SOUTH CAROLINA GENERAL ASSEMBLY
Legislative Audit Council

LAC

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A LIMITED REVIEW OF THE S.C. DEPARTMENT OF ALCOHOL AND OTHER DRUG ABUSE SERVICES

Legislative Audit Council

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Introduction and Background

Audit Objectives

Members of the South Carolina General Assembly requested that we conduct an audit of the S.C. Department of Alcohol and Other Drug Abuse Services (DAODAS) to include the agency's response to the opioid epidemic; the impact of the COVID-19 pandemic on its efforts to address alcohol and substance use disorders; its involvement with local alcohol and drug abuse authorities, especially those in rural or underserved areas; the effectiveness of gambling addiction services; administrative costs; compliance with Proviso 37.4 dealing with carry-forward funds; and agency staffing.

We conducted survey work which included reviewing relevant documentation, conducting interviews, and analyzing federal and state statutes and regulations to clarify and refine the relevant issues to address in the audit. We developed the following audit objectives:

- Review the actions of the Department of Alcohol and Other Drug Abuse Services in response to the opioid epidemic.
- Review the impact of the COVID-19 pandemic on efforts by the Department of Alcohol and Other Drug Abuse Services to respond to gambling and non-opioid substance use disorders.
- Review administrative costs, management of carry-forward funds, procurement, and staffing.
- Review DAODAS' reimbursement process, communication practices, and overall involvement with service providers.

Scope and Methodology

Our audit work covered the period from FY 16-17 through FY 20-21 with consideration of earlier and more recent periods when relevant. To conduct this audit, we used a variety of evidentiary sources:

- Interviews with DAODAS' employees, employees of other state agencies, interested parties, and staff of local treatment authorities and opioid treatment providers.
- Federal and state laws and regulations.
- DAODAS' policies and procedures.
- U. S. Government Accountability Office (GAO) reports.
- Reports and data from the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services.
- Data from the S.C. Department of Health and Environmental Control (DHEC).
- Survey of other states.
- Medicaid state plan for behavioral health services.
- Inter-agency agreements.
- Contracts between DAODAS and service providers.
- Survey of DAODAS' employees.
- Appropriations and expenditure data.
- Procurement card data.
- South Carolina Enterprise Information System.
- DAODAS' website and the websites of agencies similar to DAODAS in other states.

We notified or met with other South Carolina state agencies because of their involvement with substance use disorders, the state's response to the opioid crisis, or regulating service providers. These agencies were:

S.C. DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL (DHEC)
S.C. DEPARTMENT OF MENTAL HEALTH (DMH)
S.C. DEPARTMENT OF SOCIAL SERVICES (DSS)
S.C. DEPARTMENT OF LABOR, LICENSING AND REGULATION (LLR)
S.C. DEPARTMENT OF CORRECTIONS (SCDC)
S.C. STATE LAW ENFORCEMENT DIVISION (SLED)

Criteria used to measure performance included contractual requirements, federal and state law, agency program manuals, and policies and procedures. We relied on data from DAODAS, DHEC, state financial reports, and South Carolina appropriations acts. We surveyed a judgment sample of neighboring states, local alcohol and drug abuse authorities, and opioid treatment providers, and all DAODAS' staff except the director.

We interviewed DAODAS' staff about the various information systems used by the agency. We determined how data was maintained and what levels of control were in place. We reviewed internal controls and noted any identified weaknesses in the report.

We conducted this performance audit in accordance with generally accepted governmental auditing standards. Those generally accepted government auditing standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

S.C. Code §2-15-50(b)(2) requires us to review the effectiveness of an agency to determine if it should be continued, revised, or eliminated. We did not conclude from this audit that DAODAS should be eliminated. However, our audit report includes recommendations for improvement in several areas.

Background

The mission of DAODAS is to ensure the availability and quality of a continuum of services, thereby improving the health status, safety, and quality of life of individuals, families, and communities across South Carolina.

Statutory Authority

S.C. Code §44-49-10 *et seq.* establishes the department, its functions, powers, and duties. S.C. Code §61-12-20 requires that each county government designate a single public or private entity to act as the sole agency for drug and alcohol abuse treatment and prevention programs.

Funding

DAODAS relies heavily on federal funding which has provided more than half of the agency's total funding. Since FY 16-17, federal funds have represented from 61% to 81% of the agency's total budget, with state appropriations representing 18% to 24%. In contrast, in 1980, when we audited the state's alcohol and drug abuse agency, federal dollars represented 39% of the agency's budget while state funds represented 61%.

Chart 1.1: Appropriations FY 16-17 – FY 20-21

	FY 16-17	FY 17-18	FY 18-19	FY 19-20	FY 20-21
State	$11,398,181 (21.79%)	$8,651,140 (17.65%)	$11,700,737 (19.69%)	$17,762,302 (24.10%)	$11,983,171 (17.64%)
Federal	31,938,406 (61.06%)	33,254,410 (67.86%)	40,617,730 (68.36%)	54,872,054 (74.44%)	54,872,054 (80.78%)
Other	8,968,132 (17.15%)	7,096,362 (14.48%)	7,096,362 (11.94%)	1,074,397 (1.46%)	1,074,397 (1.58%)
TOTAL	$52,304,719 (100%)	$49,001,912 (100%)	$59,414,829 (100%)	$73,708,753 (100%)	$67,929,622 (100%)

Source: LAC Analysis of Appropriations Acts

Staffing

As of March 2022, DAODAS had 39 employees and 4 vacancies. We were told that DAODAS underwent a reduction in force at some point in the early 2000s, when, we were told, the agency had as many as 100 employees.

DAODAS relies on liaisons at the S.C. Department of Mental Health, the S.C. Department of Social Services, and the S.C. Department of Corrections. These liaisons help to connect people to services. DAODAS has relationships with the S.C. Department of Veterans' Affairs and the S.C. Department of Probation, Parole and Pardon Services. DAODAS also collaborates with community recovery organizations to ensure support is provided to individuals living in recovery from substance use disorders.

Prevention, Treatment, and Recovery

While not a direct service provider, DAODAS provides funding, technical assistance, and training to providers and monitors prevention, treatment, and recovery services implemented through a provider network. Primary prevention includes all services that reduce the risk of developing alcohol, tobacco, and other drug problems or enhance factors that protect individuals and groups from developing these problems. Primary prevention services are based on annual needs assessments in the counties.

DAODAS supports treatment and recovery services for substance use disorders and gambling addiction, services which include, but are not limited to, assessments, medication, individual and group counseling, family education and counseling, and follow-up care. Providers offer evidence-based treatment models, and clinical staff in county alcohol and treatment facilities must meet certain minimum requirements.

Provider Network

DAODAS is not a direct service provider. It accomplishes its mission through a community-based system of care. DAODAS contracts with county alcohol and drug abuse authorities to provide most of the services throughout the state's 46 counties. DAODAS also contracts with other public and private service providers to address substance use disorders.

The community-based system dates to 1973 when the South Carolina General Assembly created the single and multi-county provider system that exists today. Act No. 301 of 1973 required each county to designate a single county authority on alcohol and drug abuse to be governed by a single policy-making board and to develop a county plan to receive mini-bottle tax revenue. One year later, with passage of Act No. 1065, the S.C. Commission on Alcoholism assumed the duties of the Office of the Commissioner of Narcotics and Controlled Substances and became the South Carolina Commission on Alcohol and Drug Abuse. In 1993, the Commission on Alcohol and Drug Abuse became a cabinet department renamed the South Carolina Department of Alcohol and Other Drug Abuse Services.

Thirty-two local alcohol and drug abuse authorities have served South Carolina's 46 counties and received funding through DAODAS. Four of the 32, Beaufort, Charleston, Union, and Williamsburg have been county government agencies; the rest have been non-profit agencies. However, as of July 2021, that number was reduced by one as DAODAS decided against renewing its contracts, or entering any new contracts, with Williamsburg County Behavioral Health after having taken a series of steps to correct deficiencies in that agency's operations. At that point, Florence County, Berkeley County, Clarendon County, and Georgetown County providers offered treatment services to Williamsburg County residents. On April 19, 2022, Williamsburg County entered into a formal agreement with Circle Park Behavioral Health, a current Florence County provider, to provide alcohol and other drug abuse services to Williamsburg County residents.

The Opioid Crisis

In 2011, the Centers for Disease Control and Prevention (CDC) declared deaths from prescription opioids an epidemic. In 2021, the American Medical Association (AMA) released a report citing progress in reducing the number of opioid prescriptions, despite an increase in drug-related deaths. Every state, including South Carolina, reported an increase in overdose deaths during the COVID-19 pandemic. According to the AMA, the opioid epidemic is now driven by illicit fentanyl, fentanyl analogs, methamphetamine, and cocaine. Overdoses from prescription opioid and heroin have remained high and are increasingly adulterated with illicit fentanyl.

In December 2017, the Governor issued Executive Order No. 2017-42, declaring a statewide public health emergency related to opioid misuse and abuse, opioid use disorder, and opioid-related deaths. The Governor established the Opioid Emergency Response Team co-chaired by the chief of the State Law Enforcement Division (SLED) and the director of DAODAS.

Opioid Lawsuit Settlements

In February 2022, South Carolina's Attorney General announced a financial settlement agreement in a $26 billion lawsuit with drugmaker Johnson & Johnson© and three major pharmaceutical distributors, AmerisourceBergen©, CardinalHealth™, and McKesson©, over their role in the opioid addiction crisis. South Carolina's share, received over 18 years, is expected to be more than $300 million. In May 2022, the Governor signed Act No. 222, which established the nine-member South Carolina Opioid Recovery Fund Board to administer the settlement funds.

From a 2021 settlement agreement, South Carolina is to receive approximately $9 million over a five-year period from the $573 million settlement with consulting firm McKinsey & Company. In 2007, South Carolina was part of the $19.5 million settlement with Purdue Pharma©.

Fentanyl and the International Drug Trade

In our report, we highlight the role that fentanyl plays in the opioid epidemic and the deadly risk it poses. During our audit, we reviewed reports that highlighted the toxicity of fentanyl, a synthetic opiate, up to 100 times more potent than heroin, and the role that the international drug trade has played in its production and distribution in the United States. According to U.S. law enforcement and drug investigators, most of the fentanyl trafficked to the U.S. comes from China, into Mexico and, to a lesser extent, Canada, and across the border into the United States. Chinese officials have worked with the U.S. government to reduce fentanyl production and distribution. While China is a primary source of U.S.-bound fentanyl exports, Mexico and India are also major fentanyl producers.

The United States is the leading consumer of opiates in the world. Many opioids in the United States no longer originate from the opium poppy. Instead, new compounds, often sold mixed with heroin, originate in illicit laboratories in China. China's chemical and pharmaceutical companies can produce fentanyl and other lethal compounds because of a lack of regulation by Chinese officials. As these manufacturers modify the chemical makeup of fentanyl, the new chemical compound must be added to the list of scheduled drugs in the United States.

In the United States, fentanyl is a major cause of death for 18–45-year-olds. In 2015, South Carolina had 130 fentanyl related deaths. By 2020, that number increased to 1,100. U.S. Customs and Border Protection reported confiscating 11,201 pounds of fentanyl, nationwide, between October 1, 2020, and September 30, 2021. Fentanyl seizures by U.S. Customs and Border Protection agents at all United States ports of entry, alone, increased by 400% since 2018.

Opioid Services

In this chapter, we report on how opioids have impacted the state. We reviewed efforts by the S.C. Department of Alcohol and Other Drug Abuse Services (DAODAS) to address the opioid epidemic.

What We Examined

- Funding of opioid services.
- Information related to opioid use disorder.
- Drug overdose mortality data.
- DAODAS' relationship with opioid treatment programs (OTPs).
- DAODAS' monitoring efforts.
- Records of the Opioid Emergency Response Team (OERT).

What We Found

- DAODAS has failed to apply for available funding when there was a need.
- DAODAS relies on a funding allocation methodology that fails to account for need as measured by drug overdose mortality data.
- The state has seen an increase in opioid-related deaths, including an increase from fentanyl-laced substances.
- South Carolina is scheduled to receive more than $300 million from a multi-state settlement agreement involving litigation against pharmaceutical companies.
- Some mortality data released by the S.C. Department of Health and Environmental Control (DHEC) was inconsistent and inaccurate.
- DAODAS has been slow to renew onsite inspections of treatment providers.
- DAODAS lacks information on opioid treatment programs that could benefit public awareness and DAODAS in its oversight of providers.

Opioid Use Disorder

Throughout our report, a fiscal year was referenced as FY; otherwise, the calendar year applied. For charts, the calendar year was referenced as CY.

We found opioid use disorder and related drug overdoses continue to impact the state in the following ways:

- The number of drug overdose deaths involving opioids in the state increased each year from 2015 through 2020, increasing 60% from 2019 to 2020.
- At various times from 2016 through 2020, Greenville or Horry County had the highest number of patients with an opioid use disorder receiving state-funded treatment.
- Since 2017, Dillon County had the highest rate, per 1,000 persons, of patients with an opioid use disorder receiving state-funded treatment.
- Law enforcement and fire departments in rural areas have not all been trained on the administration of naloxone, an opioid overdose reversal medication.
- Emergency services personnel across the state administered naloxone, an opioid overdose reversal medication, 9,455 times in 2020, a 35% increase from 6,989 times in 2019.
- The number of drug overdose deaths in the state involving fentanyl, a synthetic opioid, increased each year from 2015 through 2020, and accounted for 79% of opioid-involved overdose deaths in 2020, yet DAODAS' home page for its website does not have information on fentanyl or the availability of fentanyl test strips.
- The number of drug overdose deaths in the state involving fentanyl increased significantly from 537 in 2019 to 1,100 in 2020, a 105% increase.
- In April 2021, the Substance Abuse and Mental Health Services Administration (SAMHSA) notified federal grantees, such as DAODAS, that federal funds could be used to purchase fentanyl test strips.
- South Carolina is set to receive more than $300 million over 18 years from the multi-state settlement from litigation against opioid manufacturers, the distribution of which is to be determined by a panel appointed by the Governor's Office and the Legislature.
- A study of 2017 data by the Centers for Disease Control and Prevention estimated the economic burden of the opioid epidemic in the United States to be $1 trillion, including $471 billion for the estimated costs of opioid use disorder.

Opioid Overview

Opioids are narcotics commonly prescribed to treat pain. Opioids are highly addictive. Since dependency to opioids can develop after three days of use, anyone using opioids for long-term chronic pain management is at risk of a drug overdose. Deliberately misusing a prescription drug, using an illicit opioid such as heroin, or using an illicit opioid contaminated with the more potent fentanyl can increase the risk of overdose.

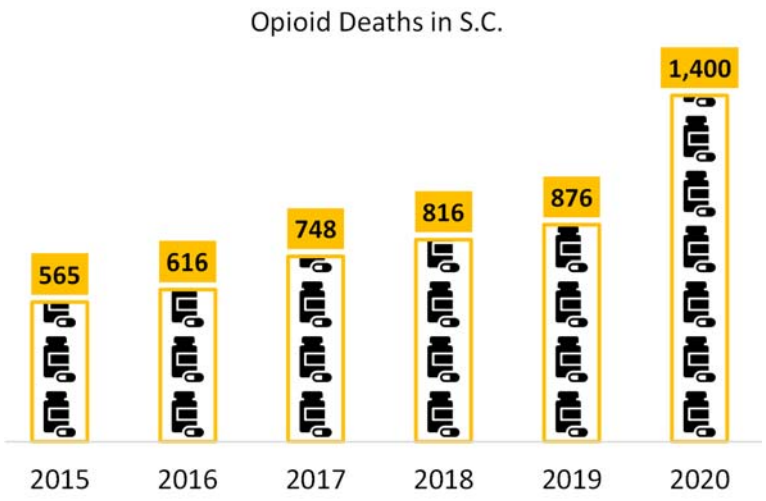
Opioids include illegal drugs like heroin and illicit fentanyl, but also include prescription medications, such as:

Morphine	Hydrocodone
Codeine	Fentanyl
Methadone	Hydromorphone
Oxycodone	Buprenorphine

When a person takes an opioid regularly, the person's body becomes accustomed to the drug and develops a tolerance to it. Once a person's body has developed a tolerance to opioids, a larger or more frequent dose is needed to continue to experience the same effect. If a person who has developed a tolerance to opioids stops taking the medication after long-term use, the tolerance is lost. Resuming opioid use after having lost tolerance means that the person may experience serious adverse effects, including overdose, even if the amount taken had not caused problems in the past.

Chart 2.1 shows the number of overdose deaths involving opioids in the state increased each year from 2015 through 2020, with the most significant increase of 60% from 2019 to 2020.

Chart 2.1: Overdose Deaths Involving Opioids in S.C., CY 2015 – CY 2020



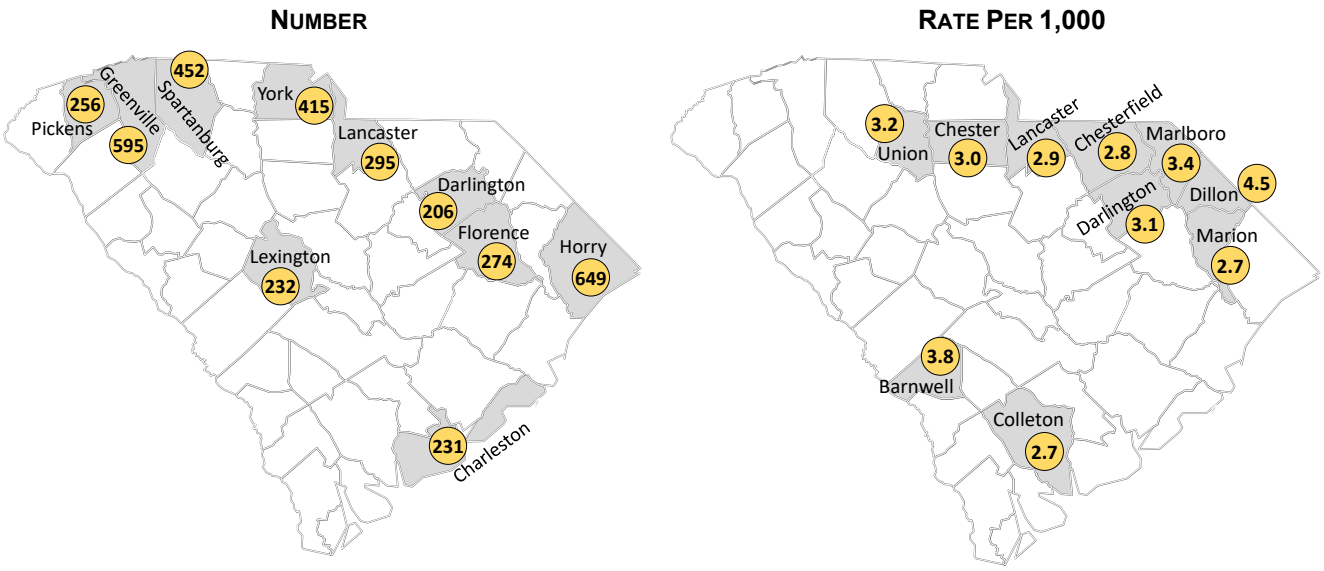
Source: DHEC's Vital Statistics, 2/28/2022

Number of Persons Receiving State-Funded Treatment for an Opioid Use Disorder in CY 2020

Chart 2.2 shows the ten highest-ranked counties for the number of persons and the rate per 1,000 persons receiving state-funded treatment for an opioid use disorder in 2020. Horry County ranked the highest in number in 2020. Since at least 2016, Greenville or Horry County has ranked the highest for the number of persons receiving state-funded treatment for an opioid use disorder (see Appendix C for more data). When the data was analyzed, Dillon County was the highest ranked in 2020 and has been since 2017.

DAODAS' funding formulas used to determine subgrantee awards' amounts do not consider drug overdose mortality data (see *DAODAS' Funding Formulas Fail to Consider Most Current Drug Overdose Mortality Data*).

Chart 2.2: CY 2020 Highest-Ranked Counties of Patients Receiving State-Funded Treatment for an Opioid Use Disorder



Source: LAC Analysis of Data from DAODAS

First Responders in Rural Areas Lack Training on Use of Opioid Reversal Medication

The Department of Health and Environmental Control (DHEC) has not held periodic training for all law enforcement and fire departments across the state, particularly in rural areas, on the administration of naloxone, an opioid overdose reversal medication. A DHEC official stated approximately 95% of the departments around the state have been trained to administer naloxone but there are smaller agencies that have yet to be trained. The DHEC official stated that employee turnover is a factor in training not being current in departments that had previously been trained. Currently, fire departments in Lexington and Horry counties receive the most naloxone in the state. As the data indicates, opioid use disorder and overdose deaths by rate of the population are highest in counties that may have smaller, rural departments.

Naloxone is a medicine that can be administered to a person to reverse an opioid overdose. S.C. Code §44-130-40 allows pharmacists to dispense naloxone without requiring a written prescription. Narcan® is the brand name of naloxone, which is a nasal spray used to treat an actual or suspected drug overdose involving an adult or child.

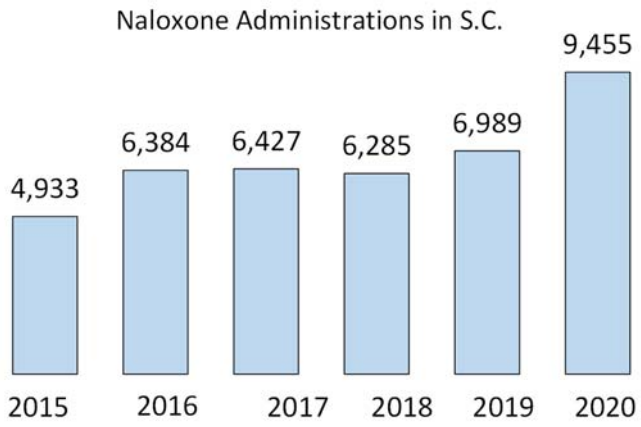
Upon completion of their training in administering naloxone, more than 80% of the law enforcement officers have said they could administer the medicine without a problem and that it was important for other police officers to be trained to use naloxone. Some critics question whether its availability and use can serve to enable addictive behavior. However, a study in Massachusetts showed rates of opioid-related emergency department visits and hospital admissions were not significantly different in communities with low or high implementation rates of overdose education and naloxone distribution.

DHEC's Bureau of Emergency Medical Services regulates and monitors naloxone usage by paramedics. It also supports two first responder programs—the Law Enforcement Officer Naloxone (LEON) program and the Reducing Opioid Loss of Life (ROLL) program for firefighters through a subgrant from DAODAS. As of March 2021, the LEON program had trained more than 10,000 police officers in 228 organizations across the state and more than 1,700 firefighters in 113 units were part of the ROLL program. According to a DHEC official, as of July 2022, 11,072 police officers and 3,646 firefighters in the state had been trained to administer naloxone over the lifetime of the program. A DHEC official explained police officers are assigned naloxone individually whereas it is assigned to a vehicle within fire departments.

Law enforcement overdose response programs have associated costs, including the costs of the naloxone kits, the costs to deliver training, and personnel costs. According to a DHEC official, the cost to the state for a box of two doses of intranasal naloxone is $70, which is 60–75% of the public list price. Additional costs may include retaining a medical supervisor to authorize naloxone access.

Chart 2.3 shows the number of naloxone administrations in South Carolina from 2015 through 2020. Naloxone administrations increased 35% from 2019 to 2020, indicating that more lives were potentially saved from an opioid overdose death.

Chart 2.3: Naloxone Administrations in S.C. by Number, CY 2015 – CY 2020



Source: LAC Analysis of Data from DHEC

Fentanyl

Overdose deaths involving fentanyl in the state increased significantly each year from 2015 through 2020. In 2020, there was a 105% increase from the 2019 data in the number of overdose deaths involving fentanyl in the state. Fentanyl was involved in 79% of all opioid-involved overdose deaths in 2020. Although fentanyl has increasingly led to overdose deaths in the state, the home page for DAODAS' website does not have information on fentanyl (see *Website Review*). Fentanyl is a potent synthetic opioid drug approved by the U.S. Food and Drug Administration to be used for treatment of chronic severe pain or as a sedative during surgical operations. It is legally manufactured and distributed in the United States but may be diverted by theft, fraudulent prescriptions, and illicit distribution by patients, physicians, and pharmacists. Fentanyl was introduced in the 1960s as an intravenous anesthetic and is currently available in oral lozenges, tablets, nasal sprays, and injectable formulations.

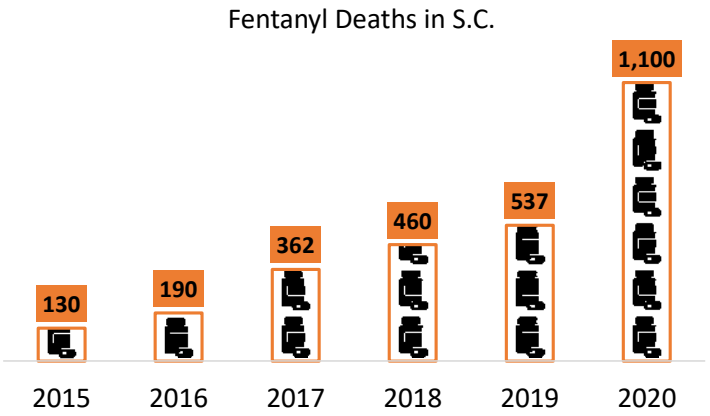
Illicitly-produced fentanyl is in the form of a powder or in counterfeit tablets meant to mimic pharmaceutical drugs such as oxycodone. It is primarily manufactured in foreign, clandestine labs and usually smuggled into the country through Mexico to be sold on the illegal drug market. Fentanyl is up to 100 times more potent than heroin or prescription opioids and is often mixed with heroin, cocaine, methamphetamine, or other street drugs. Fentanyl derivatives—such as carfentanil, which is used to anesthetize elephants—is also being mixed with heroin or prescription pills. A person may unknowingly purchase and use illicit fentanyl, resulting in an overdose death. Conversely, a person may intentionally use illicit fentanyl, but there is no way of knowing if it contains a deadly dose.

Fentanyl powder may result in death if just two milligrams are ingested, inhaled, or absorbed through the skin. To understand what constitutes 2 milligrams, consider that a small packet of sugar substitute contains 1,000 milligrams. It is possible to unknowingly be exposed to fentanyl when drug users, law enforcement officers, first responders, or family members are unaware of the drug's presence.

An analysis by the federal Drug Enforcement Administration found counterfeit pills ranging from .02 to 5.1 milligrams, more than twice the lethal dose, of fentanyl per tablet, and 42% of the pills tested for fentanyl contained at least 2 milligrams, a potentially deadly dose.

Chart 2.4 shows overdose deaths involving fentanyl from 2015 through 2020. By not having information about fentanyl on the home page for its website, DAODAS is not adequately informing the public of the dangerous impact of fentanyl.

Chart 2.4: Overdose Deaths Involving Fentanyl in S.C., CY 2015 – CY 2020



Source: DHEC's Vital Statistics, 2/28/2022

Fentanyl Test Strips

DAODAS does not have information about fentanyl test strips on the home page for its website. Because of the dramatic spike in overdose deaths involving illicit fentanyl in the country, SAMHSA notified federal grantees, such as DAODAS, that federal funds could be used to purchase fentanyl test strips beginning in April 2021.

DAODAS notified its community distributors (local alcohol and drug abuse authorities, opioid treatment programs, and recovery organizations) of the funding decision and added fentanyl test strips to the overdose education and naloxone distribution program. DAODAS held training webinars for the community distributors to learn about the distribution and use of fentanyl test strips.

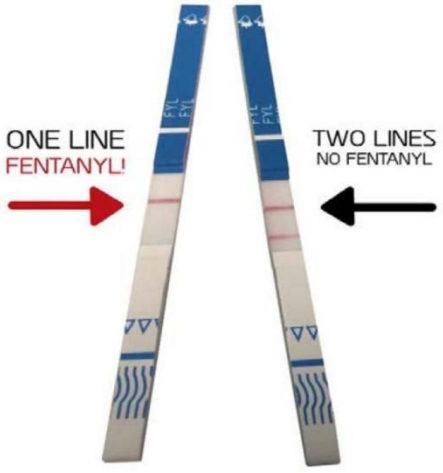
DAODAS covers the cost of educational materials delivered to the community distributors that must be provided to each patient, caregiver, and community member who receives fentanyl test strips. The community distributors request reimbursement from DAODAS monthly for related costs of the fentanyl test strips. The fentanyl test strips may be distributed separately or along with Narcan®.

The community distributors are allowed to purchase from other manufacturers of fentanyl test strips, but DAODAS recommends community distributors purchase test strips from BTNX, Inc.©, a Canadian biotechnology company specializing in drug testing research and development. The majority of fentanyl test strips on the market are manufactured by BTNX, Inc.©, whose test strips can detect at least ten fentanyl analogs (imitations), including carfentanil. DAODAS informed the community distributors that BTNX, Inc.© offers a 25% discount and free shipping for a minimum order of 1 box of 100 test strips. Fentanyl test strips can be purchased for as little as 70¢ each.

The recommended method to test for the presence of fentanyl is to dissolve all of the substances intended to be consumed in water. Once the substances are fully dissolved, the end of the test strip is dipped into the liquid solution for approximately 15 seconds. The strip should be placed on a flat surface for two minutes to complete the test and interpret the results. After testing is complete, the liquid solution may be consumed by drinking it if deemed to be safe.

Chart 2.5 shows how to interpret the results of fentanyl test strips. DAODAS emphasizes that fentanyl test strips are used as a harm reduction tool, but a negative result does not conclusively prove that a sample is free from fentanyl and is safe to use.

Chart 2.5: Results of Fentanyl Test Strips



One red line on top is a POSITIVE result for the presence of fentanyl or one of its analogs.

Two red lines is a NEGATIVE result.

No red lines (or a red line at the bottom) means the test is invalid.

Source: DAODAS

Opioid Litigation Settlement

South Carolina is poised to receive $300 million over the next 18 years to address the opioid epidemic. In late February 2022, a $26 billion opioid settlement was reached for litigation against the "Big Three" pharmaceutical distributors—AmerisourceBergen©, CardinalHealth™, and McKesson©. Johnson & Johnson© was also a defendant in the litigation. The settlement is the result of three years of negotiations and is the second-largest multi-state agreement in the nation's history after the tobacco master settlement agreement.

According to a press release by the S.C. Attorney General, South Carolina is set to receive more than $300 million from the settlement over the next 18 years. Ninety-two percent of the funds will be used to directly address the opioid epidemic in ways such as supporting treatment, recovery, harm reduction, and other strategies. The remaining 8% will be used to pay attorneys' fees. Receipt of the funds by the state is expected to begin in the second quarter of 2022.

In May 2022, the Governor signed Act No. 222, which established the S.C. Opioid Recovery Fund and the S.C. Opioid Recovery Fund Board. The board will be comprised of nine members who will be appointed. All Opioid Recovery Fund Board members are required to be academic, medical, licensed health or other professionals with significant experience in opioid prevention, treatment, or intervention. In accordance with S.C. Code §11-58-70(B), the board shall be appointed as follows:

(1) the Governor shall appoint one member, who shall serve as chairperson;
(2) the President of the Senate shall appoint one member;
(3) the Speaker of the House of Representatives shall appoint one member;
(4) the Governor shall appoint three members, the Speaker one member, and the President of the Senate one member from a list provided by the South Carolina Association of Counties, with at least one member selected from each of the South Carolina public health regions as defined by the South Carolina Department of Health and Environmental Control; and
(5) the Governor shall appoint one member from a list provided by the Municipal Association of South Carolina.

