military family issues. The state of South Carolina is home to six military installations and 80 Army National Guard Units. The South Carolina National Guard itself is composed of approximately 10,000 service men and women. Anecdotal evidence or information shows increased incidences of substance abuse, violence, and suicide among war veterans, and currently programs are being utilized to address the emotional and social needs of children of soldiers actively or recently serving in Middle Eastern Asia war territories. However, there is recognition that the availability of valid, reliable data that examines these factors may lead to the development and implementation of new and additional evidence-based programs and strategies that produce better outcomes for military families.

The contribution of the SEOW to both prevention and treatment is under consideration and will be addressed fully by July 1, 2012. In a related development that affects both treatment and prevention functions, DAODAS is developing a Strategic Plan for a Recovery-Oriented System of Care (ROSC) program. To complement the needs assessment developed for the FY2012 SAPT BG State Plan, the ROSC Needs Assessment Committee will assess and map resources that are available across the state. The department expects to use the resource assessment to fill the gaps we presently see regarding the provision of services by those agencies and providers that are not county authorities.

Note: For ease of use, the composition of the SEOW is found in its entirety on the next page.

State Epidemiological Outcomes Workgroup (SEOW)

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Khosrow Heidari, State Epidemiologist (Chronic) Bureau of Community Health and Chronic Disease Prevention, DHEC
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II: Planning Steps

Table 2 Step 3: Prioritize State Planning Activities

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Start Year:

End Year:

Number	State Priority Title	State Priority Detailed Description
No Data Available		

Footnotes:

Table 2 Step 3 will be completed by May 1, 2012.

II: Planning Steps

Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

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Start Year:

End Year:

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
No Data Available				

Footnotes:

Table 3 Step 4 will be completed by July 1, 2012.