The *South Carolina's Guide to Approved Uses for Investing Opioid Settlement Funds* was issued in June 2022 and was a collaboration between DAODAS and the South Carolina Institute of Public Health, who convened a group of subject matter experts to assist in explaining the most effective abatement strategies. The board is required to meet at least four times per year and is to be staffed by a member of the S.C. Office of the Attorney General for necessary legal services. The board will oversee funds for counties and eligible municipalities, which must submit requests seeking funds for an approved abatement strategy listed in the settlement agreement. All settlement funds must be used for one or more of the approved remediation uses. All money allocated to counties and eligible municipalities that has not been used for three years will be moved to the Discretionary Subfund. It would be prudent for members of the appointed board to consider the areas of greatest need, as described in the following section, when distributing settlement funds.

Economic and Social Burden of the Opioid Epidemic

A study of 2017 data by the Centers for Disease Control and Prevention (CDC) estimated the economic burden of the opioid epidemic in the United States to be $1 trillion, including $471 billion for the estimated costs of opioid use disorder. Cost components of opioid use disorder and fatal opioid overdose included the costs of healthcare, substance use treatment, criminal justice, lost productivity, reduced quality of life, and the value of statistical life lost. Chart 2.6 lists the CDC's estimates of these components per case.

Chart 2.6: Cost Components of the Opioid Epidemic Per Case, CY 2017

Component	Opioid Use Disorder Cost	Fatal Opioid Overdose Cost
Healthcare	$14,705	$5,462
Substance use treatment	$1,660	N/A
Criminal justice	$6,961	N/A
Lost productivity	$14,707	$1.443M
Reduced quality of life	$183,186	N/A
Value of statistical life lost	N/A	$10.1M

N/A = Not Applicable

Source: CDC

Chart 2.7 shows the estimated costs to South Carolina and other Southeastern states of the opioid epidemic, according to the CDC analyses of 2017 data. Because the most current data released by the CDC in November 2021 estimated overdose deaths in the United States to be over 100,000 annually, with 75,673 of the deaths attributable to opioids, it is clear the economic impact would have increased since the 2017 study.

Chart 2.7: Estimated Costs of the Opioid Epidemic to Southeastern States, CY 2017

		MS	SC	GA	TN	NC	FL
Case Count	OUD* (Estimated)	20,000	37,000	41,000	44,000	76,000	140,000
	FOO**	185	749	1,014	1,269	1,953	3,245
Cost (In Millions)	OUD*	$4,424.4	$8,185.1	$9,070.0	$9,733.6	$16,812.6	$30,970.6
	FOO**	2,136.4	8,649.5	11,709.8	14,654.6	22,553.5	37,473.7
	TOTAL	**$6,560.8**	**$16,834.6**	**$20,779.8**	**$24,388.2**	**$39,366.1**	**$68,444.3**
Per Capita Cost	OUD*	$1,483	$1,629	$870	$1,449	$1,637	$1,476
	FOO**	716	1,722	1,123	2,182	2,195	1,786
	TOTAL	**$2,199**	**$3,351**	**$1,992**	**$3,631**	**$3,832**	**$3,262**

* OUD = Opioid Use Disorder
** FOO = Fatal Opioid Overdose

Source: CDC

A separate independent study on the disparities in years of potential life lost due to drug-involved overdose deaths in South Carolina from 2014 to 2018 found opioid-involved overdoses accounted for a critical cause of mortality in the state. The deaths demonstrated a significant impact on the years of potential life lost and showed disparities in gender, race, and rural/urban settings. The study found the years of potential life lost in the state was 124,451, with synthetic opioids increasingly impacting the number.

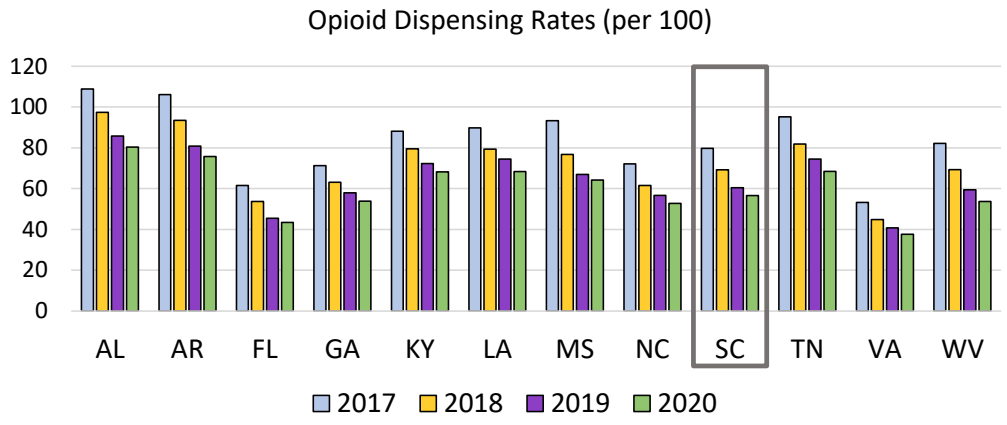
The largest change in years of potential life lost was in Black males with synthetic opioid-involved deaths that had an increase of 2,234%. Despite rural counties containing only 34% of the state's population, rural counties comprised 44–48% of the study's population adjusted for years of potential life lost. The study indicates disparities are a vital component to be considered to address the opioid epidemic.

The results show analyzing data for the cost components of opioid use disorder and fatal opioid overdoses, as well as considering the demographics of race and gender, would be helpful in determining areas of need. However, DAODAS does not consider overdose death data in its funding formula (see *DAODAS' Funding Formulas Fail to Consider Most Current Drug Overdose Mortality Data*).

Prescription Opioid Dispensing Rates in Southeastern States

We found the prescription opioid dispensing rates for South Carolina and other Southeastern states declined each year from 2017 through 2020, as shown in Chart 2.8. The CDC plans to release an updated version of its guidelines for prescribing opioids in late 2022.

Chart 2.8: Opioid Dispensing Rates in Southeastern States, CY 2017 – CY 2020



Source: LAC Analysis of Data from the CDC

Recommendations

1. The S.C. Department of Health and Environmental Control should take steps to ensure all first responders across the state have been trained to administer naloxone.

2. The S.C. Department of Alcohol and Other Drug Abuse Services should include information about the toxicity of fentanyl and the availability of fentanyl test strips on the home page of its website.

3. The S.C. Department of Alcohol and Other Drug Abuse Services should encourage the S.C. Opioid Recovery Fund Board to direct the use of settlement funds from the opioid litigation to the areas of greatest need based on opioid overdose deaths, including demographically, by race and gender, to combat the opioid epidemic.

Mortality Data

We reviewed mortality data released by the S.C. Department of Health and Environmental Control (DHEC) on JUSTPLAINKILLERS.COM, an initiative of DAODAS, and found:

- Data points for two drug categories, Prescriptions and Total Drug Overdoses for the state, had inconsistencies in the rate per 100,000 people.
- Inconsistencies remain in the rate per 100,000 people after DHEC made revisions as a result of our inquiry.
- From 2019 to 2020, the number of deaths involving fentanyl increased 105%, the largest increase of any drug category in the mortality report.
- Horry County and Charleston County had the highest number of deaths in all drug categories of overdose deaths reported in 2020.
- Jasper County had the highest death rate per 100,000 people in five of seven drug categories reported for 2020 and had significantly higher rates in those categories than the next highest-ranked county.

Data Inconsistencies

During our review and analyses of mortality data released by DHEC, we found inconsistencies in the rates per 100,000 people in two drug categories for the state totals—Prescriptions and Total Drug Overdoses. We did not find inconsistencies in the county data.

We contacted DHEC and an agency official agreed there were inconsistencies in the data. As a result, DHEC released revised mortality data in late February 2022. However, DHEC did not include notice of the revision with the data description or on the website. Without notification of the release of revised data, users of the original data may not be aware that revisions were made and could be relying upon inaccurate data. According to DHEC, it does not have the ability to upload the data to the JUSTPLAINKILLERS.COM website—only DAODAS and its contractor have authority to post data to the website.

Our review of the revised mortality data shows inconsistencies remain in the data for the rates per 100,000 people for the state totals. Chart 2.9 shows the original mortality data and the related revised data. The highlighted areas in the data indicate areas we found to be inconsistencies for 2014 through 2018. The numbers of deaths in the categories of Prescriptions and Total Drug Overdoses were different yet the rates per 100,000 were the same.

The only revisions DHEC made to data for 2015 through 2017 were the rounding of the rates per 100,000, whereas the original data rates were not rounded. For example, the number of deaths in 2017 involving Prescription Drugs was 782 with a rate of 15.95 originally but revised to 16.00; for Total Drug Overdoses, the number of deaths was 1,001 with a rate of 15.95 originally but revised to 16.00.

IN ORDER TO CALCULATE THE RATE OF DEATH PER 100,000, THE STEPS INCLUDE:

- Divide the number of deaths by the total population.
- Then multiply the result by 100,000.

Because the number of deaths were different in the two categories, when divided by the population of the state at that time (which would have been the same for both categories), the resulting rates should also be different. Although DHEC made revisions to the mortality data based on our inquiry, inconsistencies in the data remain.

DHEC corrected the error in the rate for 2018 but also changed the method for rounding the result. As shown in Chart 2.9, DHEC did not include 2014 data in the revised data. DHEC made no revisions to the 2019 data, nor did we find inconsistencies that should have been revised. However, DHEC failed to correct the inconsistencies for 2015 through 2017 in its revised data.

Chart 2.9: Comparison of Original Mortality Data and Revised Mortality Data, CY 2015 – CY 2019

Original Data — October 2, 2020												
	2014		2015		2016		2017		2018		2019	
Drug Category	Number of Deaths	Adjusted Rate per 100,000	Number of Deaths	Adjusted Rate per 100,000	Number of Deaths	Adjusted Rate per 100,000	Number of Deaths	Adjusted Rate per 100,000	Number of Deaths	Adjusted Rate per 100,000	Number of Deaths	Adjusted Rate per 100,000
Cocaine	88	2.00	117	2.43	139	2.93	235	4.75	254	5.10	230	4.64
Fentanyl	68	1.46	130	0.00	190	4.13	362	7.62	460	9.80	537	11.18
Heroin	57	1.28	95	2.03	108	2.18	144	3.06	168	3.43	196	4.06
Opioids	508	10.51	565	11.59	616	12.86	748	15.49	816	16.72	876	17.83
Prescriptions	572	11.65	641	13.09	684	14.00	782	15.95	863	17.39	923	18.56
Total Drug Overdoses	718	11.65	789	13.09	876	14.00	1,001	15.95	1,103	17.39	1,131	22.72
Revised Data — February 28, 2022												
Prescriptions	2014 data was not included in the revised mortality data release.		641	13.00	684	14.00	782	16.00	863	17.00	923	18.56
Total Drug Overdoses			789	13.00	876	14.00	1,001	16.00	1,103	22.00	1,131	22.72

Indicates areas LAC found to have inconsistencies.

Represents a correction made by DHEC.

NOTE: Because drug overdose deaths may involve more than one drug, a single death may be included in more than one category.

Sources: LAC Analysis of Data from JUSTPLAINKILLERS.COM; DHEC, Vital Statistics

DHEC's Response to Mortality Data Revisions

We followed up with DHEC regarding data inconsistencies in the revised data. The revised data shows DHEC rounded the rates for 2015 through 2018 to a whole number but carried it out to the hundredths for 2019 and 2020. A DHEC official stated the raw numbers of overdose deaths were correct, but the related rates had been updated and revised, including changing the rounding rule to ensure consistency across years of data. The DHEC official stated the agency also made changes to processes and responsibilities for future data releases. However, DHEC did not address the fact that inconsistencies may remain in the revised data.

Regarding the revised 2014 data not being released, the DHEC official stated the agency made the decision to release six years of data. Because the February 2022 data release included newly available 2020 data along with the revised mortality data for prior years, DHEC's six-year period extended only to 2015. DHEC stated the release of 2020 mortality data had been delayed pending required review and approval from the Centers for Disease Control and Prevention.

Drug Overdose Deaths in South Carolina

The most recent mortality data shows the number of deaths involving fentanyl increased from 537 in 2019 to 1,100 in 2020—an increase of 105%, the largest increase by raw number and by percentage of the categories reported by DHEC. Drug overdose deaths are identified by reviewing death certificates registered with DHEC's Vital Statistics and represent deaths that occurred in the state, regardless of the residency status of the decedents. The categories reported include drug overdose deaths involving:

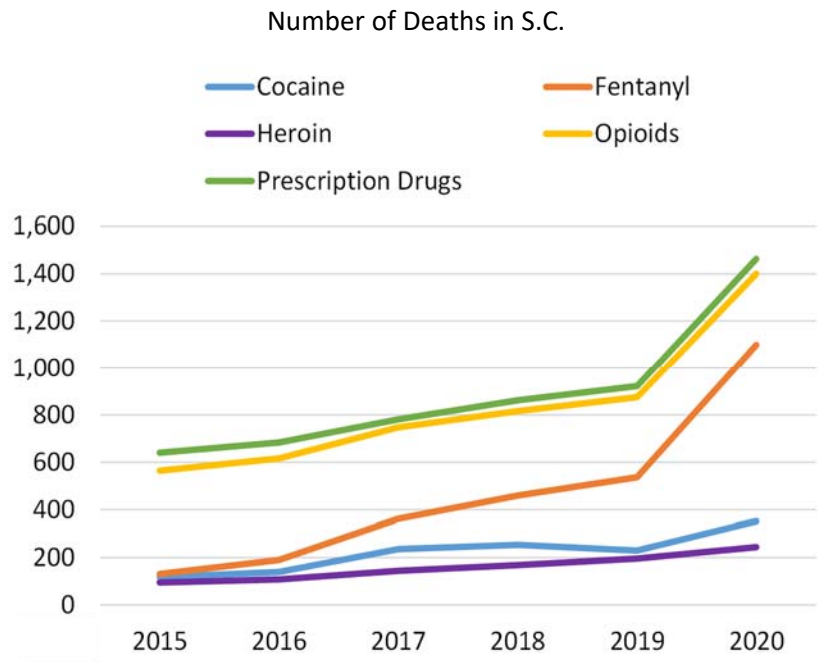
- Cocaine
- Fentanyl
- Heroin
- Opioids (legal and illegal)
- Prescription drugs (opioid and non-opioid)
- Psychostimulants (implemented with 2020 data)
- Total drug overdoses (any drug resulting in an overdose death)

Because drug overdose deaths may involve more than one drug, a single death may be included in more than one category. For example, if an overdose death involved heroin and fentanyl, the death would be recorded in the following categories of involvement:

- Heroin
- Fentanyl
- Opioids
- Prescription drugs

Chart 2.10 shows overdose data from 2015 through 2020 for the drug categories reported by DHEC, excluding psychostimulants which were first reported with 2020 data. Total drug overdoses were excluded from the chart for clarity.

Chart 2.10: Mortality Totals by Number of Deaths in South Carolina, CY 2015 – CY 2020



NOTES: Deaths involving psychostimulants were first reported in CY 2020 and were excluded.
Deaths involving opioids include both legal and illegal opioids.
Deaths involving prescription drugs include both opioid and non-opioid prescription drugs.

Source: LAC Analysis of Data from DHEC, Vital Statistics

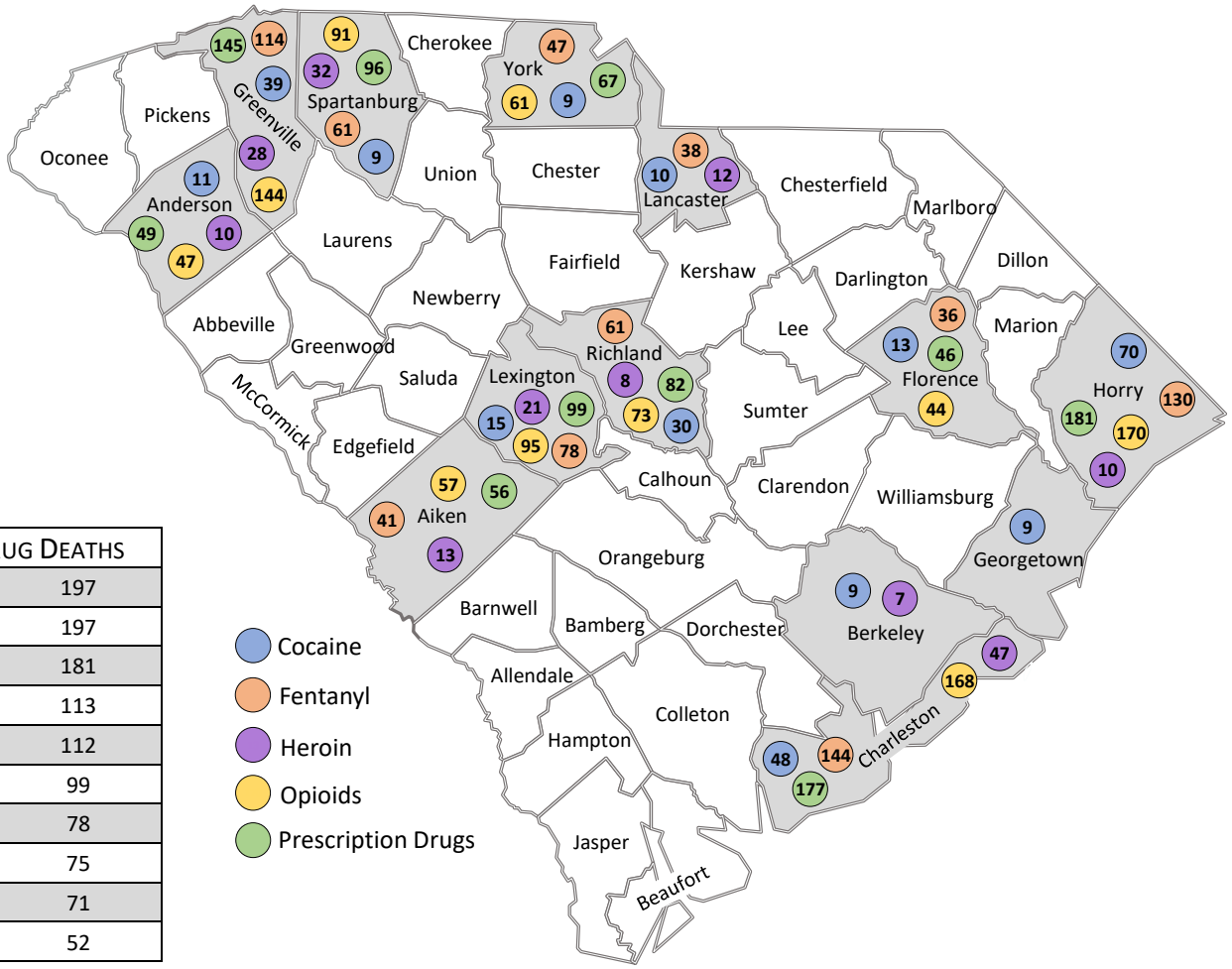
Number of Drug Overdose Deaths by County

DHEC's mortality data identifies the county in which a drug overdose death occurred. We reviewed the data, by county, for 2017 through 2020 by the number of overdose deaths in each drug category. The number of drug overdose deaths involving fentanyl increased 105% from 2019 to 2020, the largest increase of any drug category in the mortality report.

Chart 2.11 shows the ten highest-ranked counties by the number of overdose deaths and in each drug category for 2020. In all drug categories reported, Horry County or Charleston County ranked at the top (see Appendix F for more data).

Chart 2.11: CY 2020 Ten Highest-Ranked Counties by Total Number of Drug Overdose Deaths

DEATHS BY DRUG TYPE



OVERALL DRUG DEATHS	
Charleston	197
Horry	197
Greenville	181
Spartanburg	113
Lexington	112
Richland	99
York	78
Anderson	75
Aiken	71
Florence	52

NOTE: More than ten counties appear on the map where deaths by drug category were tied.
Because drug overdose deaths may involve more than one drug, a single death may be included in more than one category.

Appendix F contains more data of overdose deaths CY 2017 – CY 2020.

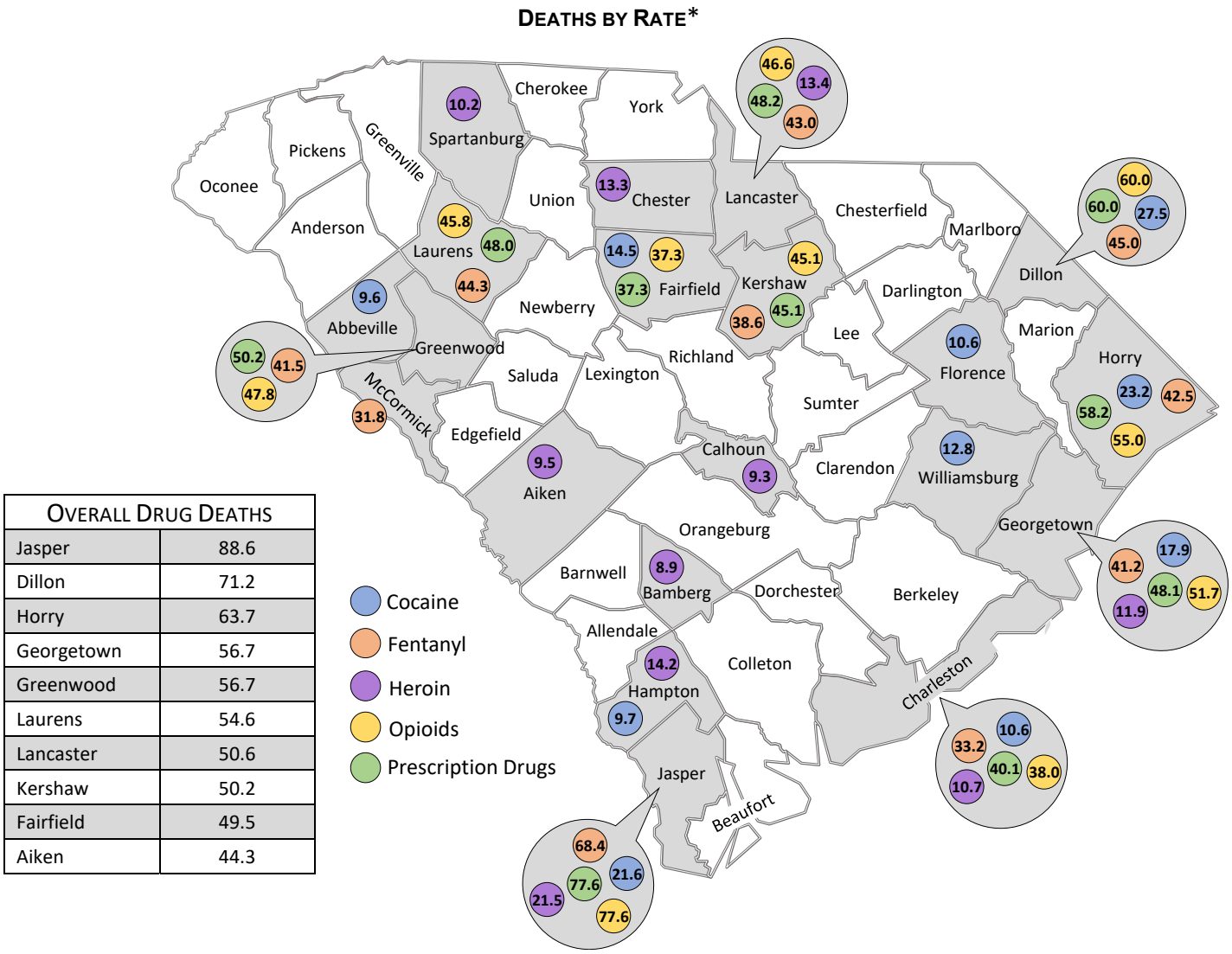
Source: LAC Analysis of Data from DHEC, Vital Statistics

Rate of Drug Overdose Deaths by County

Although we found inconsistencies with the rate per 100,000 people in the data for the state, we did not find inconsistencies at the county level. DHEC made changes to the rounding method for 2015 through 2018 for the rates per 100,000 people in the 2022 revised data release. When comparing data, the rate per 100,000 people allows the user to look at how a particular county measures against another county because the county populations differ. Using a standard population size of 100,000 is a statistical tradition used for comparison that does not change the underlying population.

Chart 2.12 shows the highest-ranked counties by the rate per 100,000 people of overdose deaths in each drug category for 2020. Jasper County had the highest death rate in five of seven categories reported for 2020. In each of those instances, the rate was significantly higher than the next highest-ranked county. For example, the total deaths from drug overdose, by rate, for Jasper County in 2020 was 88.62 whereas the next highest rate was Dillon County with 71.22. The chart lists only five of the seven categories.

Chart 2.12: CY 2020 Ten Highest-Ranked Counties by Rate* of Drug Overdose Deaths



OVERALL DRUG DEATHS	
Jasper	88.6
Dillon	71.2
Horry	63.7
Georgetown	56.7
Greenwood	56.7
Laurens	54.6
Lancaster	50.6
Kershaw	50.2
Fairfield	49.5
Aiken	44.3

NOTE: More than ten counties appear on the map where rates* were tied.
Because drug overdose deaths may involve more than one drug, a single death may be included in more than one category.

*Per 100,000 people.

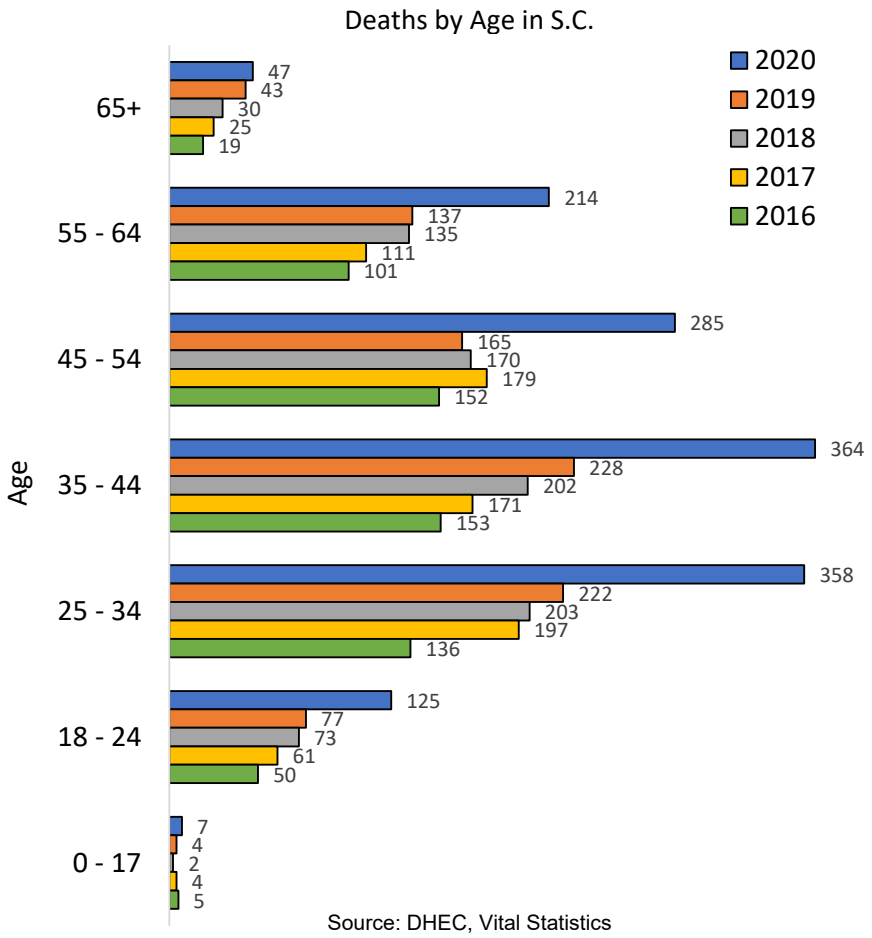
Appendix F contains more data of overdose deaths CY 2017 – CY 2020.

Source: LAC Analysis of Data from DHEC, Vital Statistics

Mortality Data Demographics

In DHEC's *Drug Overdose Deaths 2020* report, the agency analyzed data by demographics, including age, race, sex, and education. As shown in Chart 2.13, opioid-involved overdose deaths increased in 2020 for each age group. Additionally, the data shows the occurrences of deaths in 2020 by select drug categories were predominantly among white males—opioids (55%), cocaine (44%), and psychostimulants with abuse potential (56%). Finally, the data shows the most impacted group by education level was consistently a high school graduate—opioids (45%), cocaine (47%), and psychostimulants with abuse potential (48%). DHEC's analysis of the demographics indicates areas for efforts to be targeted by DAODAS, local alcohol and drug abuse authorities, other stakeholders, and the General Assembly. However, a DAODAS official stated the agency does not track race and gender to determine whether its subgrantees are tailoring programs for certain populations.

Chart 2.13: Opioid-Involved Deaths by Age, CY 2016 – CY 2020



Recommendations

4. The S.C. Department of Health and Environmental Control should review the rates per 100,000 for mortality data for 2015 through 2017 and revise the data if necessary.

5. The S.C. Department of Alcohol and Other Drug Abuse Services should provide notification on the website, JUSTPLAINKILLERS.COM, and within the document when it re-releases revised public data from the S.C. Department of Health and Environmental Control.

6. The S.C. Department of Alcohol and Other Drug Abuse Services should analyze mortality data and ensure efforts by the local alcohol and drug abuse authorities and the opioid treatment programs are targeted to the needs of populations that could be underserved yet have the highest mortality rates.

Funding for Opioid-Related Services

We reviewed DAODAS' funding for opioid-related services and found that DAODAS:

- Relies mostly on federal grants to fund prevention and treatment services.
- Allocates funding to local alcohol and drug abuse authorities without regard to need based on impacts from drug overdose deaths.
- Has forgone an opportunity to apply for all federal grants for which the state has needs.
- Used a distributed management system for overseeing more than $100 million in federal grants.

As a result, the state could have received more federal grant funding to be used to address the opioid epidemic.

DAODAS Must Rely on Infusion of Federal Dollars to Fund State Opioid Programs

We reviewed DAODAS' expenditures for opioid-related programs over a five-year period from FY 16-17 through FY 20-21 and found that 75% came from federal grants. Chart 2.14 shows DAODAS' annual expenditures for opioid-related services and the funding sources.

Chart 2.14: Opioid-Related Expenditures, FY 16-17 – FY 20-21

Fiscal Year	Expenditures		TOTAL
	State Funds	Federal Funds	
16-17	$1,794,245	$690,374	$2,484,619
17-18	$1,729,063	$3,606,287	$5,335,350
18-19	$3,038,259	$11,142,959	$14,181,218
19-20	$3,833,775	$14,029,179	$17,862,954
20-21	$4,315,996	$15,485,786	$19,801,782

Source: DAODAS

During this five-year period, DAODAS relied mostly on federal funding through three federal grants—Substance Abuse Prevention and Treatment Block Grant (block grant) and two federal opioid response grants, as shown in Chart 2.15. In FY 20-21, through the American Rescue Plan, DAODAS was awarded supplemental block grant funding of $19,199,380 for a four-year period which began in September 2021. The purpose of the funding is to increase community-level support for Americans dealing with emotional and mental challenges during the COVID-19 pandemic.

Chart 2.15: Federal Grants, FY 16-17 – FY 20-21

Grant	Purpose	Amount
Substance Abuse Prevention and Treatment Block Grant*	To plan, implement, and evaluate activities that prevent and treat substance abuse and promote public health, including program evaluation strategies aimed at evaluating effectiveness. Block grant funds can be used to supplement Medicaid, Medicare, and private insurance services.	$78,066,723
State Opioid Response Grant	To provide treatment services with methadone, buprenorphine, and injectable naltrexone—three drugs approved by the Food and Drug Administration for maintenance treatment of opioid use disorder—but cannot be used to fund treatment with marijuana. Starting in FFY 2021, stimulants were included in the covered services.	$35,949,405
State Opioid Response Grant 2.0*		$35,878,964
Overdose Prevention Grant**	To provide Narcan® (naloxone) and related supplies to first responders through the LEON and ROLL programs.	$3,217,722
Empowering Communities for Healthy Outcomes***	To reduce prescription drug misuse/abuse by those aged 12 to 25 and to reduce impaired driving among the general population.	$8,240,940

* Funding continues until September 2022.
** DAODAS was awarded $4,265,381 for 8/2021 through 8/2026.
*** The grant ended in September 2020. An independent evaluation found the program did not result in changes in risk and protective factors associated with drug misuse and impaired driving.

Source: DAODAS and SAMHSA

DAODAS' Funding Formulas Fail to Consider Most Current Drug Overdose Mortality Data

We reviewed DAODAS' formulas for allocating federal block grant funds to the state's 32 local alcohol and drug abuse authorities and found that both its prevention funding formula and its treatment funding formula consider population size but do not use the most current drug overdose mortality data. Basing the funding formulas for distribution of block grant funds on population size does not consider how a particular area has been impacted by deaths from drug overdoses. Because the block grant is the largest source of federal funds for DAODAS, consideration of how deaths from opioids have impacted an area should be a priority in allocating funding to local alcohol and drug abuse authorities.

The block grant requires set-asides of 5% of the funding for administrative costs, 20% for prevention services, 5% for HIV services for designated states, and a minimum of $2.4 million for women's services (based on the state's past expenditures). The remainder of the funding is allocated to treatment services. According to DAODAS officials, the agency uses block grant funding on alcohol and tobacco programs, because it receives other funding for opioid response, such as the State Opioid Response grant.

Prevention Funding Formula

DAODAS uses a standard formula for distribution of the prevention block grant funds that was first implemented in FY 13-14 to 32 local alcohol and drug abuse authorities. DAODAS updated the funding formula to include a population-adjusted figure for FY 19-20, which is expected to be phased in and fully implemented by FY 22-23. Effective July 2021, DAODAS did not renew its contract with Williamsburg County Behavioral Health following a series of steps to correct operating deficiencies. This decision resulted in a reduction in the number of local alcohol and drug abuse authorities from 32 to 31. Williamsburg County residents were directed to other providers. On April 19, 2022, Williamsburg County entered into a formal agreement with Circle Park Behavioral Health in Florence, the current Florence County provider, to provide alcohol and other drug abuse services to Williamsburg County residents.

The amount of funding to be given "off the top" to the alcohol enforcement teams did not change from the previous formula—it remained $35,000, $40,000, or $50,000, based on population of the judicial circuit. Additional funds are awarded based on a range for the population of the county. Chart 2.16 shows the differences in the original and updated prevention funding formulas. However, need based on overdose deaths is not included in the prevention funding formula.

Chart 2.16: Prevention Funding Formula for Block Grant Subgrantees

Description	Original FY 13-14	Updated FY 19-20
Base Per County Authority	$40,000	$60,000
Additional Amount for County Authorities Serving More Than One County	$10,000 per each additional county	$15,000 per each additional county
Range for Population Adjustments*	$4,856 –$158,039	$6,300–$209,700

* After the base allocation, the remainder of the prevention funds are allocated according to county population size.

Source: DAODAS

Treatment Funding Formula

DAODAS' treatment funding formula allocates the remainder of the block grant funds after the prevention set asides have been allocated. However, the treatment funding formula does not consider overdose death data, as shown in Chart 2.17.

Chart 2.17: Treatment Funding Formula for Block Grant Subgrantees

DESCRIPTION	AMOUNT
Base Per County Authority	$100,000
Additional Amount for County Authorities Serving More Than One County	$15,000
County Authorities Serving Counties with Rural Designation	$30,000
Additional Amount for County Authorities Serving More Than One Rural County	$15,000 per each additional county

NOTE: After the base allocation, the remainder of treatment funds are split in half—50% allocated based on population and 50% allocated based on a performance measure.

Source: DAODAS

Process for Grant Selection

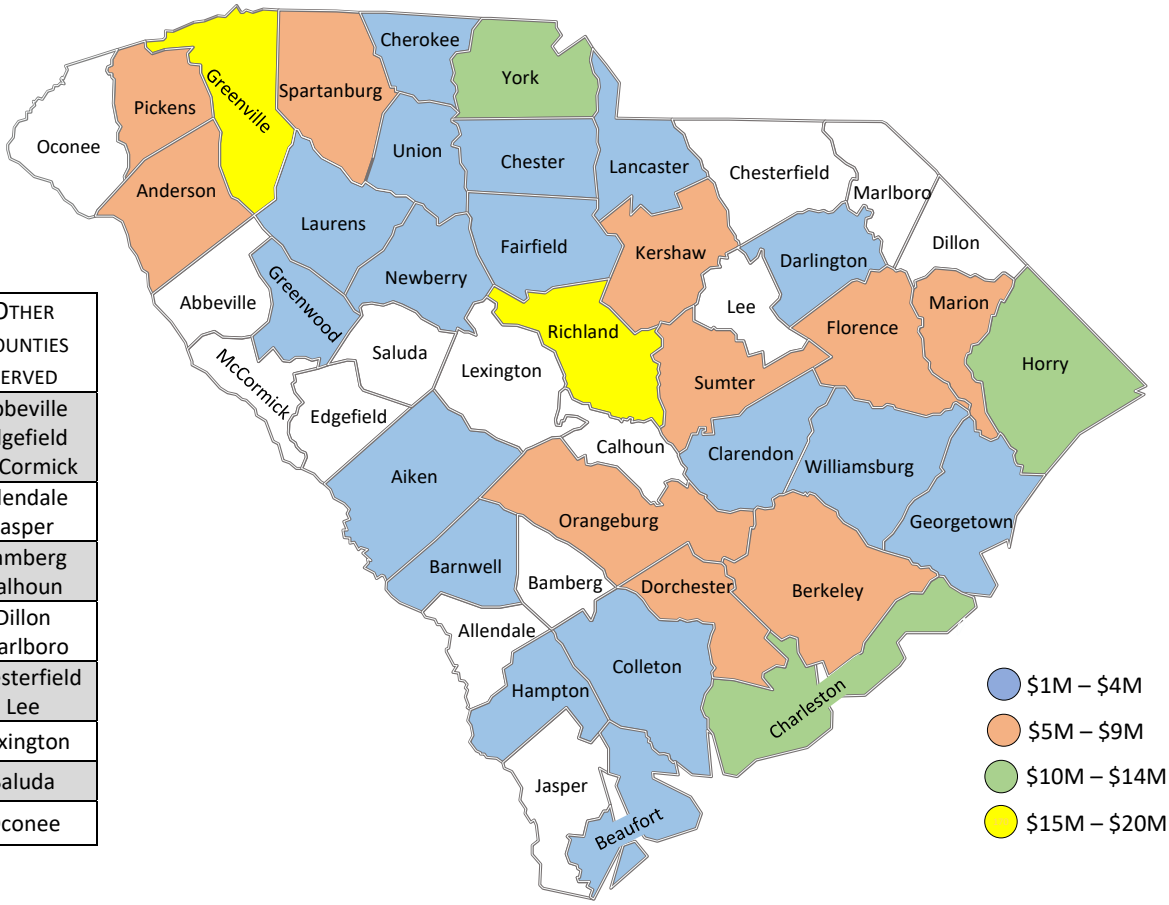
DAODAS' program management staff reviews funding announcements from the Substance Abuse and Mental Health Services Administration (SAMHSA), a division of the U.S. Department of Health and Human Services, and other federal agencies and seeks guidance from DAODAS' executive management. Together, they determine if the agency should apply for a particular grant. A DAODAS official stated the review process includes an internal assessment of:

- The consistency with agency mission, values, and goals.
- Why the funding should be pursued.
- Matching requirements.
- The project's impact on the current staff.
- Whether funding is available to increase capacity at the state and/or local level.
- Cost restrictions.
- The potential for strengthening the state and local prevention and treatment system.
- The potential benefits.

Funding of County Alcohol and Other Drug Abuse Authorities

Chart 2.18 shows the total amount of funds each local alcohol and drug abuse authority received from DAODAS for FY 16-17 through FY 20-21. By comparison, Chart 2.19 shows the ten highest-ranked counties for drug overdose deaths involving opioids in 2019 by number and the rate per 100,000 of the population. Data from 2019 was used for comparison because it would have been the most recent data available to DAODAS to have potentially included in its funding formula due to the delayed release of the 2020 data, which had been awaiting approval from the Centers for Disease Control and Prevention. As the charts indicate, some counties that could be considered rural, such as Lancaster and Jasper Counties, had high overdose death rates yet received the lowest funding amounts from DAODAS.

Chart 2.18: Amount of Funds from DAODAS to Local Authorities, FY 16-17 – FY 20-21*

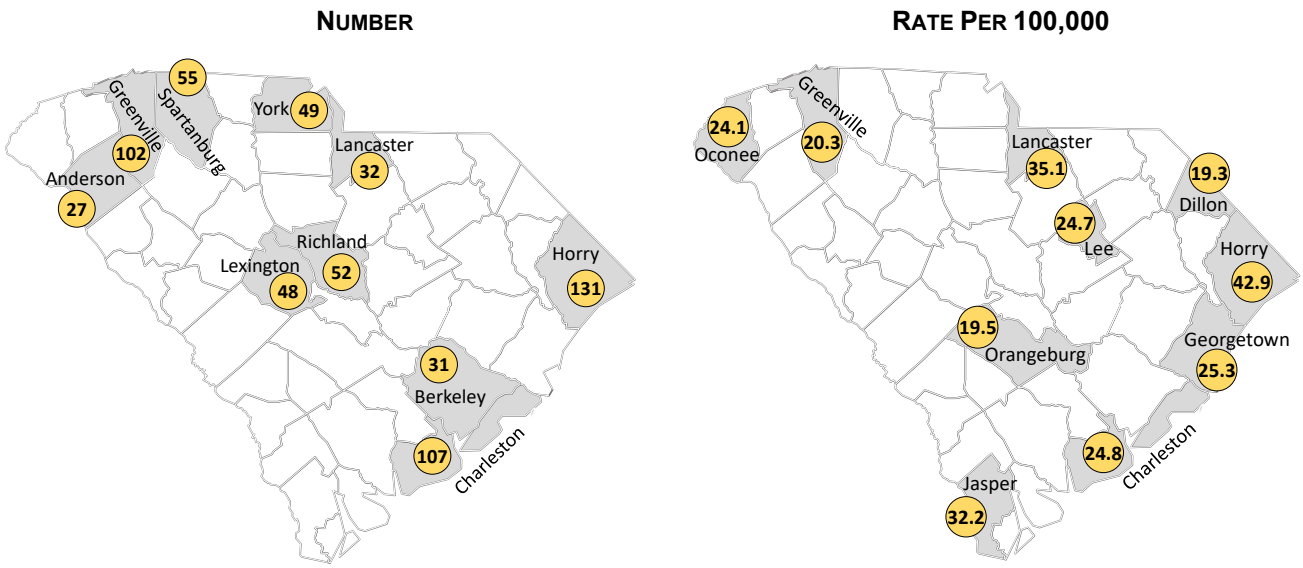


Main Location	Other Counties Served
Greenwood	Abbeville Edgefield McCormick
Hampton	Allendale Jasper
Orangeburg	Bamberg Calhoun
Marion	Dillon Marlboro
Kershaw	Chesterfield Lee
Richland	Lexington
Newberry	Saluda
Anderson	Oconee

* Areas with no color indicate counties where local alcohol and drug abuse authorities serve multiple counties (see table). The local authorities' main locations were used for LAC's analysis.

Source: LAC's Analysis of Data from DAODAS

Chart 2.19: Drug Overdose Deaths Involving Opioids in CY 2019



Source: LAC Analysis of Data from JUSTPLAINKILLERS.COM; DHEC, Vital Statistics

Harm Reduction Grant

DAODAS did not apply for the Harm Reduction Grant, which was a missed opportunity to receive additional federal grant funding. In December 2021, SAMHSA announced its new Harm Reduction Grant program with the intent to issue $30 million in awards. SAMHSA planned for 25 awards of up to $400,000 per award each year for up to 3 years. Applications could be submitted by state, local, tribal, and territorial governments and by tribal, non-profit community-based, and primary and behavioral health organizations. The grant application deadline was February 7, 2022. The funding would allow organizations to expand their community-based overdose prevention programs by:

- Distributing overdose-reversal medications and fentanyl test strips.
- Providing overdose education and counseling.
- Managing or expanding syringe service programs to help control the spread of infectious diseases like HIV and hepatitis C.

An agency official stated DAODAS provided letters of support for some of its local alcohol and drug abuse authorities who applied for the grant. The support letters stated, among other things, DAODAS would continue to supply naloxone and fentanyl test strips and educational materials to the local alcohol and drug abuse authorities, contingent upon funding availability. However, subgrantees are not required to inform DAODAS of other grants received. Because the state continues to be impacted by the opioid epidemic, applying for all grant funding aimed at combatting substance use should be a priority for DAODAS. Since DAODAS did not apply for the Harm Reduction Grant, it was a missed opportunity to have received more federal grant funding.

Grants Management

DAODAS has used a manual grants management system based within its finance and operations division. Through the publication of a request for proposal published in July 2020, DAODAS purchased a grants management system, GrantVantage®. DAODAS did not seek the assistance of a consultant to advise which product would be most beneficial. The planned rollout period was March to mid-June 2022. However, DAODAS stated the final phase of the rollout has been delayed until early July 2022 due to revisions in internal control processes and SAMHSA requirements. Currently, federal funds are being used to finance the new grants management system, which will cost approximately $1.2 million over seven years. An official stated DAODAS may consider using state funds if federal resources become limited.

DAODAS does not have a grants administrator or similar job position. The grants administrator would coordinate grants management functions and activities, including providing grant oversight and identifying grant funding opportunities. In South Carolina state government, the average salary for a Grants Administrator I is $58,701. Currently, DAODAS' program staff writes the grant applications, reviews the monthly reimbursement requests from subgrantees, and monitors the programs. During our interviews with local alcohol and drug abuse authorities, several agencies mentioned communication issues when contacting DAODAS for assistance and felt DAODAS was understaffed. We are unable to verify that DAODAS is understaffed. However, elsewhere in this report, we discuss the fact that DAODAS has fewer staff than it had approximately 20 years ago, the need for a staffing analysis, and that improvements can be made in program monitoring and in pursuit of additional grant funding (see *Staffing* and *Monitoring Process and Effectiveness for Opioid Services*).

If a staffing analysis completed by human resource professionals from outside the agency determined the agency could benefit from having a grants administrator, and if DAODAS implemented such a recommendation, current program staff might have more time to respond to the local alcohol and drug abuse authorities and to devote even more time to their other responsibilities.

Recommendations

7. The S.C. Department of Alcohol and Other Drug Abuse Services should revise the block grant funding formula to incorporate the state's most current substance use and drug overdose data to direct funds to the highest-ranked counties based on number and rate of opioid overdoses.

8. The S.C. Department of Alcohol and Other Drug Abuse Services should submit grant applications for all federal grants aimed towards addressing the opioid epidemic.

9. The S.C. Department of Alcohol and Other Drug Abuse Services should consider hiring a grants administrator after a staffing analysis has been completed by external qualified human resource analysts, if the analysis results in a finding that the agency could benefit from such a position.

Review of Opioid Treatment Programs

We reviewed DAODAS' monitoring of opioid treatment programs (OTPs) and conducted interviews with OTP officials. We found:

- As of April 2022, DAODAS has not conducted any site visits in more than two years since the start of the COVID-19 pandemic, nor has it conducted the required amount of clinical quality assurance reviews.
- DAODAS does not track which OTPs treat co-occurring mental health disorders or certain demographic information of the patients they serve.
- OTPs in the state do not offer naltrexone, a medication required under the State Opioid Response (SOR) grant.
- Patients seeking medication-assisted treatment from OTPs may have accessibility issues.
- DAODAS' website does not show each OTP location.

Overview

OTPs operate accredited medication-assisted treatment programs with SAMHSA certification and U.S. Drug Enforcement Administration registration. Medication-assisted treatment programs utilize U.S. Food and Drug Administration approved medications and evidence-based psychosocial services, which serves as the standard of care for opioid use disorder. DAODAS uses SOR grant funding awarded by SAMHSA to reimburse OTPs for prevention, treatment, and recovery services for opioids and stimulants. OTPs receiving federal funding to administer medication-assisted treatment services under the SOR grant must offer methadone, buprenorphine, or naltrexone—three U.S. Food and Drug Administration approved medications used to treat opioid use disorder.

OTPs under contract with DAODAS must provide adequate medical, counseling, vocational, educational, mental health, and other treatment services provided to Medicaid patients onsite or by referral to other practitioners without discrimination. In July 2020, DAODAS began reimbursing OTPs through a bundled Medicaid reimbursement rate.

DAODAS' Monitoring of OTPs is Inadequate

Although not a requirement of the contract with the S.C. Department of Health and Human Services, DAODAS staff seeks to conduct clinical quality assurance reviews, either on-site or through desk reviews, on a minimum of ten files to monitor the effectiveness of OTPs' treatment services. We performed an analysis of DAODAS' clinical quality assurance reviews conducted between FY 16-17 to FY 20-21. We found that of the eight clinical quality assurance reviews completed during this timeframe, DAODAS never reviewed ten files for each OTP. DAODAS does not maintain a system to track OTPs' performance on clinical quality assurance reviews.

DAODAS stated that it did not conduct any on-site clinical quality assurance reviews in 2020 or 2021. According to a DAODAS official, depending on the state of the COVID-19 pandemic, it plans to resume in-person site visits in FY 22-23. Conversely, a different DAODAS official told us it plans to resume audits through desk reviews or in-person site visits in FY 22-23. Improved monitoring of OTPs through on-site clinical quality assurance reviews will ensure that South Carolinians with opioid use disorder receive adequate and effective medication-assisted treatment services.

Issues With Tracking Access to Mental Health Treatment Services and Demographic Information

DAODAS does not track which OTPs treat co-occurring mental health disorders and does not track patients by race or gender. OTPs must offer mental health treatment and other medication-assisted treatment services without discrimination to have access to funding from DAODAS. According to 2020 data from SAMHSA, only 18% of OTPs in South Carolina offer treatment for mental health disorders in addition to opioid use disorder, which is below the national average. DAODAS should utilize existing SAMHSA data and other pertinent resources to track which OTPs treat co-occurring mental health and substance use disorders. By doing this, DAODAS can inform consumers seeking mental health treatment in addition to medication-assisted treatment which OTPs treat co-occurring disorders.

In 2017, under the State Targeted Resource grant, now the SOR grant, DAODAS began a program with OTPs to target services to indigent pregnant and post-partum women. We found that DAODAS' documentation to monitor the program's success was incomplete. DAODAS is unable to effectively ensure that OTPs are offering adequate medication-assisted treatment services to vulnerable populations and underserved communities without tracking access to mental health treatment services. Additionally, DAODAS should improve its tracking of demographic information, specifically but not exclusively, race and gender.

Lack of Availability of Naltrexone

DAODAS informed us that none of the state's OTPs offer injectable extended-release naltrexone as they can only offer this medication if they possess the necessary DHEC licensure. In accordance with SOR grant requirements, DAODAS, recognized as the single state agency for substance abuse services in South Carolina by SAMHSA, must ensure naltrexone is accessible to patients to assist in comprehensive treatment of opioid use disorder.

We contacted DHEC to clarify whether there are any licensing requirements that regulate OTPs' ability to offer this medication. One DHEC official informed us that extended-release naltrexone is not a controlled substance under S.C. Code §44-53-10 *et seq*., the S.C. Controlled Substances Act. A different DHEC official informed us that the Standards for Licensing Facilities for Chemically Dependent or Addicted Persons set forth in S.C. Reg. 61-93 *et seq*. do not prevent an OTP from administering injectable extended-release naltrexone. Expanding the availability of naltrexone at OTPs can improve a patient's access to life-saving treatment for an opioid use disorder.

Accessibility of OTP Locations

We found that there are various areas across the state where those with an opioid use disorder do not have access to medication-assisted treatment services at an OTP. The 27 OTPs in South Carolina are located in the following cities:

Aiken	Fort Mill	Rock Hill
Anderson	Greenville	Seneca
Charleston	Greenwood	Simpsonville
Clinton	Hartsville	Spartanburg
Columbia	Lancaster	Sumter
Duncan	Myrtle Beach	West Columbia
Easley	North Charleston	
Florence	Ridgeland	

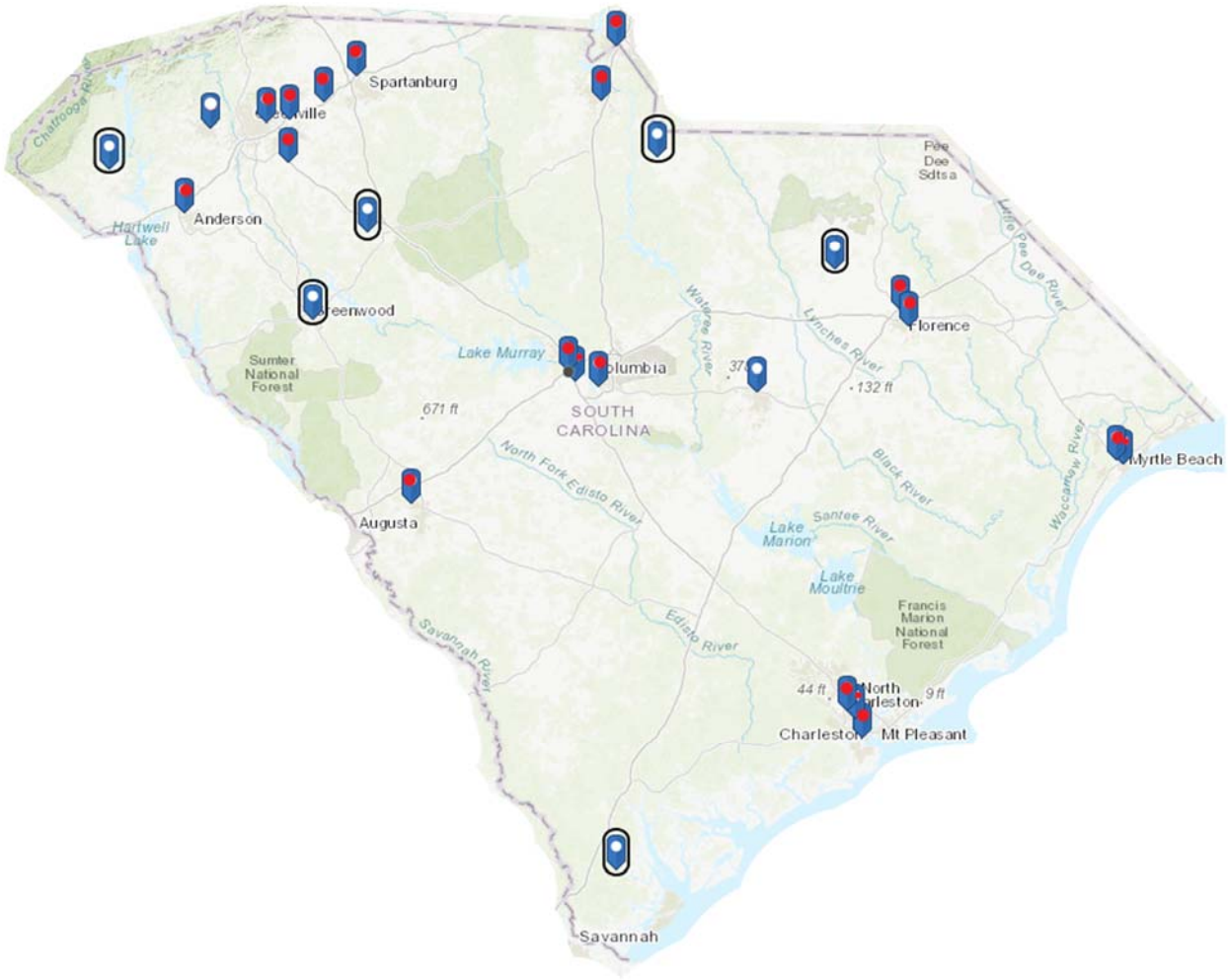
We found that two-thirds of the OTPs in the state are clustered in the areas displayed in Chart 2.20. Chart 2.21 displays the locations of OTPs in the state.

Chart 2.20: South Carolina OTP Locations

City	OTPs in the Area
Duncan Easley Greenville Simpsonville Spartanburg	6
Charleston North Charleston	3
Columbia West Columbia	3
Florence	2
Myrtle Beach	2
Rock Hill/Fort Mill	2

Source: SAMHSA

Chart 2.21: Map of South Carolina OTP Locations



Opioid Treatment Program

Opioid Treatment Program in the Ten Highest-Ranked Counties by Total Number of Deaths Involving Opioids

Opioid Treatment Program in Areas Designated as Rural

Source: DHEC and LAC Analysis

In August 2021, DAODAS received guidance from SAMHSA advising that it can allocate block grant funding to OTPs for the purchase of mobile OTP units to reach rural and underserved areas of the state. According to a DAODAS official, the agency has estimated that non-medical mobile outreach units would cost approximately $180,000 each and medical mobile units would cost substantially more. DAODAS stated it would help cover some of the operating costs for these units through reimbursement payments. Although the agency is considering procuring mobile OTP units for contracting with the OTPs, as of March 2022, DAODAS had not implemented mobile outreach services.

OTPs Missing from Agency's Website

DAODAS' website does not display locations for all OTPs. DAODAS stated it has yearly contracts with each of the 27 OTPs in the state; however, according to its website, it only has yearly contracts with 25 of the OTPs. The exclusion of OTP locations from DAODAS' website could discourage individuals from seeking medication-assisted treatment if it does not appear a facility is near their residence.

Interview Methodology

To examine issues in our audit request, we attempted to contact leadership from eight OTPs across the state that are in urban and rural areas with different population sizes, community needs, and socioeconomic demographics. Of the eight OTPs we contacted, five agreed to meet with us. We conducted virtual interviews with program directors, site managers, and chief operating officers from five OTPs serving populations with a high rate of illicit opioid use to elicit their views on service delivery, service accessibility, and interactions with DAODAS. We identified common themes brought forth by these officials.

Summary of Discussions

Interactions with DAODAS

4	Officials find DAODAS accessible and expressed satisfaction with their communication with DAODAS.
2	Officials stated that the relationship between DAODAS and the OTP community has improved significantly in the last five years.
4	Officials mentioned that occasionally DAODAS will perform audits to ensure compliance with grant requirements.
2	Officials mentioned that the deliverable requirements for the SOR grant are enough work for one employee to manage full-time.

Service Delivery

All	Offer counseling services and medication-assisted treatment using Suboxone®, Subutex® (buprenorphine), and/or methadone. Dosing Hours of Operation Monday–Friday 5:00 AM – 12:30 PM (Limited hours on weekends depending on organization)
1	Official mentioned that one of its locations is open for dosing Monday–Friday 1:00 PM – 3:00 PM in addition to their morning dosing hours of operation.
0	Offer treatment for mental health disorders and refer patients to other partners for treatment.
All	Facilities have counselors that are: • Certified alcohol and drug counselors • Advanced alcohol and drug counselors • Licensed professional counselors • Licensed addiction counselors
All	Unlicensed and uncertified counselors must be in the process of obtaining an addiction certification.
3	Officials mentioned that addiction counselors' salaries range between $16-$25 per hour, depending on their experience and facility location.
All	Have a pharmacist on-site for dosing.
4	Have a medical director, physician, or nurse practitioner on-site to prescribe medication.
3	Have patients receive take-home doses of their medication to reduce contact between patients and staff during the COVID-19 pandemic.
4	Use treatment outcome analyses or audits to evaluate the effectiveness of services by assessing indicators such as patients' compliance with treatment, advancements in recovery, reduced criminal justice activity, or overall improvement in quality of life.

Service Accessibility

All	Officials mentioned that the lack of transportation limits access to treatment. While patients can utilize non-emergency transportation, this option is only available to those on Medicaid and is not reliable.
4	Officials mentioned that the lack of ability to pay limits access to treatment.
3	Officials mentioned that the Medicaid rates were sufficient.
2	Officials believe that Medicaid rates need to be increased but failed to specify by how much.
2	Officials mentioned that their patients are primarily male and there had not been significant changes in patient demographics over time.
1	Official mentioned the facility has begun seeing more women patients.
2	Officials mentioned their facilities have begun seeing an increase in pregnant patients.

Recommendations

10. The S.C. Department of Alcohol and Other Drug Abuse Services should renew on-site visits to opioid treatment programs with which it has contracts to provide funded services.

11. The S.C. Department of Alcohol and Other Drug Abuse Services should conduct a minimum of ten clinical quality assurance reviews annually to monitor the effectiveness of opioid treatment programs with which it has contracts to provide funded services.

12. The S.C. Department of Alcohol and Other Drug Abuse Services should use Substance Abuse and Mental Health Services Administration data and other resources that are available to track which opioid treatment programs treat co-occurring mental health disorders for consumers.

13. The S.C. Department of Alcohol and Other Drug Abuse Services should improve its tracking of demographic information of patients to maximize resources and improve services, overall and for underserved populations.

14. The S.C. Department of Alcohol and Other Drug Abuse Services should encourage opioid treatment programs to refer patients seeking injectable extended-release naltrexone to another provider if they do not offer, or are not in the process of offering, the medication.

15. The S.C. Department of Alcohol and Other Drug Abuse Services should continue to identify and implement viable alternative evidence-based practices to provide mobile medication-assisted treatment services in areas that are currently underserved.

16. The S.C. Department of Alcohol and Other Drug Abuse Services should ensure that the locations of all opioid treatment programs are included on the interactive map on its website.

Monitoring Process and Effectiveness of Opioid Services

We reviewed DAODAS' process for monitoring opioid services by its providers and found DAODAS did not adequately monitor its subgrantees. As a result, DAODAS' monitoring process could be improved, making its efforts more effective.

Monitoring Process

From FY 16-17 through FY 20-21, we found DAODAS had not conducted reviews of all its subgrantees. DAODAS stated no site visits have been conducted since the start of the pandemic in 2020. DAODAS plans to resume site visits in early FY 22-23, but has not determined a specific date. As was the case before the pandemic, for example, primary prevention reviews, may be a combination of site visits and desk reviews or site visits only. Therefore, the pandemic would not have prevented the utilization of more desk reviews as a monitoring tool. DAODAS stated it continued to monitor subgrantees by conducting desk reviews as an assistance tool during the pandemic, but our review of the documentation provided by DAODAS did not indicate there was an increase in the number of desk reviews.

DAODAS gathers data for analyses but does not use the data to adequately measure effectiveness of the local alcohol and drug abuse authorities and the opioid treatment programs. DAODAS explained it sends quarterly patient outcome reports to the providers to track their clients' quality of life improvement following treatment and whether there had been a reduction in the quantity or frequency of substance use following treatment. However, for example, DAODAS stated it does not track how long it takes a person to receive treatment once treatment is sought. DAODAS, as the lead agency for opioid use disorder, could analyze the data it receives from providers to add value and enhance the performance of the providers, which may increase the effectiveness of prevention, intervention, treatment, and recovery efforts.

Clinical Quality Assurance Reviews

We found DAODAS did not consistently comply with its policy to review ten patient files during clinical quality assurance reviews. Also, DAODAS did not conduct annual reviews of all of its providers—32 local alcohol and drug abuse authorities and 27 opioid treatment programs. DAODAS monitors its providers in multiple ways, including primary prevention county reviews; clinical quality assurance reviews for local alcohol and drug abuse authorities and opioid treatment programs; and strategic management quality assurance reviews. Chart 2.22 shows a summary of the on-site or desk reviews DAODAS conducted each fiscal year from FY 16-17 through FY 20-21.

Chart 2.22: Reviews of Providers, FY 16-17 – FY 20-21

Fiscal Year	Type of Review			
	Primary Prevention County	County Clinical Quality Assurance	OTP's Clinical Quality Assurance	Strategic Management
16-17	6	10	N/A *	8
17-18	2	2	3	2
18-19	6	3	0	1
19-20	2	1	5	1
20-21	0	0	0	0
TOTAL	16	16	8	12

* According to DAODAS, no OTP reviews were conducted in FY16-17 because most of the agency's work was based on training and onboarding of OTPs for the State Targeted Resource grant.

Source: DAODAS and LAC Analysis

DAODAS' policy is to review a minimum of ten patient files during clinical quality assurance reviews of the local alcohol and drug abuse authorities, which is noted on the related form. However, of the 16 clinical quality assurance reviews conducted from FY 16-17 through FY 20-21, in only 3 instances (19%) were at least 10 patient files reviewed. A DAODAS official stated the clinical quality assurance reviews may be conducted on-site or by a desk review. Reviewing fewer than the required minimum number of files is not in compliance with DAODAS' policy and may reduce monitoring effectiveness.

Primary Prevention County Reviews

Several forms for primary prevention county reviews did not include the name of the agency reviewed, the name of the reviewer, or the date of review. DAODAS provided cover letters which had been attached when sending the forms to the local alcohol and drug abuse authorities with the name of the agency reviewed and the review date. However, good business practice would dictate the actual form contain complete information regarding the review details. Two forms only listed the name of the agency reviewed. Only 3 of 16 forms (19%) had the agency name, reviewer name, and review date. In 8 of 16 reviews (50%), DAODAS reviewers found the providers had missing required elements. Recording detailed information on the review forms, such as the name of the agency reviewed, the name of the reviewer, and the date reviewed, are important components of the monitoring process.

DAODAS does not maintain a summarization of the most recent monitoring reviews. Maintaining an easily accessible reference document may be beneficial in ensuring the providers are compliant, which may lead to better performance and effectiveness. It would also allow the program managers to see how long it has been since a review was conducted of each provider.

Incomplete or Inaccurate Submissions of Deliverables

We selected two local alcohol and drug abuse authorities in counties with high drug overdose mortality rates and reviewed documentation for their deliverables submitted to DAODAS. We found examples of incomplete documentation, errors in calculations, and files that were submitted with no data. There was a submission of documentation which had significant revisions made to prior months' data.

Additionally, the Medicaid quarterly reviews submitted to DAODAS found multiple errors indicating improvements were needed. For FFY 20-21, 318 errors were recorded related to the clinical service staff for case consultation notes, orientation, and time-oriented objectives. Other areas called for improvement related to proper documentation, training for chart auditing, and the incorporation of audit information into performance measurement and management.

We reviewed a spreadsheet submitted to DAODAS by one of the agencies but did not see that the second agency had submitted the same type of spreadsheet. We asked DAODAS about the status, and it responded that with the provider's staff changes, reports may not have been uploaded to the system. DAODAS seemed to be unaware of the missing documentation. However, the contract with the provider stated submission of the report was a requirement. Submission of timely, complete, and accurate data is an important element in ensuring DAODAS remains eligible for federal grant funding from SAMHSA.

Government Performance and Results Act Interview Tool Not Adequately Utilized

We found DAODAS subgrantees were not adequately adhering to the Government Performance and Results Act (GPRA). The federal GPRA law was enacted in 1993 for the purpose of improving government performance management and was modernized in 2010. GPRA requires agencies to engage in performance management, such as setting goals, measuring results, and reporting progress.

One GPRA tool is data collection from interviews to follow up on clients who had been in or have completed treatment. The interviews are required to be conducted one month before or up to two months after the six-month anniversary date of beginning treatment. The minimum targeted follow-up rate is 80%. However, our review of DAODAS records as of May 2022 found only 17% of subgrantees had attained the minimum targeted follow-up rate of 80%. DAODAS allows for reimbursement for the expense of an incentive gift card for clients who participate in the interview. Participation in the interviews should be encouraged, which may help to improve the effectiveness of treatment efforts.

Financial Assessment Reviews Not Conducted

We found DAODAS did not conduct financial assessment reviews of the opioid treatment programs on a regular basis. Our review shows DAODAS conducted 15 financial assessment reviews from FY 16-17 through FY 20-21, which were the only financial assessment reviews DAODAS provided in response to our request. Our analysis found DAODAS conducted 14 financial assessments in FY 18-19 and 1 in FY 19-20. The providers are required to determine a person's financial need but our review indicates DAODAS did not regularly ensure that is occurring.

Studies have found that medication-assisted treatment is more effective at treating opioid use disorder than counseling services without medication-assisted treatment. Methadone is one of the medications used for medication-assisted treatment to treat substance use disorder. However, one opioid treatment program provider stated the cost of methadone, which must be taken daily, is $15 per day. Patients may be given a price break if purchasing a week's supply at $89 or a month's supply at $320, but the cost may be prohibitive to people without insurance or other means of assistance for payment. DAODAS' state opioid response grant 2.0 application dated May 18, 2020, listed the cost of methadone as $12 per day and other FDA-approved forms of medication-assisted treatment as even more costly— buprenorphine at $20 per day and naltrexone (Vivitrol®) at $1,200 per month. Therefore, ensuring the providers are adhering to the requirement of determining a patient's financial need is paramount for effective treatment. Without a means to pay for medication, some patients may drop out of a treatment program.

Treatment Accessibility

We found lack of accessibility to treatment may be a hindrance to people in need of treatment. A DAODAS official stated the agency established funding for buprenorphine to be used in hospital emergency rooms to stabilize a patient after an overdose and attempts to get the person in treatment. The DAODAS official also stated the program, which may be an effective way to get people into treatment and potentially decrease drug overdose deaths in the state, was implemented in seven hospitals by the Medical University of South Carolina. The number of people admitted by DAODAS providers for treatment of opioid use disorder for FY 16-17 through FY 20-21 is shown in Chart 2.23.

Chart 2.23: Admissions for Treatment of Opioid Use Disorder

Fiscal Year	Number of Persons Admitted
16-17	5,725
17-18	6,770
18-19	7,577
19-20	7,080
20-21	6,410

Source: DAODAS

DAODAS stated it reimbursed subgrantees $153,201 during FY 20-21 for transportation-related expenses for clients. A DAODAS representative stated the agency has explored the possibility of purchasing mobile units to take treatment services and other services to the people. However, a DAODAS representative stated a non-medical mobile unit costs $180,000, and the cost of a medical mobile unit would be substantially higher. Operating costs would also have to be factored into the expense involved. Considering the required expenses, a better option may be to explore the possibility of contracting with another agency, such as the S.C. Department of Mental Health, to share the use of its fleet of mobile units. This might not only be more cost effective but would likely allow for a larger array of services to be provided at each location.

Recommendations

17. The S.C. Department of Alcohol and Other Drug Abuse Services should analyze the data it receives from subgrantees and maintain documentation of its analyses.

18. The S.C. Department of Alcohol and Other Drug Abuse Services should conduct annual reviews of the local alcohol and drug abuse authorities and the opioid treatment programs.

19. The S.C. Department of Alcohol and Other Drug Abuse Services should comply with its policy to review ten patient files during each site visit and desk review.

20. The S.C. Department of Alcohol and Other Drug Abuse Services should ensure every monitoring review form provides the agency name, reviewer name, and date.

21. The S.C. Department of Alcohol and Other Drug Abuse Services should maintain a spreadsheet of the most recent results from its site visits and/or desk reviews.

22. The S.C. Department of Alcohol and Other Drug Abuse Services should ensure its providers comply with contract requirements, such as the timely submission of deliverables.

23. The S.C. Department of Alcohol and Other Drug Abuse Services should ensure its subgrantees are adequately utilizing the Government Performance and Results Act Interview Tool.

24. The S.C. Department of Alcohol and Other Drug Abuse Services should ensure subgrantees are conducting patient financial assessments.

25. The S.C. Department of Alcohol and Other Drug Abuse Services should explore the possibility of contracting with the S.C. Department of Mental Health to share the use of its fleet of mobile units for community outreach services.

26. The S.C. Department of Alcohol and Other Drug Abuse Services should direct funding from the American Rescue Plan toward unmet transportation needs.

Opioid Emergency Response Team

We found recordkeeping for the Opioid Emergency Response Team (OERT) meetings to be inadequate.

- The OERT has failed to establish a regular schedule of meetings since its inception.
- The OERT failed to comply with state law for recordkeeping by a public body.

Background

In December 2017, the Governor of South Carolina signed Executive Order No. 2017-42 which declared a statewide public health emergency related to opioid misuse, opioid use disorder, and opioid-related deaths in the state. The executive order established the OERT, led jointly by the Director of DAODAS and the Chief of the State Law Enforcement Division (SLED).

The purpose of the OERT is to ensure coordination and collaboration among government entities, private entities and associations, and state and local law enforcement authorities, including coordinating best practices and addressing action items, in the fight against the opioid crisis. While the executive order specifically includes the agencies listed in Chart 2.24, participation is open to all stakeholder organizations with no term limits. The OERT identified four focus areas to address the opioid crisis:

1. Education and communication.
2. Prevention and response.
3. Treatment and recovery.
4. Coordinated law enforcement strategies.

Examples of the presentations made during OERT meetings include showing the changing drug trends, the increase in overdose deaths involving fentanyl, overdose death rates, emergency department visits, and hospitalizations. Strategies to address the issues were presented, including success stories from other states. South Carolina joined other states in implementing the High Intensity Drug Trafficking Areas Program. The program uses a data intake interface used by first responders to collect information on non-fatal and fatal overdoses and creates a map for public health and safety officials, which are not available to the general public.

We found the OERT collaborates well with other agencies in its efforts to address the opioid epidemic in each of the focus areas. Although a regular meeting schedule may be beneficial, we did not identify other areas for improvement for the OERT. Substance use disorder has been scientifically proven to be a chronic brain disease that can be managed with treatment, but it is complex and unique to each person, which presents unique challenges to ending the opioid epidemic.

Chart 2.24: Member Agencies

OERT Team Member Agencies
S.C. Department of Alcohol and Other Drug Abuse Services
S.C. State Law Enforcement Division
S.C. Emergency Management Division
S.C. Department of Health and Human Services
S.C. Department of Labor, Licensing and Regulation
S.C. Department of Health and Environmental Control
S.C. Commission on Prosecution Coordination
S.C. Department of Public Safety
Medical University of South Carolina

Source: S.C. Governor's Executive Order No. 2017-42

Meetings Have Been Infrequent

The OERT began meeting in December 2017. Regular meetings, usually monthly or every other month, were held to discuss changes in the status of the opioid crisis and related activities. However, our review of past meetings found instances where more than two months had passed between meetings:

THREE MONTHS (May 21, 2018–August 20, 2018)
: OERT Response—The base plan had been completed and was published in June 2018.

SIX MONTHS (August 20, 2018–February 11, 2019)
: OERT Response—OERT members attended the Governor's Opioid Summit in September 2018 and were immersed in opioid education and conversations.

SIX MONTHS (February 10, 2020–August 17, 2020)
: OERT Response—Due to COVID-19, in March 2020 attention was focused on the rapid response team. Aside from the rapid response team, a small group of OERT members met virtually six times between February and August 2020. Information was shared about service delivery and drug supply changes impacted by the pandemic.

An OERT official stated meetings are open to the public except for the rapid response meetings because of the confidentiality requirement. The official stated the OERT complies with the Freedom of Information Act with meeting records available upon request.

Rapid Response Team Meets Frequently

During the start of the COVID-19 pandemic in the Spring of 2020, the OERT launched a rapid response team to have weekly updates to address emerging concerns. The first meeting was held virtually on March 30, 2020. Lead agency representatives from OERT also held bi-weekly phone briefings between April and July 2020 to share updates on the pandemic. As of April 2022, the rapid response team continued to hold weekly, virtual meetings. The majority of the 24 rapid response team members are representatives from DAODAS, DHEC, and SLED. Members of the rapid response team must sign a data sharing confidentiality agreement.

Data Committee Reviews Data to Target Overdose Prevention Efforts

The OERT has a data committee to provide expertise on opioid-related data by reviewing current data to use for action, such as proactive intervention to reduce overdoses. Members of the data committee serve ad hoc and include representatives from DHEC, the S.C. Department of Health and Human Services, the Revenue and Fiscal Affairs Office, the S.C. Department of Corrections, SLED, and other state agencies. The committee's participant organizations obtain and review non-sensitive data relating to opioid dispensation, overdose, disorder treatment, toxicology screens, mortality, and hospitalizations. The data is obtained from the participating agencies. An OERT official stated the data committee meets quarterly, but only two meeting agendas were provided—for a June 2019 meeting and a collaboration call in November 2021.

An OERT official stated there is no specific requirement for the number of OERT meetings to be held annually, nor is there a requirement for the data committee to exist. However, holding meetings at regular intervals, such as monthly, allows for timely discussion and collaboration to address the state's current and emerging drug issues.

OERT Recordkeeping is Inadequate

We reviewed the OERT records and found the documentation was not in compliance with state recordkeeping laws. S.C. Code §30-4-90 states:

> (a) All public bodies shall keep written minutes of all of their public meetings. Such minutes shall include but need not be limited to:
>
> (1) The date, time and place of the meeting.
>
> (2) The members of the public body recorded either present or absent.
>
> (3) The substance of all matters proposed, discussed or decided and, at the request of any member, a record, by an individual member, of any votes taken.
>
> (4) Any other information that any member of the public body requests be included or reflected in the minutes.

The OERT meeting records indicate the team is a public body, acting in accordance with all open records and open meeting laws pursuant to the Freedom of Information Act. However, the OERT documentation consisted of notations added to the agendas instead of detailed descriptions of what took place in the meetings. Also, the documentation did not list the names of all OERT members in attendance nor a detailed description of the meeting discussions. The purpose of an agenda is to inform the attendees and the public of what will be addressed in a meeting. Meeting minutes should be recorded on a separate document from the agenda and should describe the details of what was discussed during the meeting, along with the names of persons in attendance. Detailed meeting minutes inform stakeholders of what took place in each meeting. We acknowledge that certain information may be confidential and unavailable to the general public.

There were no written minutes provided to us of the OERT meetings. Therefore, we were unable to determine the actions taken by the board. Instead, we received presentations made during the OERT meetings. The meeting minutes should include information discussed during the meeting. This would allow stakeholders to be informed of the OERT's actions in addressing the opioid epidemic in the state.

Recommendations

27. The S.C. Department of Alcohol and Other Drug Abuse Services, in its capacity as co-chair of the Opioid Emergency Response Team, should establish and adhere to a schedule for meetings to be held monthly or every other month.

28. The S.C. Department of Alcohol and Other Drug Abuse Services, in its capacity as co-chair of the Opioid Emergency Response Team, should comply with the S.C. Freedom of Information Act by ensuring the meeting minutes contain adequate details, including the names of members in attendance.

29. The S.C. Department of Alcohol and Other Drug Abuse Services, in its capacity as co-chair of the Opioid Emergency Response Team, should have separate written meeting minutes with detailed descriptions of the meetings, including actions and/or votes taken by members of the board, redacting any confidential information.

Non-Opioid Services

In this chapter, we report on the non-opioid programs, including the impact of the COVID-19 pandemic on access to services.

WHAT WE EXAMINED

- DAODAS' enabling legislation, related statutes, and appropriations acts.
- Admissions data for alcohol and other non-opioid substance use disorders.
- Alcohol and Drug Safety Action Program (ADSAP) curriculum, revenues, expenditures, and participation data.
- Responses from interviews with a sample of local service providers.
- Contract deliverables and the monitoring process.
- Research on evaluating effectiveness of treatment services.

WHAT WE FOUND

- DAODAS' enabling legislation includes outdated language pertaining to its receipt of Education Improvement Act funding, which it has not received since 2003, and makes no mention of DAODAS' authority to address gambling disorder.
- The number of persons admitted for non-opioid treatment disorder services declined in FY 19-20 and continued the decline through FY 20-21; but a review of treatment service data revealed that, following a decline from March to April 2020, numbers rebounded and, despite some fluctuation, remained relatively steady, in the following months.
- The ADSAP fees often fail to cover program costs.
- Local alcohol and drug abuse authorities have experienced difficulties in getting responses from DAODAS' staff and have had patients who lack transportation to receive treatment.
- Alcohol and marijuana addictions are the main reasons persons seek treatment from the local alcohol and drug abuse authorities, but these do not necessarily receive the most funding or focus from DAODAS.
- Restrictions associated with DAODAS grant funding make it difficult for local treatment authorities to address community addiction treatment needs.
- The S.C. Department of Health and Environmental Control's (DHEC) website does not display accurate information for all licensed outpatient treatment facilities for chemically dependent or addicted persons (CDAP).
- DAODAS' monitoring efforts could be improved, leading to more effective treatment.

Non-Opioid and Gambling Services

We reviewed the non-opioid and gambling services and found:

- The General Assembly has long assigned responsibility for gambling disorder treatment services to DAODAS, despite the fact that the agency's enabling legislation makes no mention of gambling and its authority has rested for decades in Proviso 37.2.
- DAODAS has not emphasized gambling disorder and collects no data on the scope and magnitude of gambling disorder in South Carolina.
- DAODAS' enabling legislation includes outdated language pertaining to its receipt of Education Improvement Act (EIA) funding that it has not received since 2003.

As a result, DAODAS lacks legislative guidance with which to recommend and implement policies aimed at responding to gambling disorders using its provider network and DAODAS' enabling legislation does not accurately reflect the funding and operations of the agency as it relates to programs in public schools.

Statutory Authority

DAODAS' enabling legislation does not include gambling as a focal area. Its authority has been authorized annually by Proviso 37.2. S.C. Code §44-49-10 *et seq.* authorizes DAODAS to address alcohol and drug abuse with prevention efforts and treatment programs.

DAODAS receives unclaimed lottery funds to address gambling addiction and spends between $4,100 and $7,920 for gambling treatment services annually. Chart 3.1 shows the amount of unclaimed lottery funds allocated to DAODAS and DAODAS' expenses for gambling treatment services.

Chart 3.1: Lottery Funds and Gambling Services, FY 16-17 – FY 20-21

Fiscal Year	Amount Appropriated	Gambling Expenses	
		Total	Reimbursed to Local Alcohol and Drug Abuse Authorities
16-17	$50,000	$64,520	$7,920
17-18	$50,000	$25,690	$4,460
18-19	$50,000	$26,729	$5,680
19-20	$50,000	$17,442	$5,968
20-21	$100,000	$15,892	$4,100

Source: Appropriations Acts, DAODAS

Gambling expenses include 10% of one DAODAS employee's salary and fringe benefits for duties working with the gambling hotline, the operating expenses of the hotline, and reimbursement to local alcohol and drug abuse authorities for gambling services. According to DAODAS officials, appropriated funds remaining after each fiscal year are carried forward into the next fiscal year to cover future gambling expenses, such as the newly required training module for all providers.

No Systematic Collection and Use of Data on Problem Gambling

DAODAS does not have any data on the scope and magnitude of the gambling problem in South Carolina. A DAODAS official stated that agency staff could calculate an estimate by extrapolating from national data. DAODAS' enabling legislation does not include gambling-related services among those for which it is responsible. Instead, DAODAS' responsibility in this area is authorized by annual Proviso 37.2. As a result, gambling disorder does not receive the emphasis that it might require, on a level with drugs and alcohol.

A 2016 study by Problem Gambling Solutions, Inc. found that an estimated 2.2% (84,805) of South Carolina adults are believed to manifest a gambling problem. Another study by WalletHub© compared the 50 states to determine where excessive gambling is most prevalent, and South Carolina is ranked the 28th most gambling-addicted state. Yet, demand for gambling addiction treatment services is extremely low. This could result from gamblers ignoring the problem, seeking help on their own through other providers not affiliated with DAODAS, or that DAODAS does little to draw attention to a problem that could be bubbling just below the surface because it lacks authoritative data with which to work.

However, DAODAS receives client data showing how many individuals in treatment at the local alcohol and drug abuse authorities reported they gamble. We acknowledge not everyone who gambles has a problem. Chart 3.2 shows the number of individuals seeking treatment for gambling addiction and the number of individuals who reported they gamble while seeking other treatment services.

Chart 3.2: Participants in Gambling Services versus Clients Who Gamble, FY 16-17 – FY 20-21

Fiscal Year	Participants in Gambling Services	Current Clients Who Self-Reported They Gamble
16-17	9	1,386
17-18	4	1,583
18-19	7	1,488
19-20	4	1,268
20-21	1	1,193

Source: DAODAS

Outdated Language

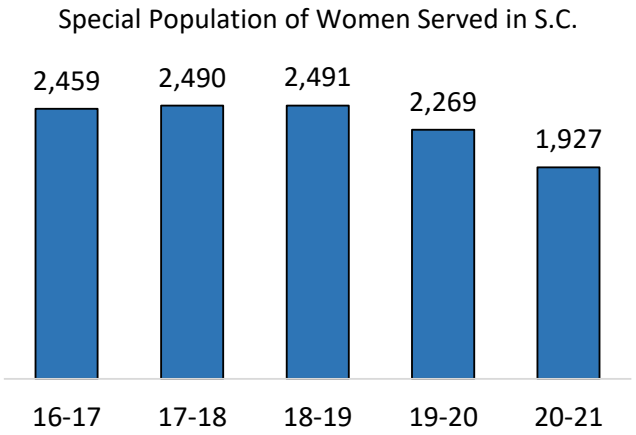
The language in S.C. Code §44-49-80 is outdated and does not reflect all of the operations of the agency. S.C. Code §44-49-80 states DAODAS shall establish a program to provide alcohol and drug abuse intervention, prevention, and treatment services for public schools, with funds annually appropriated from the EIA of 1984. We asked DAODAS how it is implementing this program. A DAODAS official stated EIA appropriations were stopped in the late 1990s. In fact, we found the last annual Appropriations Act to include EIA funding for a drug program in the schools was the FY 03-04 Appropriations Act. The official stated DAODAS provides flexibility in federal and state funding and encourages providers to work with schools based on the needs and ability to fund a counselor in their counties. We interviewed ten local alcohol and drug abuse authorities, two of whom specifically mentioned programs in schools and another specifically mentioned a desire to implement a program in schools.

Comprehensive Services for Special Populations

DAODAS supports services through a network of local alcohol and drug abuse authorities that offer individualized patient-centered, comprehensive services to pregnant and post-partum women, as well as women with dependent children. Providers also offer medication-assisted treatment, positive parenting programs, trauma recovery and empowerment models, peer support specialists, and family-centered treatment.

According to DAODAS, when local providers are working with individual clients who are pregnant, post-partum, or have children, the providers offer case management to arrange for prenatal care, primary medical care, and primary pediatric care. Women's residential treatment service providers should ensure the women meet with their medical providers throughout treatment. Chart 3.3 shows the number of women in this special population served for FY 16-17 through FY 20-21.

Chart 3.3: Number of Pregnant, Post-Partum Women, and Women with Dependent Children Served, FY 16-17 – FY 20-21



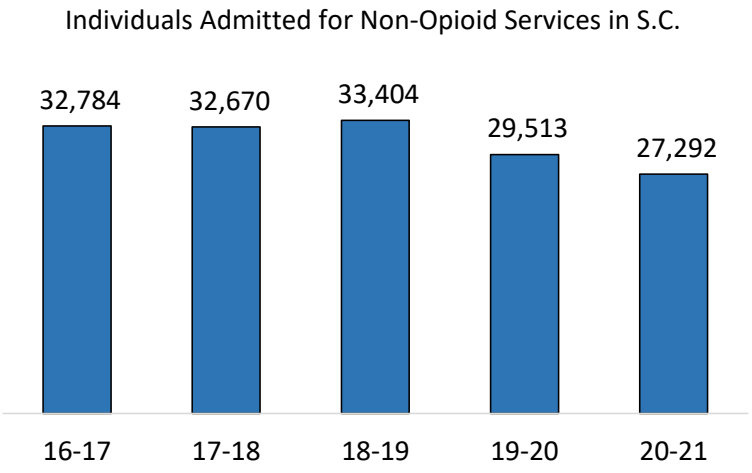
Source: LAC Analysis of DAODAS Data

There was a 15% decrease from FY 19-20 to FY 20-21 due to residential treatment facilities having to reduce the number of available beds to adhere with COVID-19 safety measures.

Utilization of Non-Opioid Services

We requested data from DAODAS on non-opioid services, including gambling services. Chart 3.4 shows the unduplicated number of individuals admitted for non-opioid services, including gambling services, for FY 16-17 through FY 20-21.

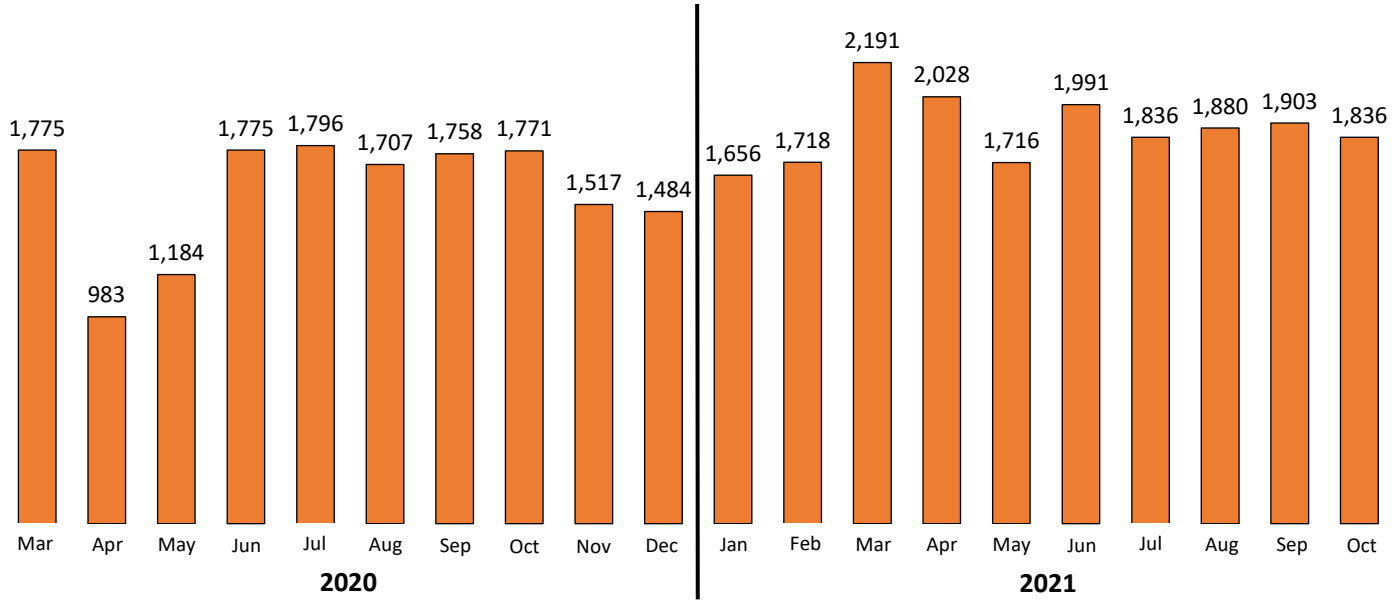
Chart 3.4: Number of Admissions for Non-Opioid Services, FY 16-17 – FY 20-21



Source: LAC Analysis of DAODAS Data

From FY 18-19, pre-pandemic, to FY 20-21, the number of non-opioid admissions decreased by 6,112 individuals, or 18%. We also received data on the number of persons receiving non-opioid services for each month of the COVID-19 pandemic. Chart 3.5 shows the number of individuals receiving non-opioid services, including gambling services, from March 2020 through October 2021.

Chart 3.5: Number of Persons Receiving Non-Opioid Services, by Month, March 2020 – October 2021



Source: LAC Analysis of DAODAS Data

While COVID-19 appears to have impacted new admissions for treatment services and the number of services delivered, providers appear to have been able to respond to the pandemic and deliver some services within the constraints of mandatory lockdowns and staff availability. The largest decline in the number of persons seeking services occurred in April 2020 and May 2020. The average decline was 39%. The decrease is likely a result of the statewide, COVID-19, stay-at-home orders and providers working to find ways to pivot their treatment services. After those months, the number of individuals receiving non-opioid services increased and remained relatively steady.

Chart 3.6 reflects the largest cohort of individuals served by all non-opioid treatment services between March 2020 through October 2021 for each demographic category.

Chart 3.6: Largest Cohort in Each Demographic Category, March 2020 – October 2021

DEMOGRAPHIC	LARGEST COHORT
Age	30-64
Race	White
Ethnicity	Not Hispanic
Gender	Male
Smoking Status	Current Smoker
Military Status	No
Marital Status	Never Married
Employment Status	Not Employed
Education	Completed High School

Source: LAC Analysis of DAODAS Data

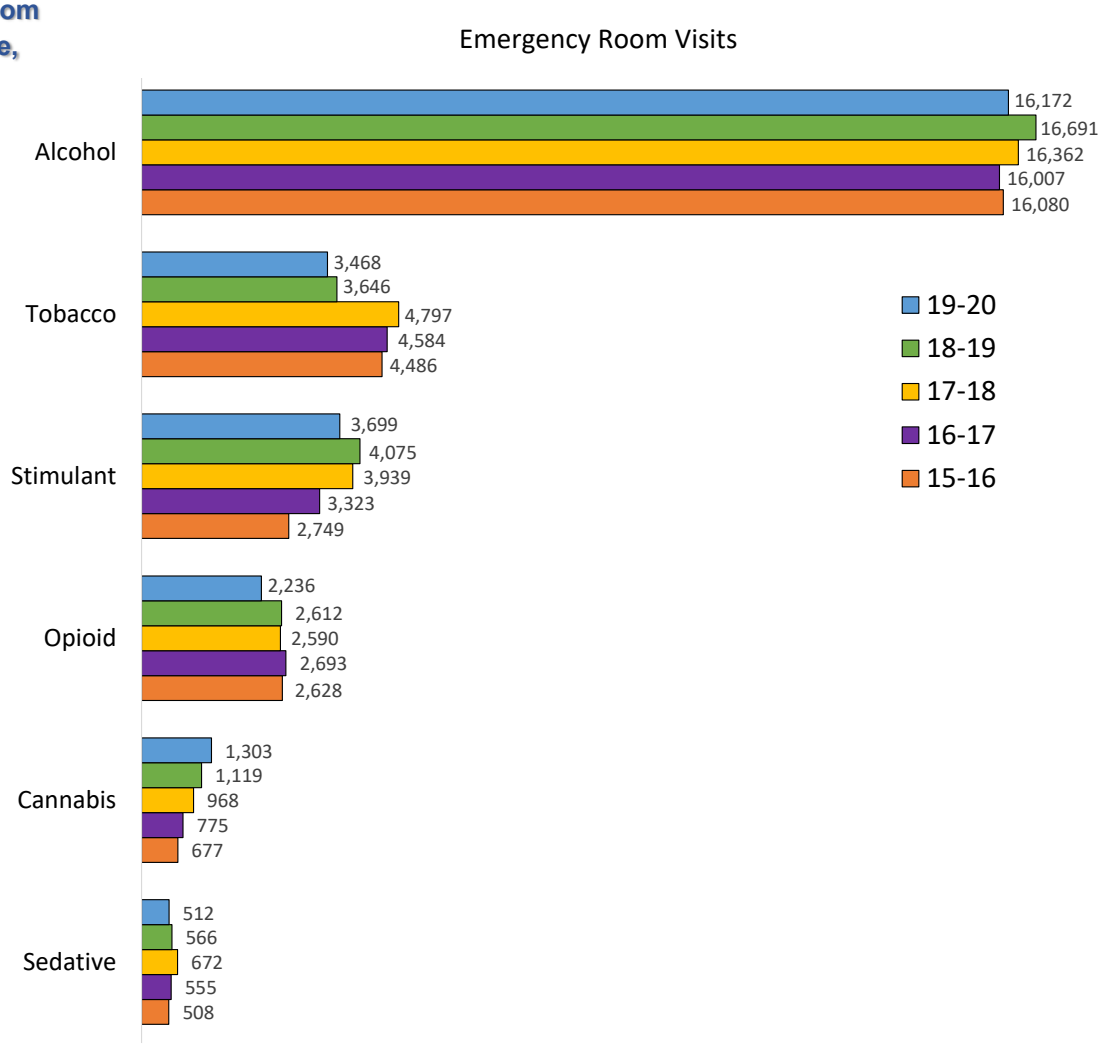
ER Visits Associated with Substance Use

We reviewed data on the number of emergency room visits for substance use related diagnosis and found alcohol-related diagnosis was the most common reason for an emergency room visit, followed by stimulant and tobacco-related diagnosis from FY 15-16 through FY 19-20, the most current data available. Data for FY 20-21 was not yet available; therefore, we could not determine if COVID-19 had an impact on ER visits.

We also interviewed ten local alcohol and drug abuse authorities. Seven of the ten providers surveyed responded that the emphasis on opioids has caused DAODAS to place less emphasis on alcohol use disorder. Six of those seven providers stated alcohol was the number one, or in the top two, reason(s) for why a person seeks substance use disorder treatment. However, visiting an emergency room for a substance use related reason does not mean that same individual sought substance use disorder treatment through a DAODAS program or service.

Chart 3.7 shows the number of emergency room visits, by substance type, for FY 15-16 through FY 19-20.

Chart 3.7: Emergency Room Visits, by Substance Type, FY 15-16 – FY 19-20



NOTE: With less than 100 visits each year, Hallucinogens, Mental/Substance Remissions, and Inhalants were excluded from the chart.

Source: LAC Analysis of Revenue and Fiscal Affairs Data

Recommendations

30. The General Assembly should enhance the role and broaden the mission of the S.C. Department of Alcohol and Other Drug Abuse Services by amending its enabling legislation to include prevention and treatment for gambling disorders.

31. The S.C. Department of Alcohol and Other Drug Abuse Services should gather and assess data on the overall scope and magnitude of the gambling problem in South Carolina.

32. The S.C. Department of Alcohol and Other Drug Abuse Services should coordinate with the General Assembly to update its enabling legislation and provisos to accurately reflect the agency's operations and funding sources.

Alcohol and Drug Safety Action Program

We reviewed the Alcohol and Drug Safety Action Program (ADSAP) and found:

- Fees collected by providers often fail to cover program costs; consequently, providers cover the costs by diverting monies from other purposes.
- The same curriculum is used for first-time and repeat offenders, and no evaluation of program performance is conducted; therefore, it is unclear if the program is effective.
- Program oversight is inadequate.

ADSAP Overview

Created in 1973, ADSAP is a statewide education and treatment program administered by local alcohol and drug abuse authorities in each county, except Williamsburg. Individuals convicted of driving under the influence (DUI) of alcohol or other drugs must complete the program to regain driving privileges. Individuals must enroll within 30 days of conviction and be assessed to determine if they should complete education services, treatment services, or both. Providers charge fees for these services, and anyone unable to pay must complete 50 hours of community service, in lieu of paying the fees.

The ADSAP education curriculum, offered over a two- to four-week period, is the same for everyone including repeat offenders and in every county. Individuals receiving treatment services experience a different schedule. To successfully complete education services, individuals must meet curriculum requirements and pass a test. Individuals assessed into treatment must achieve clinical goals and objectives as measured by a bio-psycho-social assessment.

Out-of-state individuals convicted in South Carolina must contact the Interstate ADSAP office, located in the Dorchester Alcohol and Drug Commission, to coordinate completion of the ADSAP requirements. The *ADSAP Standards Manual* states the Interstate ADSAP office will process all enrollments and terminations for non-residents charged with DUI and verify client compliance with South Carolina ADSAP requirements. However, during our audit, we received conflicting information about the requirements for people in this category.

A DAODAS official stated out-of-state individuals must meet South Carolina's requirements, then stated an out-of-state individual must participate in the ADSAP equivalent services in their states of residence. According to a DAODAS official, the Interstate ADSAP office tracks the individuals who participate out-of-state. Another DAODAS official stated, "out-of-state individuals are not tracked, per se," and if an out-of-state individual completes services outside of South Carolina, they are completed as a Dorchester resident. South Carolina law is silent on the subject. In any case, failure to enroll in ADSAP can result in the person's being found in contempt of court.

DAODAS failed to respond when we asked how the court system knows the status of an individual's enrollment and/or completion of ADSAP, and whose responsibility it is to alert the court system.

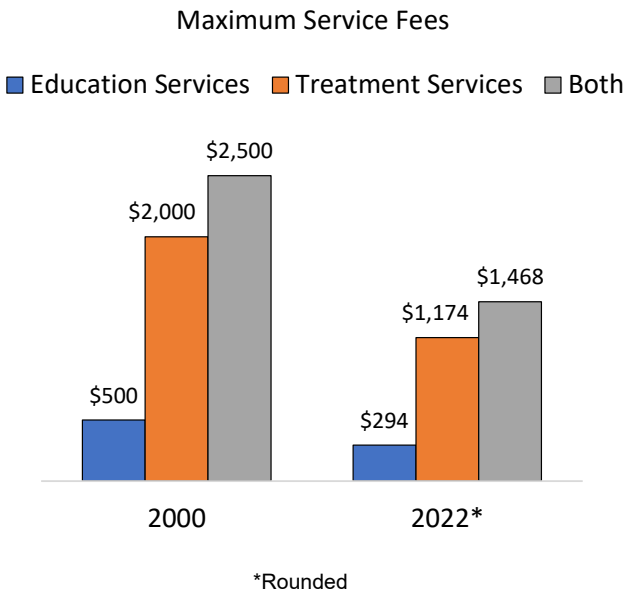
A DAODAS official told us that some counties communicate regularly with the court system in their areas and directly contact individuals convicted of DUI to remind them to come into services. If an individual is court ordered into ADSAP, the local alcohol and drug abuse authority contacts the court if the individual leaves services or does not make progress toward completion of ADSAP.

ADSAP Operates at a Deficit in Most Counties

In most counties, program costs exceed revenues. A person enrolled in ADSAP must bear the cost of the services recommended in the education/treatment plan. The fee may not exceed $500 for education services, $2,000 for treatment services, and $2,500 total for all services. In lieu of payment, ADSAP participants may complete 50 hours of community service. According to local alcohol and drug abuse authorities, most individuals will pay the fee rather than perform community service.

The fee maximums have not changed since 2000. Chart 3.8 shows the present value of these fees which have not been increased in more than 22 years.

Chart 3.8: Present Value of Fee Maximums, CY 2000 and CY 2022



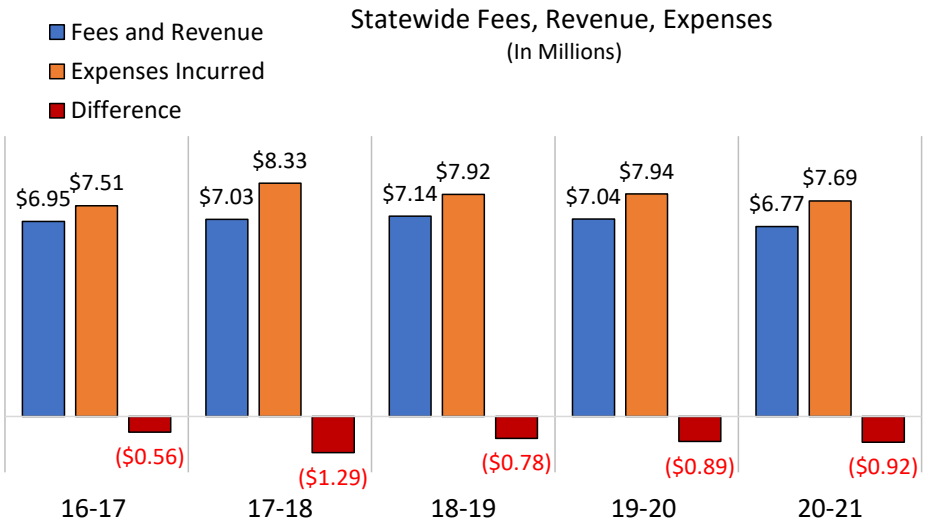
Source: U.S. Bureau of Labor Statistics

The expenses to provide ADSAP services exceed revenue from participant fees. Counselor salaries, requirements for credentialing and certifying counselors, and other operating costs have increased. The base of services is now a full continuum of care that includes prevention, intervention, treatment, and recovery. Expenses vary by location. A DAODAS official stated some providers use funds from other sources, such as county appropriations and annual alcohol excise taxes, to supplement the costs of the program, but they are not required to do so.

We interviewed ten of the local alcohol and drug abuse authorities, three of whom stated they must use other patient fees, county appropriations, and other discretionary funds to cover the gap in the ADSAP fee shortfall, and all ten providers stated the ADSAP fee maximums should be increased. Even with supplementing ADSAP with other funds, ADSAP, statewide, still operates in a deficit each year.

Chart 3.9 shows the fees and revenue, expenses incurred, and the difference between revenue and expenses.

Chart 3.9: Statewide Fees and Revenue Versus Expenses, FY 16-17 – FY 20-21



*Figures are rounded to nearest dollar.

Source: DAODAS

With community service as an option to offset the ADSAP fees, Chart 3.10 show the number of community service hours performed and the fees offset by community service.

Chart 3.10: Statewide Community Service Hours and Fees Offset, FY 16-17 – FY 20-21

Fiscal Year	Hours of Community Service	Fees Offset
16-17	12,096.50	$245,472
17-18	12,290.65	$311,573
18-19	11,234.35	$290,813
19-20	11,008.68	$257,689
20-21	6,703.00	$152,927

Source: DAODAS

Even if fees were not offset by community service, the total amount of fees collected, and other funds used to support the program, would not exceed the total amount of expenses incurred to operate ADSAP. Additionally, when providers move funds around to cover the ADSAP expenses, funds are diverted from other services.

We attempted to determine the deficit by county. DAODAS provided ADSAP revenue versus expenses reports for FY 19-20 and FY 20-21, but the data is commingled among the 32 local alcohol and drug abuse authorities, not by individual county ADSAP providers. With the revenue and expenses data commingled by local alcohol and drug abuse authorities, there is no way to determine the magnitude of the deficit.

Chart 3.11 shows an overview of the findings from the data.

Chart 3.11: ADSAP Revenue Versus Expenses Data, FY 19-20 – FY 20-21

PROVIDERS	FY 19-20	FY 20-21
With a Net Profit	14	13
With Net Profit • Offset Fees by Community Service	7	7
With Net Profit • Offset Fees by Community Service • Cover More than One County	4	4
With Net Loss • Would Switch to Net Profit if Fees Had Not Been Offset by Community Service	1	1
LARGEST AMONG PROVIDERS		
Net Profit	$235,566*	$298,606*
Net Loss	($526,986)	($537,427)*
CLOSEST BREAKEVEN AMONG PROVIDERS		
Profit/Loss	($359)*	$64*

*Rounded to nearest dollar.

Source: LAC Analysis of DAODAS Data

In FY 19-20, we found that one local alcohol and drug abuse authority, which covers only one county ADSAP provider, and in FY 20-21, that another local alcohol and drug abuse authority, which covers only one county ADSAP provider, were responsible for more than half of the statewide deficit each year.

Oversight of ADSAP Program is Inadequate

DAODAS did not provide policies and procedures pertaining to ADSAP when requested; however, DAODAS did provide the *ADSAP Standards Manual* in response to the preliminary draft. DAODAS certifies the ADSAP providers every two years from the date of the previous renewal by conducting on-site reviews. Due to COVID-19, DAODAS has not conducted on-site visits since Fall 2019.

There is a specific template used by DAODAS to review and certify the providers. The template consists of 15 criteria, including:

- Appropriate use of clinical assessment findings to direct-treatment plan and service-placement decisions.
- Signed participation contract and/or treatment plan for each participant.
- Timely admission and discharge.
- Appropriate continuing care and follow-up services.

The review also ensures the agency offers the required minimum services, including:

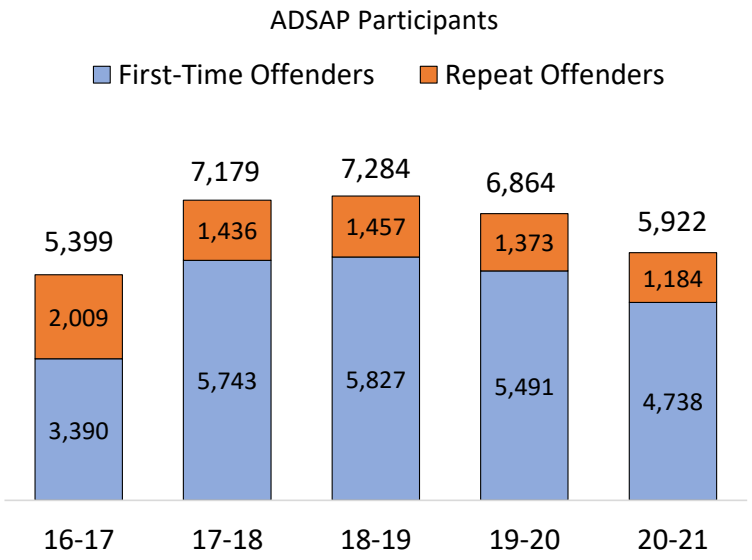
- An education curriculum.
- Individual and group counseling.
- Intensive outpatient services, and referral linkages to higher levels of care, to meet the clients' needs.

A DAODAS official stated the certification and review process are how DAODAS ensures the providers are enforcing the laws. However, the review template does not address confirmation of community service hours completed nor review of ADSAP fees collected or outstanding. Both the ADSAP fee maximums and community service hours are outlined in S.C. Code §56-5-2930. Also, the same DAODAS official stated DAODAS does not have oversight over community service. Therefore, it is unclear how DAODAS is ensuring the ADSAP providers are enforcing the laws if the reviews and certification do not include verification of fees collected and community service hours completed. Without review of the community service records, there is a potential for fraudulent activity, such as forged community service hours that were never completed by the participant.

We found no evidence that ADSAP has been evaluated for effectiveness. We asked DAODAS who determines if ADSAP is effective and how effectiveness is determined; we did not receive an answer. DAODAS did provide cumulative data of ADSAP participants.

Chart 3.12 shows the first-time offenders, repeat offenders, and total offenders participating in ADSAP for each year.

Chart 3.12: ADSAP Participants, by Offense Type, FY 16-17 – FY 20-21

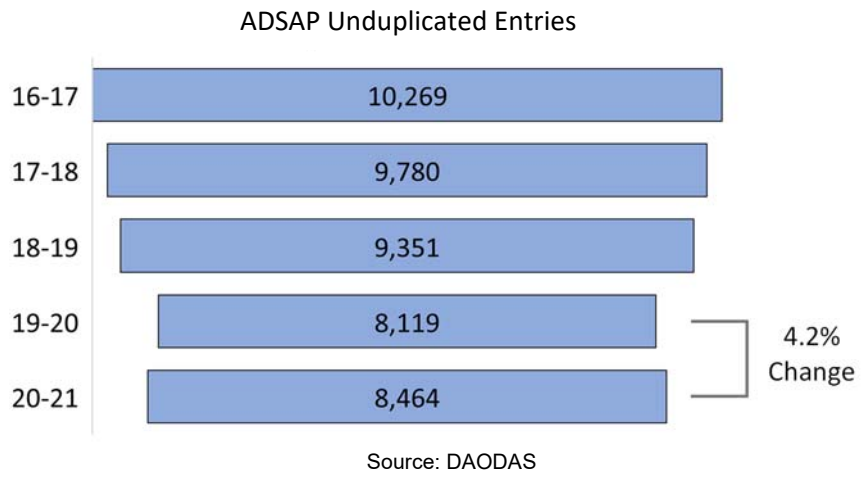


Source: DAODAS

DAODAS also provided a trend report, as of October 20, 2021, that contains an unduplicated count of all ADSAP entries. The trend report details how many individuals entered ADSAP services at each county provider, for each fiscal year, FY 16-17 – FY 20-21, and includes a "% change" between FY 19-20 and FY 20-21.

Chart 3.13 shows the unduplicated count of ADSAP entries, statewide, for each fiscal year, and the percent change between FY 19-20 and FY 20-21.

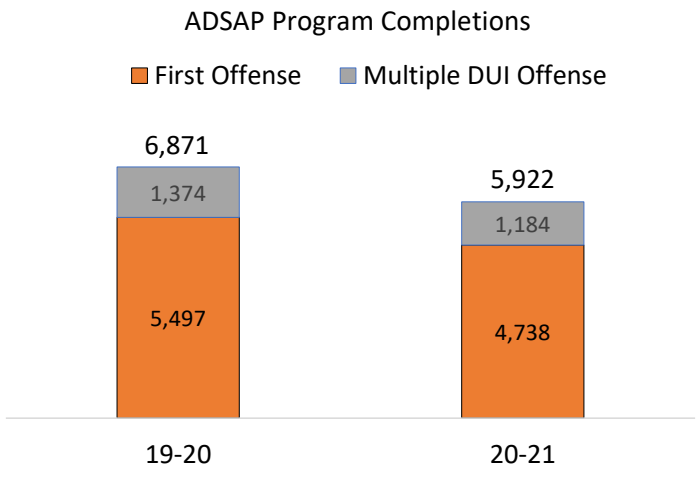
Chart 3.13: Unduplicated ADSAP Entries, FY 16-17 – FY 20-21



Source: DAODAS

The trend report also includes the number of ADSAP completions, first offense, and multiple offense, for FY 19-20 and FY 20-21. Chart 3.14 shows the completion data.

Chart 3.14: ADSAP Completions, by Offense Type, FY 19-20 – FY 20-21



Source: DAODAS

While the unduplicated count of ADSAP entries increased between FY 19-20 and FY 20-21, the number of completions between FY 19-20 and FY 20-21 decreased. The report does not provide trends or percent changes on the completion data, other than a disclaimer that the first offense and multiple offense separation is "estimated on previous fiscal years—first offense has been a stable 80% of program completions." This disclaimer signifies a 20% recidivism rate, with no additional evidence of any efforts to reduce recidivism from ADSAP participation. Without analysis of the completion data, DAODAS is not assessing the success of ADSAP.

Differences in Data

The data for participants and completions is everchanging. According to DAODAS officials, ADSAP data is collected at the local level and is constantly changing. Providers submit the data to DAODAS, and the information is often delayed. Providers may be collecting data for one quarter, then make amendments to include more fees or corrections in the next quarter. A DAODAS official characterized the inconsistency as "an oddity," as providers submit data to DAODAS, they can make changes and add or remove counts of admissions. The reports provided to us are compilations of provider data and are point-in-time reports; the later the report run date, the more accurate the data. DAODAS queries the ADSAP data once a year, in early January. DAODAS has not established a cut-off date for when data can no longer be changed.

Recommendations

33. The S.C. Department of Alcohol and Other Drug Abuse Services should conduct a study on the fee schedule for Alcohol and Drug Safety Action Program services and recommend statutory changes as necessary to offset program costs.

34. The S.C. Department of Alcohol and Other Drug Abuse Services should assess the standard education curriculum and make any adjustments deemed necessary for repeat offenders.

35. The S.C. Department of Alcohol and Other Drug Abuse Services should obtain an independent, third-party evaluation of the Alcohol and Drug Safety Action Program to determine effectiveness.

Interviews with Local Alcohol and Drug Abuse Authorities

We interviewed the executive directors of 10 of the 31 local alcohol and drug abuse authorities serving as substance use treatment providers for DAODAS. We found:

- Local alcohol and drug abuse authority directors find it difficult to reach or receive a response from DAODAS staff.
- Patients seeking treatment from the local alcohol and drug abuse authorities have difficulty obtaining transportation to services.
- Alcohol and marijuana addictions are the main reasons persons seek treatment from the local alcohol and drug abuse authorities, but these addictions do not necessarily receive the most funding or focus from DAODAS.
- Local alcohol and drug abuse authorities wish to collaborate with DAODAS on the development of policies that affect them.
- The education and treatment fees associated with the Alcohol and Drug Safety Action Program (ADSAP) are not sufficient to cover the local alcohol and drug abuse authorities' cost to provide ADSAP services.
- Restrictions associated with DAODAS grant funding make it difficult for local alcohol and drug abuse authorities to address community addiction treatment needs.

Interview Methodology

We selected a judgment sample of the 31 local alcohol and drug abuse authorities and interviewed the directors of those facilities on their operations, support from DAODAS, finance/deliverables, patient concerns/treatment, and ADSAP. Of the ten providers selected for interview, four had service areas covering multiple counties. We selected the ten providers after having considered the following:

- The top ten most populated South Carolina counties as listed in July 2020 census estimates.
- The top ten least populated South Carolina counties as listed in July 2020 census estimates.
- Counties identified as high need through the 2015 SAMHSA Empowering Communities for Healthy Outcomes grant. The aim of this grant was to reduce prescription drug abuse/misuse among persons aged 12 to 25 and to reduce impaired driving among the general population.
- Counties identified as high need by the CDC.
- Counties identified as having a high number of opioid use disorder patients in 2020.
- Counties identified as having a high opioid use rate in 2020.
- Providers that offer residential treatment beds.

Summary of Discussions

The local alcohol and drug abuse authority directors we interviewed offered both positive and negative remarks on their interactions with DAODAS. There were common themes brought forth by these ten directors.

Common Themes

10	Medicaid/MCO reimbursement rates are too low.
6	It is difficult to reach or receive a response from DAODAS staff.
8	Low counselor pay and high turnover leads to poor staff retention and recruitment for the local alcohol and drug abuse authorities.
8	The lack of transportation for patients is a major barrier to accessing care. This is especially challenging for patients who live in rural areas.
7	More focus and funding should be placed on treating alcohol—and, secondarily, marijuana—addictions since those are the primary reasons that persons present for services.
6	The relationship of local alcohol and drug abuse authorities with DAODAS needs to be more collaborative.
10	The ADSAP fee maximums should be increased.
6	Some local alcohol and drug abuse authorities provided information that was different from or was not included in the information listed on their respective local provider webpages on the DAODAS website.
5	There are issues with DAODAS being understaffed or having too much turnover.
5	There are issues with the provision and reimbursement of telehealth treatment services.

Other Comments

Other comments we received from at least one local alcohol and drug abuse authority director include the following: DAODAS should advocate more with the Department of Health and Human Services and the General Assembly on issues that affect the local authorities; there is a disparity in Medicaid reimbursement rates for mental health treatment services and substance use disorder treatment services even though they are similar; the authorities would like to have more flexibility in the use of grant funding to meet specific community needs; and South Carolina's Medicaid reimbursement rates are the lowest in the Southeast.

The local alcohol and drug abuse authority directors we interviewed also provided several positive comments about DAODAS and their interactions with the agency.

Positive Comments

DAODAS is good at managing money.
The local alcohol and drug abuse authorities' working relationships with DAODAS are mutually beneficial.
The local alcohol and drug abuse authorities feel supported by DAODAS and other partners.
DAODAS senior leadership is an ally to the local alcohol and drug abuse authorities and is very responsive. Leadership has all the local alcohol and drug abuse authority directors' telephone numbers and calls the directors as needed.
The local alcohol and drug abuse authorities appreciate that they do not have to answer to DAODAS but have the benefit of being a part of state government without having the regular bureaucratic constraints.
DAODAS and the Behavioral Health Association of South Carolina keep local alcohol and drug abuse authorities informed about what is happening with the actions of the General Assembly.
DAODAS and local legislators helped one local alcohol and drug abuse authority address some significant infrastructure issues.
DAODAS was helpful during the COVID-19 pandemic in offering funding for new incentives, such as money for staff retention, patient transportation, and contingency management programs. DAODAS also provided virtual training sessions and gave the local alcohol and drug abuse authorities flexibility in their use of grant funds.

Recommendations

36. The S.C. Department of Alcohol and Other Drug Abuse Services should respond to inquiries of the local alcohol and drug abuse authorities in a timely manner.

37. The S.C. Department of Alcohol and Other Drug Abuse Services should endeavor to identify and provide additional funding that the local alcohol and drug abuse authorities can use for transportation needs of patients.

38. The S.C. Department of Alcohol and Other Drug Abuse Services should ensure that funding for the treatment of patients with alcohol and marijuana addictions remains a priority.

39. The S.C. Department of Alcohol and Other Drug Abuse Services should actively encourage and provide opportunities for collaboration with the local alcohol and drug abuse authorities on the development of policies that will affect provider operations.

40. The S.C. Department of Alcohol and Other Drug Abuse Services should collaborate with the local alcohol and drug abuse authorities and members of the General Assembly to assess the feasibility of increasing the ADSAP education and treatment fee maximums.

41. The S.C. Department of Alcohol and Other Drug Abuse Services should endeavor to, whenever possible, allow for flexibility in the local alcohol and drug abuse authorities' use of grant funding.

Locations of Local Alcohol and Drug Abuse Authorities

We mapped the geographic service locations of DAODAS' providers and those of other licensed treatment providers on the DHEC website and found a number of inconsistencies.

Licensed Outpatient CDAP Treatment Facilities and Satellite Offices

DHEC licenses outpatient providers that offer treatment services for chemically-dependent or addicted persons (CDAP). The 31 DAODAS local alcohol and drug abuse authorities are included among the DHEC-licensed outpatient CDAP service providers.

We reviewed DHEC's comprehensive list of licensed outpatient CDAP treatment facilities and found that the list failed to include information on satellite locations where people could seek treatment, that there were errors in some of the published information, and that there were errors in DHEC's records. As a result, people seeking outpatient treatment from a licensed provider nearest them, especially those for whom transportation is a problem, risk being misinformed and could be deterred from seeking treatment that is, in fact, available.

Satellite Locations Excluded from DHEC Licensee List and Map

DHEC's Find a Facility webpage for healthcare-related licensees shows tables listing provider names by service type and offers consumers the option of generating a map of one or more types of healthcare provider locations. We reviewed the list of South Carolina outpatient CDAP treatment licensees and viewed their locations on a map. We observed that the CDAP table listing contained 92 corresponding map markers.

According to DHEC, its list of licensed outpatient CDAP treatment providers does not include additional satellite locations where people can seek treatment. None of these locations were publicly shown in the original table listing or on the original map downloaded from the Find a Facility webpage in April 2022.

Data Inconsistencies in Licensee and Satellite Lists

We also found that DHEC's publicly-available information on the Find a Facility webpage contained inconsistences. In 2021, the local alcohol and drug abuse authority in Williamsburg County closed and has yet to reopen. As of June 2022, DHEC still included the Williamsburg County authority among the licensed providers shown in both the table listing and map of the Find a Facility webpage.

Also, the January 2022 outpatient CDAP treatment licensee table listing showed that Anderson-Oconee Behavioral Health Services offered methadone medication-assisted treatment services. We asked DHEC to confirm whether this designation was correct, and DHEC stated that the facility was, in fact, not a medication-assisted treatment service provider. DHEC has since corrected this error.

We also noted that one address DHEC included in its list of outpatient CDAP treatment satellite locations is actually the location of a licensee. DHEC agreed that the inclusion of the licensee in the satellite list was an error that has since been corrected. The removal of the licensee from the original list of 27 satellites left a total of 26 satellite locations. One of the 26 satellite locations is a satellite of the Williamsburg County alcohol and drug abuse authority. However, this location in Hemingway is closed since its parent authority no longer receives funding. The satellite list DHEC provided also had at least five errors in the address listings for the allied facilities.

Lack of Transportation Undermines Access to Treatment

As mentioned earlier, eight local alcohol and drug abuse authority directors we interviewed noted that lack of transportation is a major barrier to accessing care. Transportation is particularly difficult for patients living in rural areas. This issue was echoed by the directors of five opioid treatment facilities we interviewed. We determined that 16 of the 26 (62%) outpatient CDAP treatment satellite locations are in rural communities.

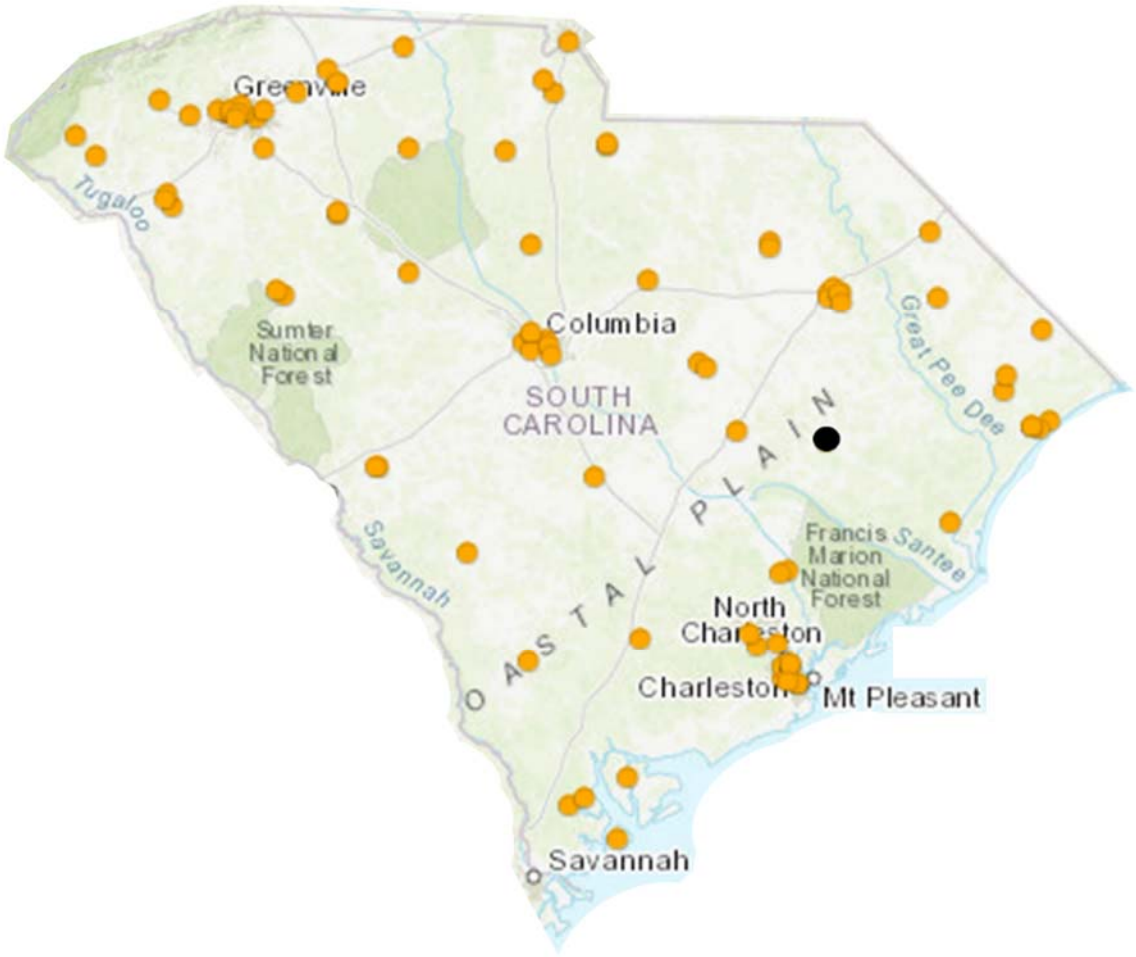
Issues Not Including Satellite Locations on the Find a Facility Table Listing or Map

If the purpose of DHEC's Find a Facility website is to help persons seeking treatment services locate the treatment facilities nearest them, the exclusion of satellite locations from the mapping tool could be a deterrent if the searcher does not find a treatment facility near his residence.

When the satellite locations for outpatient CDAP treatment licensees are added to the Find a Facility map, 11 of the satellite facilities appear in areas of the state where there are no other providers visible in the immediate vicinity.

Charts 3.15 and 3.16 show the differences in the Find a Facility map showing only outpatient CDAP treatment licensees and the Find a Facility map that includes both the licensees and their satellite locations. We added the satellite locations manually using the DHEC Find a Facility webpage's ArcGIS capabilities. As 62% of the satellite locations are classified as rural, and as persons seeking treatment who live in rural areas may have difficulty getting transportation to treatment providers, including the satellite locations of outpatient CDAP treatment licensees in the Find a Facility table listing and the map may encourage more persons who are rurally situated to seek treatment for substance use addiction.

Chart 3.15: Licensed Outpatient CDAP Treatment Providers, as of January 24, 2022

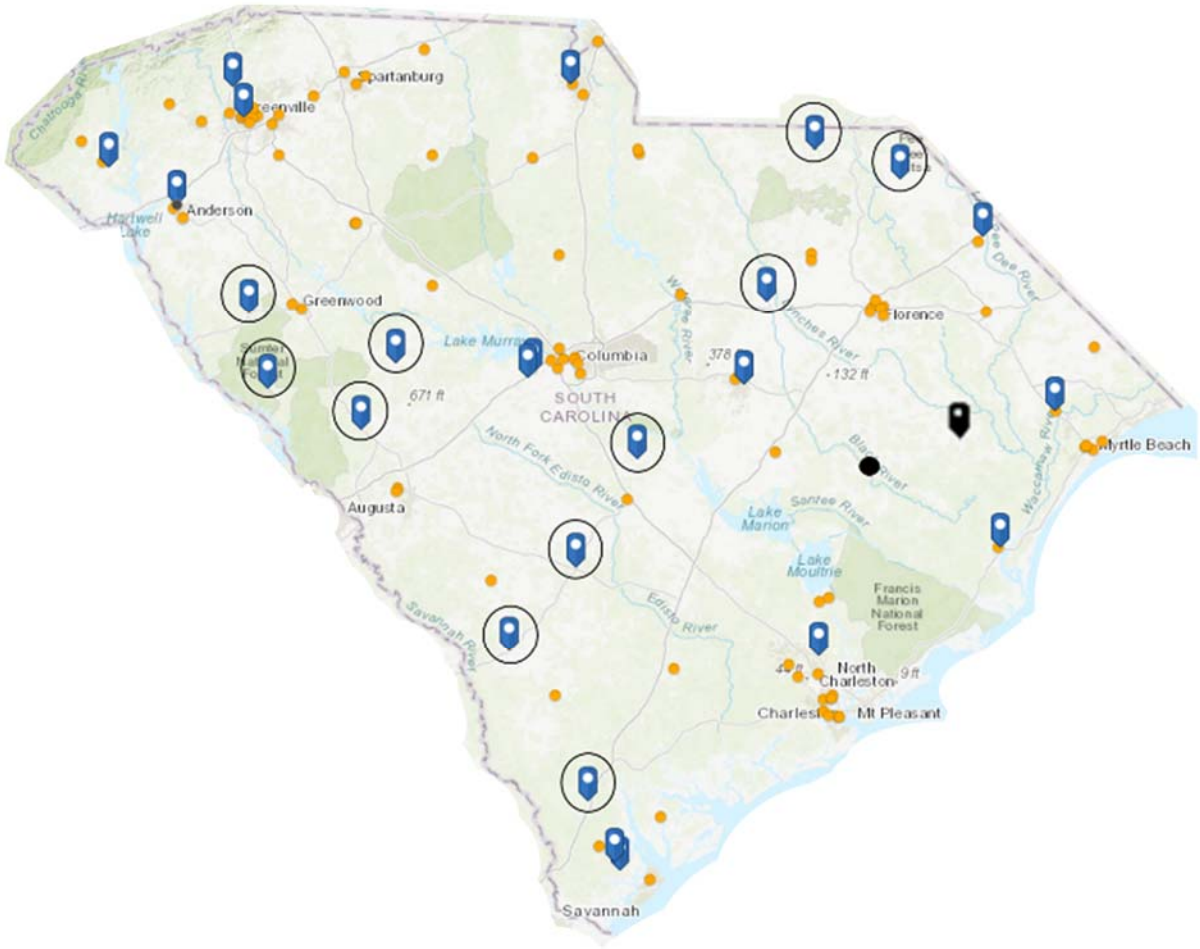


Outpatient CDAP Treatment Provider Licensed by DHEC

Closed Outpatient CDAP Treatment Provider Licensed by DHEC

Source: DHEC, LAC

Chart 3.16: Licensed Outpatient CDAP Treatment Providers and their Satellite Locations, as of April 29, 2022



Outpatient CDAP Treatment Provider Licensed by DHEC

Closed Outpatient CDAP Treatment Provider Licensed by DHEC

Satellite Location Appearing to Serve as Sole Provider in General Vicinity

Satellite Location for Outpatient CDAP Licensee

Closed Satellite Location for Outpatient CDAP Licensee

Source: DHEC, LAC

Recommendations

42. The S.C. Department of Health and Environmental Control should ensure that the locations of all outpatient CDAP treatment licensees and their satellites are included in the Find a Facility table listing and map on its website.

43. The S.C. Department of Health and Environmental Control should ensure that its published information for healthcare treatment licensees included on the Find a Facility webpage is timely, accurate, and complete.

Effectiveness of Non-Opioid Services

We reviewed DAODAS' evaluation of effectiveness of non-opioid services and found DAODAS:

- Relies on self-reporting and surveys to determine effectiveness of prevention strategies and treatment services.
- Uses the number of individuals served as the measure for effectiveness.
- Fails to assess the effectiveness of gambling addiction services.

DAODAS is missing an opportunity to improve the quality of addiction services and increase service outcomes.

DAODAS Evaluation of Effectiveness of Services

The performance of some of DAODAS' prevention strategies is based on self-reported survey responses. For example, DAODAS seeks to reduce the past-30-day use of alcohol and past-30-day use of tobacco in South Carolina high school students. The performance measure used to determine effectiveness of these prevention efforts is a self-reported, youth risk behavior survey. DAODAS also seeks to reduce retail availability of cigarettes to those under the age of 18. The effectiveness of these efforts is measured with the federally-mandated Synar Study. DAODAS' overall prevention effort to increase the number of people who receive prevention services is targeted to the state's population; no real measures are in place to determine effectiveness of these efforts. In conversations with local alcohol and drug abuse authorities, one local authority stated "DAODAS' prevention deliverables aren't outcome focused; instead, DAODAS is just focused on how many people are served, which isn't effective."

Many performance measures for treatment services emphasize increasing the number of patients, admissions, and/or services. While these measures are important, increasing the number of patients, admissions, and/or services does not indicate if the treatment efforts are working.

We interviewed ten local alcohol and drug abuse authorities to determine how they define and measure effectiveness. Local authorities administer a standard survey, the Government Performance and Results Act survey, required by SAMHSA. The survey measures patient satisfaction, recidivism, substance use while in the program, hospital or emergency room visits for alcohol or drug abuse, arrests, the time between patient contact and date of intake, and the time between assessment and first clinical service, among other factors. Local authorities administer this survey to patients 90 days after discharge. Local authorities compare responses to those received at the beginning of treatment. However, administering this instrument is challenging because some patients are incarcerated, cannot be reached, or choose not to participate. Surveys rely on self-reporting, an approach to data collection which is subjective and potentially yields inaccurate results.

DAODAS has no metrics and does not measure the effectiveness of gambling addiction services. A DAODAS official explained the agency does not have specific metrics to evaluate gambling treatment services, nor must local authorities submit deliverables documenting the services they provide to individuals with a gambling addiction. DAODAS counts the number of individuals assessed for gambling treatment services. A DAODAS official told us that information about the effectiveness of gambling services is inherent in the *Treatment Programs Manual*. However, we found nothing in the *Treatment Programs Manual*.

We reviewed research on the subject of evaluating gambling treatment outcome measures. Many of the outcome measures refer to the utilization of self-reporting surveys to determine abstinence from, or a reduction in, problematic gambling. In a 2019 review of an Oregon county's gambling treatment program, the performance measures used to evaluate the effectiveness of the gambling treatment services include the individual accessing treatment within five days and the retention of the individual in at least ten sessions.

Local Alcohol and Drug Abuse Authorities' Evaluation of Effectiveness of All Types of Addiction Services

While DAODAS does not conduct evaluations on the effectiveness of services, other than surveys and counts of individuals, some local alcohol and drug abuse authorities utilize performance measures to evaluate their effectiveness. The local authorities set measurable goals each year and are able to determine if those goals were met based on the performance measures in place. For example, one local authority sought to increase the identification and referral to services for adolescents at high-risk of substance use disorder by 10%, compared to the prior fiscal year. At the close of the fiscal year, the local authority determined it increased this measure by 8%. Without measurable performance metrics, local authorities are unable to determine if their services are effective in addressing the needs of their communities.

Importance of Performance Measures

Based on established clinical guidelines, clinical evidence, and/or expert consensus, performance measures offer standard, measurable formulas that can be consistently applied across various healthcare delivery systems. Performance measures can improve the quality of addiction treatment. The development of a core set of performance measures for addiction treatment is a critical first step.

Performance measures can be used to improve access to treatment and the quality of treatment for people with alcohol and other drug problems. One important aspect of the development and use of performance measures for alcohol and other drug services is continuum-of-care, which has four stages: prevention/education, recognition, treatment, and maintenance. Performance measures should be developed and used in each of these stages of care, because excellence in one domain at the expense of the others will result in less than optimal patient care.

Performance measures can be powerful tools for drawing attention to deficits in the current treatment systems, monitoring the effectiveness of efforts to improve quality, designing incentives for quality improvement, and targeting areas where quality improvement is needed.

Beginning in 2004, the Health Plan Employer and Data Information Set, a standardized tool used by most of the nation's health plans, added performance measures to assess treatment initiation and engagement rates for enrollees who have been diagnosed with an alcohol or other drug problem. These measures establish time-sensitive criteria for delivery of services on the front end of treatment. The initiation of treatment is measured on the basis of how many patients received addiction-related services within 14 days of diagnosis, the timeframe when patient motivation, an active ingredient of effective treatment, may be especially strong. Engagement is measured on the basis of how many patients go on to receive at least 2 additional addiction-related services within the next 30 days.

Previously, healthcare plans only calculated the percentage of patients who had received treatment for addiction and the average length of stay among patients who had been discharged from inpatient treatment. While these measures are useful in comparing utilization of treatment services, the new measures provide a better way to measure the processes of care that are integral to the success of long-term treatment for addiction.

Recommendations

44. The S.C. Department of Alcohol and Other Drug Abuse Services should develop and implement performance measures to evaluate the effectiveness of prevention strategies.

45. The S.C. Department of Alcohol and Other Drug Abuse Services should develop and implement performance measures to evaluate the effectiveness of treatment services.

46. The S.C. Department of Alcohol and Other Drug Abuse Services should research, develop, and implement valid and reliable performance measures to evaluate the effectiveness of gambling services.

Monitoring Process for Non-Opioid Services

We reviewed the agency's process for monitoring non-opioid related contracts with two select local alcohol and drug abuse authorities. We selected these particular authorities for review since the two counties served by these authorities were ranked highest for drug overdose deaths involving opioids in 2019 and 2020. We found that:

- There were multiple contract items missing, such as signatures, dates, and contract pages.
- DAODAS did not provide proof of documentation of all FY 20-21 non-opioid related contract deliverables.
- There were multiple late or missing FY 20-21 Substance Abuse Prevention and Treatment Block Grant (block grant) contract deliverables.
- The agency's FY 20-21 block grant deliverables list and tracking log did not include all required deliverables.
- The FY 20-21 block grant deliverables tracking log worksheet contained unexplained shading and data and formatting inconsistencies.
- There was no evidence that DAODAS uses data it collects as part of the contract monitoring process to make specific program improvements.

The agency's monitoring process for the block grant and other non-opioid related contracts is inadequate and may prevent DAODAS from satisfying Substance Abuse and Mental Health Services Administration (SAMHSA) requirements.

Issues with Contracts

We reviewed copies of FY 20-21 non-opioid related treatment contracts that DAODAS had with two select local alcohol and drug abuse authorities and found that the following items were missing:

- Dates
- Proof of electronic signatures
- Names on signature pages
- Contract pages

Incomplete Proof of Documentation of Contract Deliverables

We requested that DAODAS provide proof of documentation of FY 20-21 contract deliverables submitted by two select local alcohol and drug abuse authorities for non-opioid related contracts. These contracts include block grant contracts, DMH/DAODAS COVID-19 crisis response initiative grant contracts, and HIV Early Intervention Services grant contracts.

We reviewed documentation submitted by DAODAS and found that proof of a significant number of deliverables had not been provided, as shown in Chart 3.17.

Chart 3.17: Missing Proof of Documentation for Non-Opioid Related Treatment Contract Deliverables, FY 20-21

Contracts Reviewed	Number of Deliverables For Which Proof of Submission Was Not Provided By DAODAS	
	Provider 1	Provider 2
Block Grant Contract	20 of 48 (42%)	29 of 48 (60%)
DMH/DAODAS COVID-19 Crisis Response Initiative Grant Contract	27 of 28 (96%)	27 of 28 (96%)
HIV Early Intervention Services Grant Contract	18 of 20 (90%)	20 of 20 (100%)

Source: DAODAS and LAC Analysis

Late or Missing Block Grant Deliverables Per DAODAS Tracking Log Entries

SAMHSA provides block grant funding through DAODAS for local alcohol and drug abuse authorities to offer prevention services and treatment services for substance use disorders. In our review of the block grant deliverables log maintained by DAODAS of required submissions from subgrantees for FY 16-17 through FY 20-21, we found multiple submissions that were late or missing, as shown in Chart 3.18. However, the deliverables log maintained by DAODAS was not an all-inclusive listing of the block grant deliverables. DAODAS uses multiple tools to track the deliverables. This is a piecemeal approach that does not require a single point of contact to ensure all deliverables have been received.

The block grant deliverables log indicated all 32 local alcohol and drug abuse authorities had late submissions over the five-year period. (Note that now there are only 31 operating local alcohol and drug abuse authorities since Williamsburg County has closed.) However, 17 local alcohol and drug abuse authorities had missing submissions during the same period, with 1 authority not submitting 8 deliverables. DAODAS stated that the respective program manager should contact the local alcohol and drug abuse authority when a deliverable is late or missing and work with the authority on getting the deliverable submitted. However, the system used to submit the deliverables to DAODAS does not have an automated alert mechanism to warn of late or missing requirements. DAODAS stated it will not reimburse a local alcohol and drug abuse authority for services until deliverables are submitted. Because DAODAS must submit data to the SAMHSA, the timely submission of data to DAODAS is an important factor.

Chart 3.18: Late or Missing Block Grant Deliverables Per DAODAS Tracking Log Entries, FY 16-17 – FY 20-21

Fiscal Year	Number of Submissions from All Providers	
	Late*	Missing
16-17	51	6
17-18	64	3
18-19	62	17
19-20	85	15
20-21**	13	4

* Extensions approved by DAODAS were not included as a late submission.
** Approximately half the log for FY 20-21 had not been completed by DAODAS. Therefore, the data shown for FY 20-21 is not for the full fiscal year.

Source: DAODAS and LAC Analysis

Block Grant Deliverables Tracking Log and List Missing Other Required Items

DAODAS' FY 20-21 block grant deliverables list and tracking log do not contain other specific items that are required by the block grant contract. There are at least 15 additional requirements that do not appear to be tracked by DAODAS but must be monitored. Examples of these requirements include, but are not limited to, quality assurance plans, personnel standards, the Ignition Interlock Device Program, and tuberculosis programming. While DAODAS may have reviewed or inspected some of this documentation during past site visits, it is unclear how the agency has been monitoring these requirements since the cessation of site visits due to the COVID-19 pandemic.

Data and Formatting Inconsistencies in Block Grant Deliverables Tracking Log

We reviewed the FY 20-21 block grant deliverables tracking log maintained by DAODAS. We found that the FY 20-21 worksheet includes:

- Data that appeared to be incorrectly entered and cells with unexplained shading for which we found no explanation in the worksheet legend.
- Documentation of reports from providers on programs that some of those providers did not even offer.
- Identical submission dates for reports from all local alcohol and drug abuse authorities for programs that were not offered by all the authorities.
- No cells showing subsequent submission dates for updated Prevention Staff Capacity Plans or other documents that may need to be updated during a single fiscal year.

Lack of Use of Non-Opioid Related Contract Monitoring Data to Improve Effectiveness

We asked DAODAS to provide information on how it uses data it collects in monitoring non-opioid related contracts with local alcohol and drug abuse authorities and found no evidence that it uses the data to make improvements to or gauge the effectiveness of its programs. DAODAS specifically noted that it does not, for instance, employ specific metrics to evaluate gambling treatment services but merely counts the number of individuals who are assessed for gambling addictions. While DAODAS collects information from the electronic health record system of the local alcohol and drug abuse authorities, synthesizes that data for use within the agency, and provides quarterly patient outcome reports to the providers, there is no evidence these activities improve effectiveness on part of the agency.

Recommendations

47. The S.C. Department of Alcohol and Other Drug Abuse Services should ensure all non-opioid related contracts with local alcohol and drug abuse authorities have complete dates and signatures and contain all required pages.

48. The S.C. Department of Alcohol and Other Drug Abuse Services should gather proof of documentation for all non-opioid related contract deliverables.

49. The S.C. Department of Alcohol and Other Drug Abuse Services should endeavor to reduce the number of late or missing block grant contract deliverables.

50. The S.C. Department of Alcohol and Other Drug Abuse Services should ensure that all required elements of block grant contracts are included in contract deliverables lists and tracking logs.

51. The S.C. Department of Alcohol and Other Drug Abuse Services should endeavor to reduce the number of data and formatting inconsistencies in its contract deliverables tracking logs.

52. The S.C. Department of Alcohol and Other Drug Abuse Services should ensure that it analyzes all valid and reliable information collected pursuant to its contract monitoring process to make specific program improvements.

Administrative Areas

In this chapter, we report on the agency's management of carry-forward funds, provider reimbursement, staffing, internal audit, procurement cards (P-Card), website, and social media presence.

WHAT WE EXAMINED

- Carry-forward dollars and administrative costs.
- Reimbursement transactions from DAODAS to local alcohol and drug abuse authorities.
- DAODAS' staffing records.
- Survey of DAODAS' employees.
- The internal audit function of DAODAS.
- P-Card expenditure data.
- DAODAS' website and social media pages.

WHAT WE FOUND

- DAODAS allowed carry-forward dollars to lapse.
- Changes to reimbursement rates were not adequately documented.
- DAODAS failed to verify reimbursement rates for some providers before issuing final payments and failed to record payments.
- Staffing records were inaccurate.
- DAODAS failed to complete background checks consistently for all new hires.
- DAODAS has not fully implemented its internal audit function.
- Controls on the allocation and use of P-Cards are weak.
- DAODAS' website and its social media presence are potentially problematic, especially for those with hearing or visual disabilities.

Carry-Forward Dollars and Administrative Costs

We reviewed the agency's carry-forward dollars and administrative costs for FY 16-17 through FY 20-21 and found:

- For FY 17-18 and FY 18-19, DAODAS expenditure reports show it allowed over $90,000 of its carry-forward dollars to lapse each year.
- DAODAS' carry-forward funds are commingled with other general funds, allowing the agency's expenditure reports to show its carry-forward funds were overspent in FY 18-19.
- DAODAS did not expend any carry-forward dollars in FY 19-20 or FY 20-21.

DAODAS may have missed opportunities to utilize its carry-forward funds to increase services.

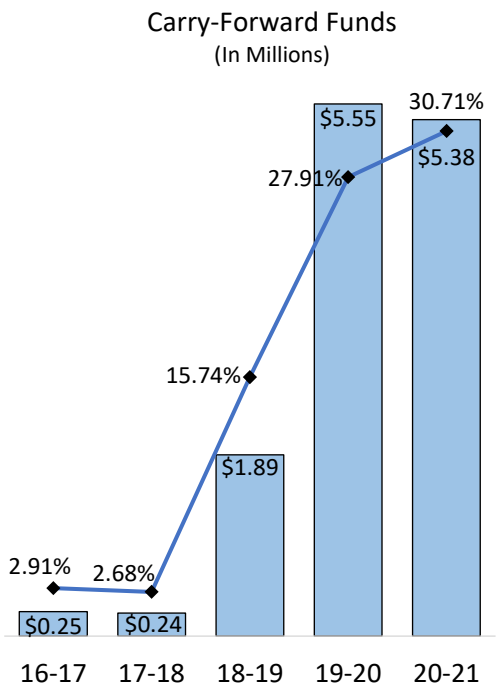
Carry-Forward Dollars

We reviewed DAODAS' carry-forward dollars and found the agency allowed funds to lapse, does not accurately track its use of carry-forward dollars, and did not expend any carry-forward funds in the last two fiscal years.

Proviso 117.23 of the FY 21-22 Appropriations Act allows all agencies to carry forward up to 10% of its general fund appropriations from the prior fiscal year, less any appropriation reductions for the current year. Since the FY 18-19 Appropriations Act and each act since, Proviso 37.4 has allowed DAODAS to carry forward from the prior fiscal year into the current fiscal year unexpended funds in excess of 10% to fund prevention, treatment, and recovery services for opioid addiction and addiction programs as prioritized by the department.

Chart 4.1 shows the carry-forward percentages and amounts for each of the last five fiscal years.

Chart 4.1: Total Carry-Forward Funds, FY 16-17 – FY 20-21



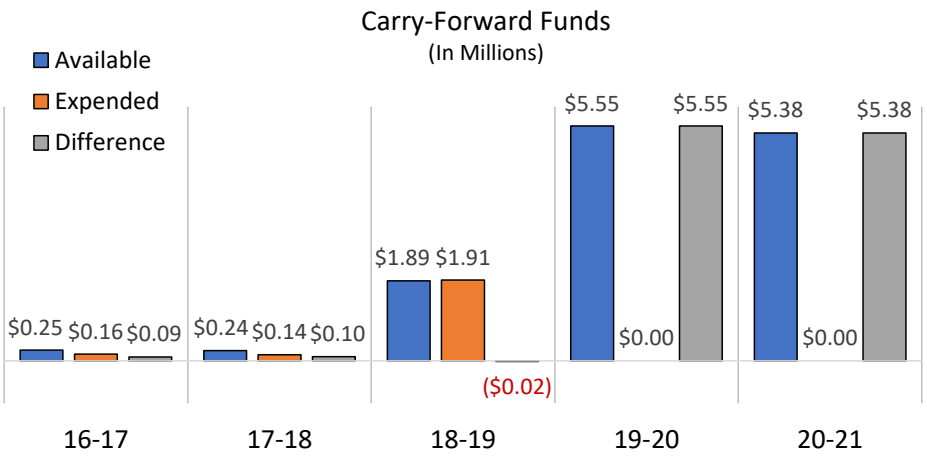
NOTES: Proviso 37.4 began in FY 18-19, removing the 10% cap on carry-forward. The percentages represent the total annual appropriations carried-forward.

Source: LAC Analysis of Comptroller General Data

DAODAS uses its carry-forward dollars to pay for medication, treatment, and medication-assisted treatment services for the local alcohol and drug abuse authorities.

Chart 4.2 shows the expenditures of carry-forward dollars.

Chart 4.2: Expenditure of Carry-Forward Funds, FY 16-17 – FY 20-21



Source: LAC Analysis of DAODAS Data

For FY 16-17 and FY 17-18, the carry-forward expenditure reports provided by DAODAS did not equal the total amount of carry-forward DAODAS had. We asked DAODAS for documentation on how the remaining funds were expended and were told "carry forward funds are used on medication-assisted treatment services along with various treatment services and medications and projects," but DAODAS did not provide documentation to support the expenditures of the additional funds. Without documentation of expenditures, it is possible DAODAS did not expend all of its carry-forward dollars. According to the Comptroller General's office, the 10% carry-forward excludes amounts carried forward from the prior year. Therefore, if DAODAS left over $90,000 in carry-forward funds in FY 16-17 and FY 17-18 unexpended, the carry-forward funds would have lapsed.

According to the expenditure reports provided by DAODAS, the agency revealed that it had over-expended its carry-forward dollars by nearly $18,000 in FY 18-19. The carry-forward dollars were used to pay for medication-assisted treatment and the collegiate recovery program at the University of South Carolina. When asked, DAODAS could not explain what additional funds were used to supplement the carry-forward dollars for FY 18-19's expenditures.

According to the Comptroller General's office, carry-forward funds are budgeted funds, meaning South Carolina Enterprise Information System (SCEIS) will not allow them to go negative; therefore, DAODAS could not have overspent its carry-forward funds in FY 18-19. However, expenditure reports from DAODAS show the carry-forward dollars are kept in the general fund, allowing the carry-forward dollars to be commingled with general fund dollars. According to the Comptroller General's office, there is no requirement to reclass the carry-forward dollars to keep them separated from general funds; and there is generally no way to tie current year expenditures to carry-forward funds without reclassing the funds to a separate account. DAODAS did not reclass any of the carry-forward dollars for FY 16-17 through FY 20-21. We asked DAODAS how carry-forward dollars are differentiated from general funds and were told DAODAS assigns internal order numbers to special projects internally for tracking expenditures. However, DAODAS' internal tracking system allowed carry-forward expenditure reports to show more carry-forward funds expended than budgeted.

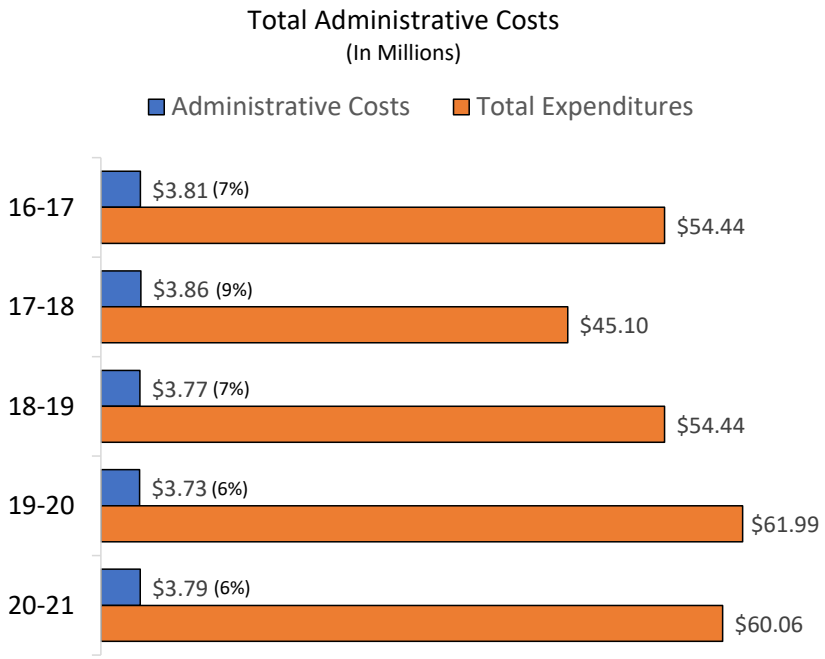
We received conflicting information about the use of carry-forward funds in FY 19-20 and FY 20-21. A DAODAS official stated that during the COVID-19 pandemic, carry-forward dollars were used to pay for telephone and telehealth services. However, when we requested documentation supporting those expenses, DAODAS stated the carry-forward funds in FY 19-20 and FY 20-21 were not expended but carried forward. According to the Comptroller General's office, Proviso 37.4 allows DAODAS to carry forward a combination of current year appropriations and unexpended carry-forward dollars from prior years. Use of the carry-forward funds in FY 19-20 and 20-21 could have increased DAODAS' support services.

According to DAODAS, FY 21-22 carry-forward dollars are being used to pay for medication-assisted treatment and to bridge the gap of federal funding for various treatments and medications.

Administrative Costs

We reviewed DAODAS' administrative costs and found the costs have been relatively constant, representing approximately 7% of agency spending annually. Administrative costs are defined as personnel, fringe, and operating costs. Operating costs include insurance, IT services, copies, etc., and a contract medical director. Chart 4.3 shows the total administrative costs from FY 16-17 through FY 20-21.

Chart 4.3: Total Administrative Costs, FY 16-17 – FY 20-21



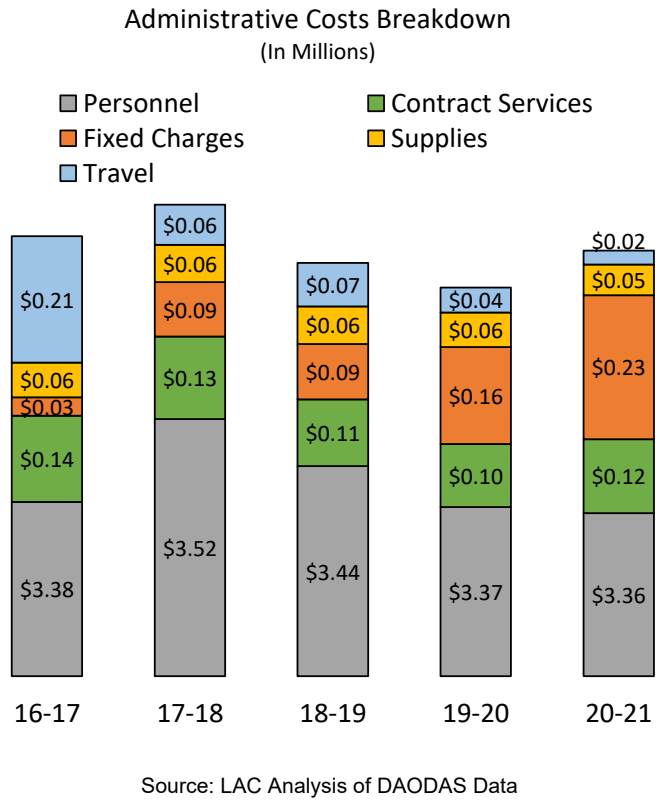
NOTE: Figures are rounded.

Source: LAC Analysis of DAODAS Data

DAODAS' administrative costs are paid with general funds, federal funds, earmarked funds, and restricted funds. A DAODAS official explained the earmarked funds are from various outside sources, such as Medicaid and BlueCross BlueShield Foundation, among others; and restricted funds are from the S.C. Education Lottery for use on gambling addiction services. Between 58% and 65% of the administrative costs are paid with federal funds each fiscal year.

Chart 4.4 shows the breakdown of the administrative costs.

Chart 4.4: Breakdown of Administrative Costs, FY 16-17 – FY 20-21



Source: LAC Analysis of DAODAS Data

Approximately 90% of the administrative costs cover personnel—between $3.3 million and $3.6 million. A DAODAS official explained the increased cost for travel for FY 16-17 reflects DAODAS' Food and Drug Administration grant with nine inspectors which included travel for inspections, labeling and licensing tobacco products; these expenses were paid with federal dollars. The official also stated the increase in fixed amounts for FY 19-20 and FY 20-21 results from increase in data services and IT programs through the Department of Administration, Division of Technology—including additional servers, Microsoft® Teams, and email services.

Recommendations

53. The S.C. Department of Alcohol and Other Drug Abuse Services should reclass the carry-forward funds in South Carolina Enterprise Information System to keep them separate from general funds.

54. The S.C. Department of Alcohol and Other Drug Abuse Services should implement a more effective tracking system to ensure carry-forward expenditure reports include only carry-forward dollars.

55. The S.C. Department of Alcohol and Other Drug Abuse Services should utilize existing funds to support the agency's needs, as appropriate and allowable by law, and minimize funds carried forward each year.

Reimbursements to Local Alcohol and Drug Abuse Authorities

DAODAS reimburses local alcohol and drug abuse authorities for the cost of prevention, intervention, treatment, and recovery services for indigent patients. We found, however, that DAODAS has:

- Not accurately documented changes to reimbursement rates among various sources including the electronic health record (EHR) system, the Medicaid fee schedule, or *Treatment Programs Manual*.
- Paid higher reimbursement rates for some providers than allowed in the Medicaid fee schedule.
- Omitted select provider billing codes from the Medicaid fee schedule and *Treatment Programs Manual*.
- Not verified that invoiced reimbursement rates are accurate before payment is issued.
- Not accurately recorded reimbursement payments.

DAODAS may have overpaid reimbursements to some local alcohol and drug abuse authorities.

Overview

DAODAS' funding and compliance contracts with local alcohol and drug abuse authorities state that a subgrantee will be reimbursed monthly, if the subgrantee provides timely financial reports. DAODAS uses Substance Abuse Prevention and Treatment Block Grant funding to reimburse subgrantees for initial assessments, assessment update services, outpatient treatment, and intensive outpatient treatment services for indigent patients who do not have insurance coverage. According to the funding and compliance contract, DAODAS will "… reimburse providers for assessments using the Medicaid fee schedule until the funding has been exhausted."

Total reimbursements to local alcohol and drug abuse authorities from FY 16-17 to FY 20-21 are found in Appendix A; Chart 4.5 is a summary for the same period. DAODAS provided the following reimbursement amounts.

Chart 4.5: Summary of Reimbursements to Local Alcohol and Drug Abuse Authorities

AMOUNT	REIMBURSEMENT
$201M	Local alcohol and drug abuse authorities.
$92.5M	21 local alcohol and drug abuse authorities in areas considered rural.
$108.6M	11 local alcohol and drug abuse authorities in areas considered non-rural.

Source: LAC Analysis of SCEIS Data

Providers must submit reimbursement requests to DAODAS by the 8th working day of the month. DAODAS seeks to process reimbursement payments by the last week of the month.

Review of Reimbursement Transactions

We reviewed a judgment sample of reimbursement transactions from DAODAS to local alcohol and drug abuse authorities from 2020 and 2021 for accuracy and compliance with the applicable funding and compliance contract, the applicable Medicaid fee schedule, and the applicable *Treatment Programs Manual*. We reviewed providers with the greatest number of reimbursement transactions and the greatest amount of reimbursement funding. The local alcohol and drug abuse authorities we reviewed serve residents of Charleston County, Greenville County, Horry County, Lexington County, Richland County, Pickens County, and York County.

We identified a list of 1,801 reimbursement transactions totaling $37,047,456 requested by these authorities and selected 236 at random for review.

Reimbursement Rate Changes Not Accurately Documented

DAODAS has not accurately documented reimbursement rate changes among various sources including the EHR system, the Medicaid fee schedule, or *Treatment Programs Manual*. We found that local alcohol and drug abuse authorities in our sample submitted claims for initial and follow-up assessments at a rate higher than the applicable Medicaid reimbursement rate. Two DAODAS officials verified that the claims did not follow the applicable Medicaid reimbursement rates and were different than the fee schedules the agency previously provided us.

These officials confirmed the rates for these services were only updated in the EHR system after the agency sent an email in 2014 to the local alcohol and drug abuse authorities regarding the rate increases. The agency had not noted this change in the applicable fee schedules or *Treatment Programs Manual*. Failing to publish reimbursement rate changes in the EHR system, Medicaid fee schedule, and *Treatment Programs Manual* may limit the accuracy of reimbursement requests and payments.

Reimbursement Rates Not Consistently Applied

DAODAS reimbursed local alcohol and drug abuse authorities at rates higher than allowed in the Medicaid fee schedule. We found that DAODAS overpaid:

$3,807	For 976 medication management, in-office care coordination, and out-of-office care coordination claims in a 3-month period.
$1,095	For 179 in-office care coordination and out-of-office care coordination claims in a 9-month period.
$411	For 50 medication management and medication management facilitated by a nurse practitioner claims in a 12-month period.

According to DAODAS, reimbursement rates billed by a provider typically follow the Medicaid fee schedule and should only differ if the billing code has a modifier that establishes a different rate based on a clinician's education level. For example, a clinical psychologist earns $48 for performing an hour-long session of group psychotherapy while a nurse practitioner earns $62. Conversely, DAODAS also told us that a provider may bill at a rate higher than what is listed on the Medicaid fee schedule or applicable *Treatment Programs Manual* as providers are reimbursed at the rates in accordance with their agreements with DAODAS. Reimbursing providers at rates that are higher than allowed reduces the number of patients that can receive subsidized substance use treatment and the overall reach of grant funding. Additionally, it is not equitable for DAODAS to reimburse local alcohol and drug abuse authorities at disparate rates.

Select Billing Codes Not Recorded in Fee Schedule and *Treatment Programs Manual*

DAODAS does not ensure that all relevant billing codes are included in the Medicaid fee schedule and *Treatment Programs Manual*. We identified several reimbursement transactions that included claims for billing codes that were not listed on the fee schedules or *Treatment Programs Manual* the agency provided us. We selected two invoices from our sample for DAODAS to review which included claims for one specific code. We requested documentation that showed the rate for this code and a DAODAS official referred us to a specific page in the agency's *Treatment Programs Manual*. However, the relevant information was not found in that document. Furthermore, the relevant information was not recorded in the fee schedule. Documenting a comprehensive list of reimbursable billing codes in the Medicaid fee schedule and *Treatment Programs Manual* ensures that each provider is aware of all the substance use treatment services DAODAS will subsidize for qualified patients.

Invoiced Rates Not Verified

DAODAS does not ensure that the reimbursement rates on provider invoices are accurate against the Medicaid fee schedule before it processes payment. DAODAS uses CareLogic©, a web-based EHR system where billing code rates are preset according to the Medicaid fee schedule or other agreed-upon rates, to process reimbursement requests. Once grant program managers review the deliverables that local alcohol and drug abuse authorities submit for contract compliance, they inform the finance division that electronic invoice submissions are acceptable for reimbursement. According to a DAODAS official, staff in the finance division are not responsible for verifying that the rates on an invoice are correct before submitting a reimbursement payment. Verifying the rates on reimbursement requests submitted by providers can reduce and prevent inaccurate and fraudulent payments.

Reimbursement Payments Are Not Recorded Accurately

DAODAS does not ensure that reimbursement payments are accurately recorded. DAODAS provided us with a report of the total amount of grant funding it allocated to local alcohol and drug abuse authorities from FY 16-17 through FY 20-21. We retrieved a report of reimbursement transactions requested by local alcohol and drug abuse authorities from SCEIS for the same period. We identified two authorities were paid using more than one vendor number in FY 19-20 and FY 20-21. We found that DAODAS paid one of these authorities $2.5 million more than the amount of funding it reported to us because it failed to include one of the vendor numbers used to pay this authority in its report of grant funding. DAODAS can ensure that reimbursement payments are accurately recorded by using one vendor number per provider when issuing reimbursement payments.

Recommendations

56. The S.C. Department of Alcohol and Other Drug Abuse Services should ensure that reimbursement rate changes are accurately documented in the *Treatment Programs Manual* and Medicaid fee schedules provided to local alcohol and drug abuse authorities.

57. The S.C. Department of Alcohol and Other Drug Abuse Services should ensure that reimbursement rates are consistently applied to each provider.

58. The S.C. Department of Alcohol and Other Drug Abuse Services should evaluate the reimbursement rates set in the Medicaid fee schedule, *Treatment Programs Manual,* and reimbursement payment system for accuracy.

59. The S.C. Department of Alcohol and Other Drug Abuse Services should ensure that staff in the finance division verify that reimbursement rates are accurate according to the applicable billing code prior to issuing payment.

60. The S.C. Department of Alcohol and Other Drug Abuse Services should ensure that it assigns one vender number per provider.

Staffing

We reviewed DAODAS' staffing records, from January 1, 2003 – December 31, 2004 (when the agency went through a reduction-in-force), and January 1, 2017 – December 1, 2021, and found:

- Staffing records are not adequately maintained.
- Three employees, including one high-level employee, were not included in the 2003–2004 staffing data.
- One current employee was included on the organizational chart but not included in the staffing data for 2017–2021.
- More than half of DAODAS' employee survey respondents feel the agency is not adequately staffed to meet demands.
- There is record of only one background check on all current DAODAS employees, as of March 25, 2022; and several high-level employees have an unknown background check status.
- DAODAS did not have an epidemiologist from October 2021 to June 2022.

DAODAS does not have timely, accurate, or complete staffing data, there is an increased risk of fraud, and important job functions might not be accomplished.

Staffing Between January 1, 2003 and December 31, 2004

DAODAS officials stated the agency underwent a reduction-in-force, during the period from 2003–2004; and the staff size was reduced by more than half. We reviewed staff records for DAODAS employees employed between January 1, 2003, and December 31, 2004, a period of time during which DAODAS reduced its staff size from 94 employees to 25 employees. Of the 25 remaining employees, 7 employees were still employed by DAODAS, as of March 25, 2022. However, there were six employees hired before 2003 that were not included in the data; three of those six employees are still employed with DAODAS, as of March 25, 2022, including one high-level employee.

Staffing Between January 1, 2017 and December 1, 2021

We also reviewed staff records for DAODAS employees employed from January 1, 2017–December 1, 2021. According to DAODAS, there were 78 people employed throughout that timeframe. We reviewed the organizational chart of DAODAS, as of August 17, 2021. At that time, DAODAS had 40 employees and 2 vacancies. We also reviewed an updated organizational chart for DAODAS, as of March 25, 2022. DAODAS had 39 employees, 4 vacancies, and 2 employees starting their positions in April 2022. We found one employee who was included on both organizational charts, but not included in the staff reports. We confirmed that the employee was hired in May 2021, a date which fell within the timeframe reviewed. With the addition of the excluded employee, the staffing data showed that on December 1, 2021, DAODAS had 38 employees.

Employee Survey

We surveyed DAODAS employees (see Appendix B) and found that approximately:

55%	Do not feel DAODAS is adequately staffed to meet the demands of the agency.
21%	Feel they must work overtime weekly to meet deadlines.
41%	Feel they must work overtime monthly to meet deadlines.
41%	Are unsure if personnel turnover has occasionally negatively impacted DAODAS' ability to perform effectively.

We also interviewed ten local alcohol and drug abuse authorities, five of which stated there are issues with DAODAS being understaffed or having too much turnover. We did not conduct a turnover analysis, but our review of staffing records did not raise any concerns about turnover.

Background Checks

DAODAS has not completed background checks on all new hires. Although not required by state law, background checks on job candidates prior to being offered a position is good business practice. Of all 79 employees employed with DAODAS between January 1, 2017 and December 1, 2021, 12 (15%) background checks were conducted. Of the 37 employees hired January 1, 2017, or later, 5 (14%) background checks were conducted. Of the 42 employees hired before January 1, 2017, 7 (17%) background checks were conducted.

Of the 38 employees still employed with DAODAS as of December 1, 2021, only one background check had been conducted. The last background check was conducted in October 2019; employees hired after October 2019 have not had a background check. According to DAODAS' staff reports, there were 30 employees with unknown background check statuses; 15 employees are still employed with DAODAS, as of March 25, 2022. Of the 15 current employees with unknown background check statuses, several are high-level employees, including the agency director and chief of staff. The employee excluded from the staffing data also did not have a background check completed, as of April 21, 2022.

A DAODAS official stated background checks could not be conducted, or were conducted reluctantly, due to not having a P-Card to pay the fee (see *P-Card Purchases and Assignments*). As of April 21, 2022, a P-Card was provided to pay the fee for background checks. Without background checks, DAODAS has increased risk of fraud and/or potential for harm.

Epidemiologist Vacancy

The epidemiologist position at DAODAS had been vacant since October 20, 2021. On June 17, 2022, DAODAS filled this position. The epidemiologist position supports DAODAS' efforts to understand the impact of substance use disorders in the state, identifying areas at risk of increased use, increased disease prevalence, increased opioid overdoses, and increased infectious diseases related to drug use. The epidemiologist also collects, reviews, analyzes, and interprets statistical data and prepares and publishes reports and maps on substance misuse and substance use disorder in South Carolina.

DAODAS posted the position for an Epidemiologist I, on October 6, 2021. The job posting advertises a salary between $60,000 and $70,000—a review of Epidemiologist I salaries, in South Carolina state government, indicates the typical salary is below $54,000. However, the average of Epidemiologist I salaries is $60,094.

In the absence of an epidemiologist, the duties this employee would normally perform have had to be performed by other DAODAS employees and DHEC staff. However, several functions cannot be performed by other staff because they lack the skills. For example, an epidemiologist interprets agency data, a task that cannot be conducted by someone other than an epidemiologist. Additionally, there are 14 committees/coalitions on which the DAODAS epidemiologist serves.

Liaisons at Other State Agencies

DAODAS has various liaisons at other state agencies. All of the liaisons are funded with federal dollars. These agencies include:

S.C. DEPARTMENT OF CORRECTIONS (SCDC)
S.C. DEPARTMENT OF MENTAL HEALTH (DMH)
S.C. DEPARTMENT OF SOCIAL SERVICES (DSS)

DAODAS has three liaisons, who are DAODAS employees and included in the aforementioned count of employees, who spend part of their time working with inmates with substance use disorders at SCDC. DAODAS also pays 100% of the salary and fringe benefits for a supervisor, employed solely by SCDC, working with inmates with substance use disorders. The memorandum of agreement (MOA) between DAODAS and SCDC began October 1, 2021, and will terminate on September 30, 2022. The DAODAS employees will directly assist in inmates' transition process from SCDC prison to local substance use disorder treatment providers. The services may include, but are not limited to, holding information sessions with inmates, maintaining contact with post-release inmates up to 90 days from release to ensure connection to services, and educating inmates on the use of nasal naloxone.

DAODAS also has a liaison at DMH and DSS. Both of these liaisons are employees of their respective agencies, but DAODAS pays 50% of their salaries and fringe benefits. DAODAS' portion of the DMH liaison salary is paid with State Opioid Response grant funds and the DSS liaison salary is paid with screening, brief intervention, and referral to treatment funds.

The MOA between DAODAS and DMH states the liaison will be employed by DMH, but will serve between both agencies to improve collaboration and communication. The DMH liaison contract began January 1, 2020, and automatically renews on June 30 for a maximum term ending June 30, 2024.

The liaison's role includes promoting the "no wrong door" treatment emphasis for South Carolina citizens living with mental illnesses and substance use disorders, in addition to facilitating trainings, attending leadership meetings for both agencies, and assessing the need for and implementation of evidence-based practice cross-training. "No wrong door" is an initiative where treatment facilities (mental health or substance use disorder) do not turn anyone away, but either accepts them as a patient or refers them to the appropriate service provider.

The MOA between DAODAS and DSS states the liaison will be employed by DSS, but will serve between both agencies to improve collaboration, coordination, and communication. The DSS liaison contract began on April 1, 2020, and automatically renews on June 30 for up to four additional years. The liaison's role includes serving on an extensive list of committees and coalitions, attending leadership meetings for both agencies, and focusing attention on pregnant and post-partum women, and their children.

Staffing in Neighboring States

SAMHSA maintains a directory of the single state authority for substance abuse services in each of the 50 states. According to the directory, the location of each state's substance abuse services is within:

- Standalone substance abuse/addiction agencies (3)
- Department of Health/Human Services (28)
- Department of Mental/Behavioral Health (13)
- Department of Social Services (2)
- Department of Aging (1)
- Other miscellaneous departments (3)

We contacted ten states to obtain comparative information about the staffing levels for the equivalent of DAODAS in their states. The ten states contacted are:

New York	Tennessee
Pennsylvania	Georgia
West Virginia	Florida
Virginia	Alabama
North Carolina	Louisiana

Like South Carolina, only New York and Pennsylvania had a standalone alcohol and drug abuse agency, but neither state responded to our request for comparative data. Despite our attempts to elicit information from these states, only three agreed to provide information. The responses are detailed in Chart 4.6.

Chart 4.6: Other State Responses Regarding Structure and Staff

STATE	RESPONSE
Tennessee	Division of Substance Abuse Services is within the TN Department of Mental Health and Substance Abuse Services 31 staff 2 vacancies
Virginia	Substance Use/Addiction Services is within the VA Office of Behavioral Health Wellness 13 staff 0 vacancies
North Carolina	Substance Use Division is within the NC Department of Health and Human Services 159 staff 32 vacancies

Source: LAC Analysis of Other State Responses

Recommendations

61. The S.C. Department of Alcohol and Other Drug Abuse Services should review its current tracking system for agency employees and ensure its staff data is timely, accurate, and complete.

62. The S.C. Department of Alcohol and Other Drug Abuse Services should request that the S.C. Department of Administration, Human Resources Division, conduct an analysis to ensure that it has adequate staffing to meet its statutory obligations.

63. The S.C. Department of Alcohol and Other Drug Abuse Services should conduct and document background checks on all employees to develop a record and ensure all employees have passed background checks.

Results of Employee Survey

We surveyed all DAODAS staff, excluding the DAODAS director. We designed both closed- and open-ended questions to obtain anonymous feedback on issues including staffing, funding, internal coordination of work functions, opportunities for improvement, and relations between the agency and outside stakeholders and found the following:

Employees who do not feel the agency is adequately staffed to meet its demands.
Issues with agency hiring and recruiting of additional staff.
Employees who must occasionally assist others to meet a deadline before completing their own work.
Employees concerned with the inability to work remotely and a lack of adequate training.
Employees who expressed positive thoughts on the agency's diligence and performance.
Employees who believe the agency takes steps to improve collaboration with providers to increase service accessibility, to improve outreach to clients during the COVID-19 pandemic, and to deliver an appropriate response to the opioid epidemic.
The agency adequately considers the impact its decisions regarding policies and procedures have on service providers.
The agency is committed to getting information from its external stakeholders through meetings, telephone calls, and emails, about how to improve prevention and treatment services.

We contacted DAODAS employees through their agency e-mail addresses. Of the 37 potential respondents, we received responses from 29 employees, yielding a response rate of 78%. A complete list of aggregated responses can be found in Appendix B but a summary of the survey responses appears in Chart 4.7. We summarized open-ended responses and referenced them throughout the report. We designed the survey using question logic to direct respondents to specific questions based on their responses. This resulted in some questions with low response counts as they only applied to a small number of employees.

Chart 4.7: Summary of DAODAS Employees' Responses

PERCENT	RESPONSE
28%	A minority of respondents have been at the agency for over ten years.
41%	Fewer than half of respondents have been at the agency less than three years.
58%	A majority of these respondents believe senior management staff and their direct supervisor are open to employee suggestions for improving productivity and quality of services.
21%	Almost a quarter of respondents say they must occasionally work overtime daily or weekly to meet a deadline.
63%	A majority of respondents that have worked at the agency for more than ten years say they must occasionally work overtime monthly to meet a deadline.
48%	Slightly less than half of respondents say they must occasionally assist other employees to meet a deadline before they complete their own work.
79%	A majority of these respondents do not believe the agency is adequately staffed to meet the demands of the agency.
38%	Slightly more than one-third of respondents believe personnel turnover has occasionally negatively affected the agency's ability to perform effectively.
45%	Slightly less than half of these respondents do not believe the agency is adequately staffed to monitor and ensure service providers are meeting compliance requirements.
66%	Two-thirds of respondents believe that the agency adequately considers the impact its decisions regarding policies and procedures have on service providers.
59%	A majority of respondents believe the agency actively solicits input from service providers and other stakeholders when making and amending policies and procedures that will affect them.
72%	Almost three-fourths of respondents believe the agency is committed to getting information from its external stakeholders about how to improve prevention and treatment services.
72%	A majority of respondents believe the agency responds to questions from its external stakeholders in a timely manner.
62%	A majority of respondents believe the agency has always allocated funds for opioid-related services to areas of greatest need.

Source: LAC Survey of DAODAS Employees

Internal Audit Function

DAODAS does not have a viable or sufficient internal audit function. We reviewed the internal audit function of DAODAS and found:

- No risk assessment to evaluate what areas of the agency need to be reviewed.
- An outdated audit plan, reportedly developed with the assistance of an expert from outside the agency, that is not dated, contains the word "draft" in two locations, and calls for an internal audit to be completed in FY 20-21 which was never done.
- No audit schedule identifying agency processes to be reviewed.
- No evidence of policies and procedures governing the internal audit function.
- Financial documents prepared as part of the agency's internal audit functions that do not contain signatures or dates, omissions that call into question whether agency management ever reviewed or approved them.

Employee Hired to Serve as Internal Auditor

On September 2, 2020, DAODAS hired a person to be its internal auditor and report to the agency director. However, as of August 2021, the agency's organizational chart listed the internal auditor as reporting to the agency's general counsel. Once the employee was hired, the employee was immediately assigned to assist in the agency's financial section instead of commencing direct internal audit work. The agency approved an internal audit charter in June 2021, but, as of May 2022, no audits had been completed.

No Audit Risk Assessment, Audit Schedule, or Policies and Procedures

DAODAS has never conducted an audit risk assessment even though the agency's internal audit charter requires adherence to the International Standards for the Professional Practice of Internal Auditing, published by the Institute of Internal Auditors (IIA). Section 2010.A1 of the IIA standards requires that the "internal audit activity's plan of engagements must be based on a documented risk assessment, undertaken at least annually." Risk assessments allow an internal audit program to ensure that the planning process involves and is understood by stakeholders as a basis for the risks identified. Risk assessment reports may ultimately contain interviews and documentation of identified risks, ranking of residual and inherent risks, and residual risk scores. By failing to undertake a risk assessment, DAODAS is violating its own charter, is non-compliant with professional standards, and is less likely to target areas of significantly higher risk, which may limit improvements.

Despite not having completed a risk assessment, DAODAS developed an FY 20-21 audit plan with the assistance of an audit professional from outside the agency. We requested, and agency officials provided, a copy of that plan. While the document is signed by the appropriate parties, it is not dated and refers to the plan as being a "draft" on two pages of the document.

The audit plan required the internal auditor to conduct an audit in FY 20-21, but the audit was never completed. Agency officials also stated that an audit schedule had been created prior to September 2021 but did not provide a copy of that schedule.

We also found no evidence that DAODAS had developed any policies or procedures for internal auditing. According to a DAODAS official, the agency relies on professional standards to serve as its policies and procedures. Section 2040 of the IIA Standards requires the chief audit executive to "establish policies and procedures to guide the internal audit activity." Policies form the written basis of operation in the audit department and represent the agency's position on the topics covered, prescribe limits, identify responsibilities, and indicate the parameters under which the department operates. Procedures provide instructions for implementing policies and describe sequences of activities for interpreting those policies. Documenting policies and procedures ensures effective quality assurance practices and may fulfill regulatory and/or accreditation requirements.

Projects Conducted by the Internal Auditor

In FY 20-21, the internal auditor completed an internal review of independent financial audits completed for each of the state's 32 local alcohol and drug abuse authorities and completed a financial case study report for one local alcohol and drug abuse authority. (One local authority has since been closed, so the current total is 31.) Agency officials stated that the financial compliance review and the case study were both internal audit projects. The financial compliance review consisted of a reconciliation of grant funding and expenditures of the local alcohol and drug abuse authorities with financial records of DAODAS. The case study was a specific financial review DAODAS completed for one local alcohol and drug abuse authority and was prompted by questions the county brought forth concerning FY 20-21 data issues. Neither document was dated, and the financial review was not signed; therefore, it is unclear whether agency management had reviewed or approved either document. As of May 2022, no other reviews or audits had been conducted by the internal auditor.

Recommendations

64. The S.C. Department of Alcohol and Other Drug Abuse Services should conduct an annual risk assessment before developing its audit plan to target areas that are of higher risk for fraud and abuse.

65. The S.C. Department of Alcohol and Other Drug Abuse Services should ensure that all internal audit plans reflect the risk assessment and should ensure that audit reports are dated, are appropriately marked as "draft" or "final," and are signed by authorized staff.

66. The S.C. Department of Alcohol and Other Drug Abuse Services should develop and follow policies and procedures for its internal audit operations.

67. The S.C. Department of Alcohol and Other Drug Abuse Services should ensure that all financial documents prepared as part of the agency's internal audit functions contain signatures and dates.

68. The S.C. Department of Alcohol and Other Drug Abuse Services should either modify its existing internal audit plan to require that an internal audit be conducted upon a given interval or should update the plan each year to reflect that the internal audit should be conducted for the current fiscal year.

P-Card Purchases and Assignments

We reviewed a sample of procurement card (P-Card) expenditures made by DAODAS from FY 16-17 through FY 20-21 and found purchases that violated state policy. We also found the agency's internal controls to prevent misuse were inadequate. We identified:

- DAODAS employees made purchases for travel-related lodging expenses using P-Cards that the agency did not designate as lodging cards.
- P-Card purchases made in violation of the Comptroller General's office policy of blocking certain merchant category codes (MCCs).
- A DAODAS employee was assigned multiple P-Cards in 2019, 2020, and 2021.
- P-Card purchases made by an individual not listed by DAODAS as the applicable cardholder.

Overview

State P-Card purchases are subject to the S.C. Consolidated Procurement Code and the South Carolina purchasing card policy and procedures. Bank of America (BOA) issues state P-Cards with assistance from the Comptroller General's office. P-Card purchases are subject to a single transaction limit (STL) of $2,500 and the code's small purchase "no competition limit" of $10,000. The agency head or governing board must provide prior authorization to employees before they use a P-Card for purchases that exceed the STL or the "no competition" limit. Employees cannot split purchases into multiple transactions to avoid the STL.

The Comptroller General's office establishes and manages MCC blocks to reduce unauthorized or prohibited purchases. BOA assigns an MCC to each merchant or vendor based on the type of goods or services the vendor typically provides. By blocking the MCC, BOA would decline any purchase attempted at a blocked vendor unless the Comptroller General's office provides an agency with prior written approval. An agency may send a request to the Comptroller General's office to unblock specific MCCs, but it may decline such requests.

State policy prohibits unauthorized purchases or unauthorized use of a P-Card by an individual other than the applicable cardholder. These actions can result in disciplinary action up to termination. Prohibited purchases include:

- Personal purchases of any kind.
- Cash advances in any form.
- Gift cards, stored-value cards, calling cards, pre-paid cards, or similar products.
- Employee travel expenses, including lodging, transportation (except airline tickets and rental cars), and meals.
- Entertainment.
- Alcoholic beverages.
- Tobacco products.
- Fuel for state-owned vehicles.
- Professional services.
- Food for consumption by state employees.
- Payment of state and local taxes.

Each agency must maintain an internal control process to ensure compliance with these policies. According to the P-Card policies provided to DAODAS cardholders, employees must supply the procurement officer with completed summary sheets and receipts by the 10th of the following month after the P-Card bill cutoff date. Supervisors must review transactions and receipts before signing off on the summary sheets.

Lodging Purchasing Card Program

The State of South Carolina lodging purchasing card program permits the use of certain P-Cards for employee travel-related lodging expenses. Lodging expenditures must not exceed the maximum lodging rates indicated by the U.S. General Services Administration without prior approval from the agency head. Employees must not incur discretionary charges for meals, beverages, discretionary charges, entertainment, internet/fax/computer services, laundry, or for lodging facilities that are within 50 miles of the official agency headquarters or employee's residence.

Review of Agency P-Card Purchases

We reviewed P-Card purchases made by DAODAS employees to determine if the agency has adequate internal controls to prevent misuse. We identified several areas where the agency needs to improve its internal controls to strengthen its P-Card administration, including general compliance with state policy regarding:

- Agency purchases made to vendors that have blocked MCCs.
- Which employees are using P-Cards.
- Which P-Cards DAODAS employees use for travel-related lodging expenses.
- Recordkeeping of agency P-cardholders.

DAODAS made 80 P-Card purchases from FY 16-17 through FY 20-21. We selected 20, at random, for review. We evaluated these purchases to determine compliance with the state's purchasing card policy and procedures and the state lodging purchasing card program policies.

Non-Compliance with State Law and Policy

The state's P-Card policy and procedures manual states that employee travel-related lodging expenses "… are prohibited by State policy. No exceptions will be granted unless obtained in writing...." Limiting employees to using authorized lodging P-Cards for travel-related lodging expenses will reduce the risk of fraud and misuse.

We identified 13 purchases, totaling $4,524, in travel-related lodging expenses using P-Cards that DAODAS did not list as authorized lodging P-Cards on documentation provided by the agency.

Chart 4.8: P-Card Purchases for Travel-Related Lodging Expenses, FY 16-17 – FY 20-21

Lodging Expenses	Amount
Oak Manor Inn – Hartsville, SC	$110
Sheraton Convention Center Hotel - Myrtle Beach, SC	$112
The Inn at The Crossroads – Lake City, SC	$133
The Inn at The Crossroads – Lake City, SC	$156
Elliott House Inn – Charleston, SC	$195
Gaylord Opryland Retail – Nashville, TN	$257
Gaylord Opryland Retail – Nashville, TN	$257
Gaylord Opryland Retail – Nashville, TN	$257
Gaylord Opryland Retail – Nashville, TN	$257
Embassy Suites – Nashville, TN	$441
Hyatt House – SC	$570
Gaylord Texan – Grapevine, TX	$805
Hyatt Regency Crystal CI - VA	$975
TOTAL	$4,524

Source: SCEIS

These purchases should have been blocked under the Comptroller General's office policy of blocking certain MCCs since DAODAS did not list the P-Cards used as authorized lodging P-Cards. We asked DAODAS for documentation to support these purchases and it told us that eight purchases were made using a P-Card that has always been an authorized lodging card for DAODAS. DAODAS provided us with internal approval for the remaining five purchases but did not clarify that the P-Card used for these purchases was an authorized lodging card.

Merchant Category Code Blocks Not Implemented Effectively

One important internal control for preventing potential abuse of the P-Card is the blocking of certain MCCs. During our review, we identified purchases made by agency employees at vendors that, in the absence of an exception by the Comptroller General's office, should have been blocked. The Comptroller General's office did not approve the purchases listed in Chart 4.9.

Chart 4.9: P-Card Purchases Which Should Have Been Blocked

Number	Description
3	Exam Professor subscription, a web-based tool used to create exams for education or training, totaling $72. Use of state P-Cards to purchase professional services should have been blocked. A DAODAS official stated that this is a monthly recurring charge approved by an employee in the IT department.
3	Civic, social, and fraternal associations totaling $643 which should have been blocked. DAODAS stated that a supervisor authorized one purchase for books/supplies, a supervisor approved one purchase for conference registration fees, and a supervisor approved one purchase for membership dues.
4	Miscellaneous house furnishing specialty shops totaling $777 which should have been blocked. According to DAODAS, one purchase was verbally approved for the purchase of a lamp for a manager's office and three purchases were for the purchase of pencil cases for Narcan® kits.
2	S.C. State Fair admissions totaling $270. Since this purchase was from an amusement park, it should have been blocked. DAODAS stated that there is an annual discussion among its executive management team regarding whether the agency will participate in the S.C. State Fair. According to DAODAS, once approved by the executive management team, the DAODAS procurement manager is notified to proceed with the purchase.
1	U-Haul totaling $140. Use of the P-Card to purchase truck and utility trailer rentals should have been blocked. DAODAS did not provide a written approval but told us this is a recurring monthly charge approved by a Food and Drug Administration (FDA) manager.
1	Mark Lundholm Enterprise totaling $2,500 which should have been blocked since this is for an entertainer. DAODAS provided an email clarifying that this purchase was for a deposit for speaker and comedian Mark Lundholm's air, hotel, and ground expenses.

Source: LAC Analysis of SCEIS Data

We requested documentation that shows the prior approval of these P-Card purchases. DAODAS officials only provided us with an explanation and documentation that showed internal approval for these purchases. However, the agency did not provide documentation showing where it received prior written approval from the Comptroller General's office to make any of these purchases at blocked vendors.

Cardholders with Multiple P-Cards

The state's P-Card policy and procedure manual states that there is a limit of "… one P-Card per Cardholder." Limiting P-Cards to one per cardholder can help reduce fraud and misuse. Increasing oversight of agency P-Cards and ensuring cardholders receive proper training of the requirements of the program can prevent frequently assigning more than one card to a cardholder in a calendar year. We identified one employee assigned:

2019	3 P-Cards, including one lodging P-Card
2020	3 P-Cards, including one lodging P-Card
2021	4 P-Cards, including one lodging P-Card

We asked DAODAS why it assigned this employee multiple P-Cards in a calendar year, but DAODAS did not provide us with an explanation. DAODAS informed us that, normally, it would assign an employee more than one card in a calendar year if:

- An employee loses his P-Card.
- An employee's P-Card is stolen.
- An employee's P-Card is damaged.
- The agency assigns an employee a lodging P-Card.

Improved Oversight of P-Card Program Needed

During our review, we identified eight purchases made by a DAODAS employee not listed as the applicable cardholder. We asked DAODAS about these purchases and an agency official stated that the cardholder left the agency in February 2021 and the agency reassigned the card to a different DAODAS employee. The agency had not noted this transfer in its records.

During the preliminary phase of our audit, a DAODAS official stated that borrowing other employees' P-Cards was necessary to complete job duties, a practice which may have given these employees access to confidential information. Agency staff told this official that the P-Card would not be in the employee's name because the agency already assigned enough P-Cards to other employees. In April 2022, seven months later, this DAODAS official informed us that a P-Card was received.

Recommendations

69. The S.C. Department of Alcohol and Other Drug Abuse Services should improve internal controls to ensure that employees only use specified South Carolina lodging P-Cards for travel-related lodging expenses.

70. The S.C. Department of Alcohol and Other Drug Abuse Services should comply with state policy and discontinue removing blocks on merchant category codes without prior authorization from the Comptroller General's office.

71. The S.C. Department of Alcohol and Other Drug Abuse Services should comply with state policy by limiting cardholders to one card per eligible employee.

72. The S.C. Department of Alcohol and Other Drug Abuse Services should improve internal controls to ensure that agency officials have an accurate record of agency cardholders to ensure internal records are accurate.

Website and Social Media

We reviewed DAODAS' website and social media pages and found:

- DAODAS' home page does not contain a direct link to any information on fentanyl, a substance responsible for a significant increase in overdose deaths in recent years, nor does it contain a direct link to information on how and where to obtain fentanyl test strips.
- Specific subjects (e.g., priority populations) that were linked in the earlier version of the agency's website are no longer linked on the latest version of the website or must be located using the search function.
- DAODAS' YouTube channel has not been updated in over a year and does not contain videos on nicotine, gambling, or illicit drug addiction other than for opioids.
- There are no pictures on any of DAODAS' webpages except for the agency's home and contact pages.
- DAODAS' website does not contain direct links to important consumer issues highlighted on other states' websites, such as crisis detoxification, sequential intercept mapping, and recovery courts.
- The website content or formatting has potential accessibility issues that may not conform with SC.GOV's accessibility policy.

Website and Social Media Content

As of June 2022, DAODAS' website contained 32 separate webpages. During our audit, between April 2022 and June 2022, we identified the following issues related to website and social media content.

Lack of Links to Fentanyl-Related Information on DAODAS' Home Page

The home page of DAODAS' website does not contain direct links to fentanyl-related pages sponsored by DAODAS. While there is a mention of fentanyl test strips that is included on DAODAS' Overdose Death Prevention website subpage, there are no links on the home page for information on fentanyl test strips, nor are there links to how or where to access the test strips. As the number of drug analysis cases involving fentanyl has increased by 2,593% between 2015 and 2021, and as the number of drug overdose deaths involving fentanyl have increased 105% from 2019 to 2020, the lack of information on fentanyl and fentanyl test strips on DAODAS' home page could result in consumers missing vital safety information.

Specific Subjects No Longer Readily Accessible on DAODAS' Website

Information and links that were readily available in an earlier version of the website were no longer directly available on the June 2022 version of the website. Such subjects include law enforcement, priority populations, qualified substance abuse professionals, the South Carolina Workforce Development plan, and the Partnership to End Addiction. The exclusion of or non-apparent linkage to these topics on the latest version of the website may be an impediment to persons needing this type of information.

DAODAS' YouTube Channel Lacks Timely Updates and Specific Addiction Information

We reviewed DAODAS' Twitter, Facebook, and YouTube social media pages and found that DAODAS has not uploaded new content to or otherwise updated its YouTube channel for at least one year. While each social media source contains a variety of prevention and recovery content, the YouTube page does not contain any videos addressing nicotine, gambling, or illicit drug (other than opioid) addiction. The Twitter and Facebook webpages appear to be updated routinely. As Facebook tops the list of the 20 most popular social media sites of 2022, with 2.9 billion monthly active users, DAODAS' frequent Facebook page updates are likely to garner a large number of viewers. However, YouTube has the second largest number of monthly active users at 2.2 billion and is the second largest social media site; as such, DAODAS may be missing opportunities to reach a larger audience by failing to more frequently update or expand the types of videos posted on its YouTube channel.

Few Visual Images on DAODAS' Website

The earlier version of the website contained pictures on every one of the eight main webpages, but the new version of the website contains pictures on only the home and contact webpages, which gives the viewer a text-heavy experience. According to a study conducted by the marketing company, Skyword, Inc., including images in online content increases views by 94%. The lack of pictures and images on DAODAS' website may limit the amount of internet traffic the website receives.

Section 508 Accessibility

Section 508 of the Rehabilitation Act of 1973 requires federal agencies (such as SAMHSA) to provide electronic and information technology that is accessible to persons with disabilities. SC.GOV websites use a variety of testing tools and adopt web content accessibility guidelines to ensure compliance with Section 508 requirements. One tool that can be used to assess web content accessibility guidelines is the U.S. Social Security Administration's ANDI Accessibility Testing Tool. We used this tool to check the entire DAODAS website map for accessibility issues and found that there were 325 total accessibility alerts. An accessibility alert indicates potential impediments to those with disabilities seeking information from DAODAS' website.

Comparison to Other State Substance Use Authority Websites

We reviewed the websites for four other states' substance use authority websites—Florida, Georgia, North Carolina, and Tennessee. Tennessee's website is particularly extensive, in that its home page contains links to items such as a substance use best practice tool guide, student surveys, crisis detoxification, fentanyl information and resources, recovery courts, criminal justice behavioral health liaisons, sequential intercept mapping, and a faith-based recovery network. DAODAS' home page does not contain links to these types of subjects, but its home page viewers may benefit from having direct access to this type of information.

Recommendations

73. The S.C. Department of Alcohol and Other Drug Abuse Services should provide direct links to information on fentanyl and fentanyl test strips on its home page.

74. The S.C. Department of Alcohol and Other Drug Abuse Services should consider including, on its current website, direct links to resources and information that were available on the previous version of its website.

75. The S.C. Department of Alcohol and Other Drug Abuse Services should more frequently update its YouTube channel and add video content related to nicotine, gambling, and illicit drug addiction, as well as fentanyl and fentanyl test strips.

76. The S.C. Department of Alcohol and Other Drug Abuse Services should consider adding more pictures or images to its webpages.

77. The S.C. Department of Alcohol and Other Drug Abuse Services should review and update its website content and structure to ensure compliance with SC.GOV accessibility policies.

78. The S.C. Department of Alcohol and Other Drug Abuse Services should review the content of the Tennessee substance abuse treatment authority home page and consider incorporating links to similar resources on its home page.

Total Reimbursements to S.C. Alcohol and Drug Abuse Authorities, FY 16-17 – FY 20-21

S.C. Alcohol and Drug Abuse Authority County	FY 16-17	FY 17-18	FY 18-19	FY 19-20	FY 20-21	TOTAL
South Carolina	**$ 37,661,614**	**$ 34,770,897**	**$ 39,087,689**	**$ 45,608,731**	**$ 44,083,111**	**$ 201,212,041**
Richland	$ 3,856,982	$ 4,032,314	$ 3,812,196	$ 3,679,095	$ 3,831,416	**$ 19,212,002**
Greenville	$ 3,699,699	$ 3,468,467	$ 3,477,153	$ 3,385,971	$ 3,348,539	**$ 17,379,829**
Charleston	$ 2,467,314	$ 2,712,034	$ 2,745,805	$ 2,806,648	$ 3,130,534	**$ 13,862,336**
Horry	$ 1,460,083	$ 1,902,772	$ 2,763,974	$ 3,736,054	$ 2,749,885	**$ 12,612,767**
York	$ 1,909,356	$ 1,951,933	$ 2,215,956	$ 2,383,757	$ 2,612,791	**$ 11,073,793**
Florence	$ 2,352,728	$ 1,743,388	$ 2,010,755	$ 1,796,187	$ 1,827,762	**$ 9,730,820**
Orangeburg	$ 1,929,065	$ 1,890,420	$ 1,871,699	$ 1,903,541	$ 1,880,852	**$ 9,475,577**
Spartanburg	$ 1,485,523	$ 1,379,637	$ 1,617,546	$ 1,976,360	$ 2,327,154	**$ 8,786,220**
Marion	$ 1,644,268	$ 1,193,227	$ 1,581,240	$ 1,838,151	$ 1,844,305	**$ 8,101,190**
Berkeley	$ 1,561,864	$ 1,298,611	$ 1,394,052	$ 1,521,175	$ 1,403,450	**$ 7,179,153**
Anderson	$ 1,469,203	$ 1,298,452	$ 1,361,065	$ 1,396,301	$ 1,280,961	**$ 6,805,981**
Kershaw	$ 819,857	$ 857,858	$ 1,413,138	$ 2,053,075	$ 1,427,622	**$ 6,571,549**
Pickens	$ 1,029,097	$ 964,026	$ 1,196,152	$ 1,638,313	$ 1,652,002	**$ 6,479,590**
Sumter	$ 961,239	$ 855,389	$ 1,088,443	$ 1,339,865	$ 1,396,231	**$ 5,641,167**
Dorchester	$ 964,036	$ 891,753	$ 1,064,321	$ 1,197,353	$ 1,338,079	**$ 5,455,541**
Greenwood	$ 1,035,538	$ 915,573	$ 953,223	$ 1,085,338	$ 1,007,952	**$ 4,997,625**
Laurens	$ 544,235	$ 517,904	$ 1,016,155	$ 1,285,107	$ 1,030,929	**$ 4,394,330**
Aiken	$ 817,324	$ 750,120	$ 748,187	$ 862,163	$ 1,151,702	**$ 4,329,495**
Darlington	$ 603,443	$ 694,104	$ 865,126	$ 956,136	$ 883,483	**$ 4,002,293**
Lancaster	$ 484,963	$ 494,242	$ 560,040	$ 1,364,733	$ 859,856	**$ 3,763,834**
Hampton	$ 605,372	$ 556,383	$ 654,010	$ 696,458	$ 830,603	**$ 3,342,827**
Newberry	$ 648,194	$ 575,316	$ 545,643	$ 638,526	$ 776,210	**$ 3,183,888**
Barnwell	$ 447,418	$ 434,802	$ 443,825	$ 1,198,937	$ 579,408	**$ 3,104,390**
Georgetown	$ 560,577	$ 412,443	$ 424,916	$ 641,012	$ 649,490	**$ 2,688,437**
Beaufort	$ 542,535	$ 475,489	$ 454,012	$ 582,752	$ 572,403	**$ 2,627,191**
Fairfield	$ 1,048,872	$ 270,314	$ 331,583	$ 439,533	$ 536,807	**$ 2,627,109**
Clarendon	$ 396,150	$ 414,981	$ 456,382	$ 640,423	$ 635,530	**$ 2,543,467**
Chester	$ 547,659	$ 470,179	$ 470,577	$ 530,415	$ 482,063	**$ 2,500,893**
Colleton	$ 388,585	$ 280,611	$ 495,080	$ 621,935	$ 613,744	**$ 2,399,954**
Williamsburg	$ 602,445	$ 380,698	$ 369,778	$ 518,088	$ 429,455	**$ 2,300,462**
Union	$ 410,316	$ 377,104	$ 370,902	$ 524,213	$ 589,123	**$ 2,271,659**
Cherokee	$ 367,676	$ 310,353	$ 314,756	$ 371,116	$ 402,771	**$ 1,766,672**

Source: SCEIS

Appendix A
Total Reimbursements to S.C. Alcohol and Drug Abuse Authorities, FY 16-17 – FY 20-21

DAODAS Employee Survey Results

The LAC survey of DAODAS employees was conducted between March 22, 2022, and April 1, 2022, using SurveyMonkey®. We sent a total of 37 survey invitations. We received 29 complete responses, yielding a response rate of 78%. The survey was conducted anonymously, and the open-ended responses have been omitted to preserve anonymity for the DAODAS employees who participated.

The survey was designed using question logic to direct respondents to specific questions based on their responses. This resulted in some questions with low response counts as they only applied to a limited number of employees.

1. How long have you been employed with DAODAS? Please select the closest option.		
Answer Options	**Response Percentage**	**Response Count**
Less than 3 years	41.38%	12
3 years to less than 6 years	17.24%	5
6 years to less than 10 years	13.79%	4
More than 10 years	27.59%	8
	answered question	**29**
	skipped question	**0**

2. DAODAS is adequately staffed to meet the demands of the agency.		
Answer Options	**Response Percentage**	**Response Count**
Strongly Agree	3.45%	1
Agree	24.14%	7
Neutral	17.24%	5
Disagree	41.38%	12
Strongly Disagree	13.79%	4
Unsure	0.00%	0
	answered question	**29**
	skipped question	**0**

3. What recommendations do you have to improve staffing at DAODAS?	
Answer Options	**Response Count**
Open-Ended Responses Only	
answered question	**15**
skipped question	**14**

4. DAODAS' employees must occasionally assist other employees to meet a deadline before they complete their own work.		
Answer Options	**Response Percentage**	**Response Count**
Strongly Agree	13.79%	4
Agree	34.48%	10
Neutral	41.38%	12
Disagree	10.34%	3
Strongly Disagree	0.00%	0
Unsure	0.00%	0
	answered question	**29**
	skipped question	**0**

5. Please explain why you responded as you did, including any examples and recommendations for improvement.	
Answer Options	**Response Count**
Open-Ended Responses Only	
answered question	**13**
skipped question	**16**

6. DAODAS' employees must occasionally assist other employees to meet a deadline before they complete their own work.		
Answer Options	**Response Percentage**	**Response Count**
Never	37.93%	11
Daily	3.45%	1
Weekly	17.24%	5
Monthly	41.38%	12
Prefer not to answer	0.00%	0
	answered question	**29**
	skipped question	**0**

7. Agency policies and procedures help me manage my day-to-day workload.		
Answer Options	**Response Percentage**	**Response Count**
Yes	72.41%	21
No	27.59%	8
Prefer not to answer	0.00%	0
	answered question	**29**
	skipped question	**0**

8. Please provide comments or suggestions that you think might help you manage your workload.	
Answer Options	**Response Count**
Open-Ended Responses Only	
answered question	**8**
skipped question	**21**

9. There is good cooperation among the staff of DAODAS.		
Answer Options	**Response Percentage**	**Response Count**
Yes	82.76%	24
No	17.24%	5
Prefer not to answer	0.00%	0
answered question		**29**
skipped question		**0**

10. What would improve the cooperation among DAODAS' staff?	
Answer Options	**Response Count**
Open-Ended Responses Only	
answered question	**5**
skipped question	**24**

11. Senior management staff and my direct supervisor are open to employee suggestions for improving productivity and quality of services.		
Answer Options	**Response Percentage**	**Response Count**
Strongly Agree	37.93%	11
Agree	27.59%	8
Neutral	20.69%	6
Disagree	0.00%	0
Strongly Disagree	13.79%	4
Prefer not to answer	0.00%	0
answered question		**29**
skipped question		**0**

12. Please explain why you responded as you did, including any examples and recommendations for improvement.	
Answer Options	**Response Count**
Open-Ended Responses Only	
answered question	**4**
skipped question	**25**

13. I am well-trained on the federal and state laws, policies, and procedures needed to perform my job effectively.		
Answer Options	**Response Percentage**	**Response Count**
Strongly Agree	27.59%	8
Agree	55.17%	16
Neutral	10.34%	3
Disagree	6.90%	2
Strongly Disagree	0.00%	0
Prefer not to answer	0.00%	0
answered question		**29**
skipped question		**0**

14. Please explain why you responded as you did, including any examples and recommendations for improvement.	
Answer Options	**Response Count**
Open-Ended Responses Only	
answered question	**2**
skipped question	**27**

15. DAODAS is adequately staffed to monitor service providers and ensure they are meeting compliance requirements.		
Answer Options	**Response Percentage**	**Response Count**
Strongly Agree	6.90%	2
Agree	27.59%	8
Neutral	34.48%	10
Disagree	20.69%	6
Strongly Disagree	6.90%	2
Prefer not to answer	3.45%	1
answered question		**29**
skipped question		**0**

16. Please explain why you responded as you did, including any examples and recommendations for improvement.	
Answer Options	**Response Count**
Open-Ended Responses Only	
answered question	**6**
skipped question	**23**

17. Personnel turnover has occasionally negatively affected DAODAS' ability to perform effectively.		
Answer Options	**Response Percentage**	**Response Count**
Yes	37.93%	11
No	20.69%	6
Unsure	41.38%	12
answered question		**29**
skipped question		**0**

18. Please provide details explaining how personnel turnover has impacted DAODAS' performance.	
Answer Options	**Response Count**
Open-Ended Responses Only	
answered question	**11**
skipped question	**18**

19. DAODAS has always allocated funds for opioid-related services to areas of greatest need.		
Answer Options	**Response Percentage**	**Response Count**
Yes	62.07%	18
No	0.00%	0
Unsure	37.93%	11
answered question		**29**
skipped question		**0**

20. Please explain why you feel DAODAS has not allocated funds for opioid-related services to areas of greatest need.	
Answer Options	**Response Count**
Open-Ended Responses Only	
answered question	**0**
skipped question	**29**

21. DAODAS' actions in response to the opioid epidemic are overshadowing non-opioid substance use disorders to the detriment of persons with other forms of addiction.		
Answer Options	**Response Percentage**	**Response Count**
Strongly Agree	0.00%	0
Agree	6.90%	2
Neutral	34.48%	10
Disagree	24.14%	7
Strongly Disagree	17.24%	5
Unsure	17.24%	5
	answered question	**29**
	skipped question	**0**

22. In general, are you aware of any spending of state or federal funds inconsistent with agency policies or contracts by DAODAS?		
Answer Options	**Response Percentage**	**Response Count**
Yes	3.45%	1
No	96.55%	28
Prefer not to answer	0.00%	0
	answered question	**29**
	skipped question	**0**

23. Please explain why you responded as you did, including any examples of spending that is inconsistent with agency policies.	
Answer Options	**Response Count**
Open-Ended Responses Only	
answered question	**1**
skipped question	**28**

24. Are you aware of any unusual or inappropriate use of agency purchasing cards (P-cards)?		
Answer Options	**Response Percentage**	**Response Count**
Yes	0.00%	0
No	100.00%	29
Prefer not to answer	0.00%	0
	answered question	**29**
	skipped question	**0**

25. Please explain why you responded as you did, including any examples of questionable spending.	
Answer Options	**Response Count**
Open-Ended Responses Only	
answered question	**0**
skipped question	**29**

26. DAODAS adequately considers the impact its decisions regarding policies and procedures have on service providers.		
Answer Options	**Response Percentage**	**Response Count**
Strongly Agree	34.48%	10
Agree	31.03%	9
Neutral	17.24%	5
Disagree	0.00%	0
Strongly Disagree	0.00%	0
Unsure	17.24%	5
answered question		**29**
skipped question		**0**

27. DAODAS has formal procedures in place to receive input from service providers and other stakeholders when making policy decisions that will affect them.		
Answer Options	**Response Percentage**	**Response Count**
Yes	55.17%	16
No	3.45%	1
Unsure	41.38%	12
answered question		**29**
skipped question		**0**

28. Please provide details explaining what formal procedures DAODAS has in place to receive input from service providers and other stakeholders.	
Answer Options	**Response Count**
Open-Ended Responses Only	
answered question	**13**
skipped question	**16**

29. DAODAS is proactive and actively solicits the input of service providers and other stakeholders when it considers amending policies and procedures that would affect them.		
Answer Options	**Response Percentage**	**Response Count**
Strongly Agree	13.79%	4
Agree	44.83%	13
Neutral	24.14%	7
Disagree	0.00%	0
Strongly Disagree	0.00%	0
Unsure	17.24%	5
	answered question	**29**
	skipped question	**0**

30. Please provide details explaining how DAODAS solicits the input of service providers when it considers amending policies and procedures.	
Answer Options	**Response Count**
Open-Ended Responses Only	
answered question	**17**
skipped question	**12**

31. DAODAS is committed to getting information from its external stakeholders about how to improve prevention and treatment services.		
Answer Options	**Response Percentage**	**Response Count**
Strongly Agree	17.24%	5
Agree	55.17%	16
Neutral	13.79%	4
Disagree	0.00%	0
Strongly Disagree	3.45%	1
Unsure	10.34%	3
	answered question	**29**
	skipped question	**0**

32. Questions or complaints from providers and external stakeholders are addressed in a timely manner.		
Answer Options	**Response Percentage**	**Response Count**
Strongly Agree	24.14%	7
Agree	48.28%	14
Neutral	13.79%	4
Disagree	0.00%	0
Strongly Disagree	0.00%	0
Unsure	13.79%	4
	answered question	**29**
	skipped question	**0**

33. DAODAS takes steps to improve collaboration with providers to increase service accessibility and to improve outreach to clients during the COVID-19 pandemic.		
Answer Options	**Response Percentage**	**Response Count**
Strongly Agree	41.38%	12
Agree	44.83%	13
Neutral	6.90%	2
Disagree	0.00%	0
Strongly Disagree	0.00%	0
Unsure	6.90%	2
	answered question	**29**
	skipped question	**0**

34. DAODAS takes steps to improve collaboration with providers to deliver an appropriate response to the opioid epidemic.		
Answer Options	**Response Percentage**	**Response Count**
Strongly Agree	37.93%	11
Agree	48.28%	14
Neutral	3.45%	1
Disagree	0.00%	0
Strongly Disagree	0.00%	0
Unsure	10.34%	3
	answered question	**29**
	skipped question	**0**

35. What changes would you recommend to improve collaboration between DAODAS and service providers?	
Answer Options	**Response Count**
Open-Ended Responses Only	
answered question	**0**
skipped question	**29**

36. Please provide any other concerns, comments, or suggestions that you think might be useful to our review of DAODAS. Please remember that your responses are anonymous.	
Answer Options	**Response Count**
Open-Ended Responses Only	
answered question	**15**
skipped question	**14**

Opioid Use Disorder in South Carolina, CY 2017 – CY 2020

County of Occurrence	2017		2018		2019		2020	
	Number of Patients with an OUD	Rate per 1,000	Number of Patients with an OUD	Rate per 1,000	Number of Patients with an OUD	Rate per 1,000	Number of Patients with an OUD	Rate per 1,000
South Carolina	**7,615**	**1.52**	**8,578**	**1.69**	**9,713**	**1.89**	**6,462**	**1.24**
Abbeville	21	0.86	30	1.22	12	0.49	25	1.02
Aiken	137	0.81	156	0.92	86	0.50	126	0.73
Allendale	<5	-	<5	-	24	2.76	<5	-
Anderson	250	1.26	212	1.06	98	0.48	123	0.60
Bamberg	18	1.25	13	0.91	<5	-	13	0.93
Barnwell	58	2.72	51	2.42	99	4.74	78	3.75
Beaufort	86	0.46	102	0.54	28	0.15	70	0.36
Berkeley	230	1.07	249	1.13	176	0.77	189	0.80
Calhoun	6	0.41	7	0.48	<5	-	11	0.76
Charleston	421	1.05	385	0.95	979	2.38	231	0.55
Cherokee	93	1.63	70	1.23	46	0.80	57	0.99
Chester	51	1.58	80	2.48	65	2.02	95	2.95
Chesterfield	126	2.74	176	3.85	175	3.83	126	2.76
Clarendon	55	1.62	67	1.99	76	2.25	46	1.38
Colleton	105	2.79	111	2.95	130	3.45	100	2.67
Darlington	154	2.30	211	3.16	189	2.84	206	3.10
Dillon	126	4.12	158	5.16	178	5.84	135	4.45
Dorchester	266	1.67	230	1.43	147	0.90	157	0.95
Edgefield	12	0.45	12	0.44	8	0.29	5	0.18
Fairfield	39	1.72	35	1.56	29	1.30	37	1.68
Florence	316	2.28	372	2.69	355	2.57	274	1.99
Georgetown	160	2.59	163	2.62	171	2.73	159	2.51
Greenville	632	1.25	746	1.45	1,397	2.67	595	1.12
Greenwood	100	1.42	151	2.13	104	1.47	102	1.44
Hampton	27	1.38	43	2.22	11	0.57	26	1.44
Horry	690	2.07	834	2.42	754	2.13	649	1.78
Jasper	13	0.46	27	0.93	12	0.40	30	0.95
Kershaw	107	1.64	187	2.85	223	3.35	119	1.76

County of Occurrence	2017		2018		2019		2020	
	Number of Patients with an OUD	Rate per 1,000	Number of Patients with an OUD	Rate per 1,000	Number of Patients with an OUD	Rate per 1,000	Number of Patients with an OUD	Rate per 1,000
Lancaster	183	1.98	236	2.47	263	2.68	295	2.92
Laurens	117	1.75	213	3.18	185	2.74	118	1.74
Lee	18	1.04	16	0.93	25	1.49	12	0.72
Lexington	345	1.19	418	1.42	232	0.78	232	0.76
Marion	78	2.49	95	3.06	132	4.31	81	2.69
Marlboro	67	2.51	78	2.95	35	1.34	86	3.36
McCormick	9	0.94	9	0.96	<5	-	<5	-
Newberry	35	0.91	54	1.40	28	0.73	45	1.17
Oconee	111	1.43	106	1.35	77	0.97	50	0.62
Orangeburg	107	1.22	111	1.28	129	1.50	64	0.75
Pickens	257	2.08	296	2.37	329	2.59	256	2.00
Richland	410	1.00	422	1.02	821	1.97	188	0.45
Saluda	7	0.34	7	0.34	7	0.34	6	0.30
Spartanburg	504	1.64	530	1.69	592	1.85	452	1.39
Sumter	136	1.28	120	1.13	172	1.61	128	1.20
Union	56	2.04	53	1.93	63	2.31	87	3.22
Williamsburg	52	1.67	48	1.57	106	3.49	28	0.94
York	449	1.69	539	1.97	897	3.19	415	1.44

OUD = Opioid Use Disorder

Rate = For the calculation of OUD, numerators are the total number of OUD diagnoses among individuals that utilize state-funded treatment services in a given year for the corresponding county of occurrence. Annual resident population denominator estimates were obtained from the U.S. Census Bureau. The rates are provided per 1,000 people.

Number of patients with an OUD = Total number of OUD diagnoses among individuals that utilize state-funded treatment services in a given year for the corresponding county of occurrence.

NOTE: Non-zero numbers less than 5 are censored due to confidentiality restrictions.

Source: DAODAS

Opioid Overdoses in South Carolina, CY 2017 – CY 2020

County of Occurrence	2017		2018		2019		2020	
	Number of Cases	Rate per 1,000	Number of Cases	Rate per 1,000	Number of Cases	Rate per 1,000	Number of Cases	Rate per 1,000
South Carolina	**7,037**	**1.40**	**6,812**	**1.34**	**6,801**	**1.32**	**7,830**	**1.50**
Abbeville	24	0.98	25	1.02	35	1.43	48	1.97
Aiken	104	0.62	98	0.58	147	0.86	221	1.28
Allendale	8	0.89	<5	-	5	0.58	<5	-
Anderson	187	0.94	210	1.05	173	0.85	213	1.04
Bamberg	7	0.49	<5	-	10	0.71	17	1.22
Barnwell	27	1.26	17	0.81	21	1.01	51	2.45
Beaufort	264	1.42	171	0.91	243	1.26	254	1.30
Berkeley	350	1.63	308	1.39	298	1.31	398	1.69
Calhoun	6	0.41	7	0.48	12	0.82	11	0.76
Charleston	619	1.54	547	1.35	578	1.40	629	1.50
Cherokee	74	1.30	52	0.91	47	0.82	77	1.34
Chester	42	1.30	50	1.55	65	2.02	74	2.30
Chesterfield	32	0.70	34	0.74	30	0.66	24	0.53
Clarendon	45	1.32	52	1.54	45	1.33	36	1.08
Colleton	80	2.13	59	1.57	85	2.26	62	1.65
Darlington	150	2.24	149	2.23	111	1.67	126	1.89
Dillon	44	1.44	27	0.88	45	1.48	52	1.71
Dorchester	303	1.91	239	1.49	229	1.41	265	1.60
Edgefield	11	0.41	13	0.48	9	0.33	16	0.59
Fairfield	31	1.37	29	1.29	28	1.25	29	1.31
Florence	256	1.85	241	1.74	204	1.48	272	1.98
Georgetown	221	3.57	229	3.68	217	3.46	183	2.89
Greenville	671	1.32	733	1.43	693	1.32	707	1.33
Greenwood	123	1.74	141	1.99	141	1.99	206	2.90
Hampton	30	1.54	33	1.71	37	1.92	39	2.16
Horry	817	2.46	836	2.43	850	2.40	812	2.22
Jasper	26	0.92	36	1.24	41	1.36	57	1.80
Kershaw	81	1.24	89	1.36	75	1.13	102	1.51

County of Occurrence	2017		2018		2019		2020	
	Number of Cases	Rate per 1,000	Number of Cases	Rate per 1,000	Number of Cases	Rate per 1,000	Number of Cases	Rate per 1,000
Lancaster	106	1.14	101	1.06	98	1.00	150	1.49
Laurens	121	1.81	102	1.52	98	1.45	131	1.93
Lee	28	1.62	27	1.58	25	1.49	25	1.50
Lexington	333	1.15	303	1.03	295	0.99	476	1.57
Marion	55	1.76	57	1.84	47	1.53	55	1.82
Marlboro	23	0.86	10	0.38	17	0.65	20	0.78
McCormick	8	0.84	5	0.53	7	0.74	6	0.64
Newberry	38	0.99	54	1.40	41	1.07	50	1.30
Oconee	116	1.50	110	1.40	84	1.06	99	1.24
Orangeburg	83	0.95	69	0.79	87	1.01	105	1.23
Pickens	191	1.54	241	1.93	197	1.55	214	1.67
Richland	377	0.92	416	1.00	409	0.98	408	0.97
Saluda	12	0.59	11	0.54	9	0.44	10	0.49
Spartanburg	478	1.56	437	1.39	410	1.28	488	1.50
Sumter	89	0.84	101	0.95	105	0.98	133	1.25
Union	54	1.96	39	1.42	33	1.21	70	2.59
Williamsburg	51	1.64	57	1.86	80	2.63	53	1.78
York	241	0.91	241	0.88	285	1.01	352	1.22

Rate = For the calculation of opioid overdose, numerators are the total number of opioid overdoses as identified through inpatient/outpatient discharge codes in a given year for the corresponding county of occurrence. Annual resident population denominator estimates were obtained from the U.S. Census Bureau. The rates are provided per 1,000 people.

NOTE: Non-zero numbers less than 5 are censored due to confidentiality restrictions.

Source: DHEC, Vital Statistics, 2/28/2022

Opioid Prescriptions in South Carolina, CY 2017 – CY 2020

Chart E.1: Number of Prescriptions

County of Occurrence	2017		2018		2019		2020	
	Number of Prescriptions	Rate per 1,000	Number of Prescriptions	Rate per 1,000	Number of Prescriptions	Rate per 1,000	Number of Prescriptions	Rate per 1,000
South Carolina	**4,463,410**	**888.91**	**3,965,893**	**780.05**	**3,764,838**	**731.22**	**3,578,913**	**685.87**
Abbeville	12,938	526.79	11,562	471.13	10,385	423.41	10,303	422.18
Aiken	141,258	839.54	123,481	728.93	115,772	677.54	111,979	647.67
Allendale	6,412	712.37	5,493	616.98	5,297	609.69	5,027	603.41
Anderson	181,300	914.42	165,963	827.82	155,090	765.66	147,079	719.73
Bamberg	14,077	977.77	12,187	853.73	11,741	834.71	11,032	793.33
Barnwell	21,195	992.46	17,953	850.37	17,512	839.26	18,173	873.49
Beaufort	123,136	660.27	112,796	597.71	105,743	550.40	103,628	529.64
Berkeley	133,536	622.63	120,152	543.45	126,028	552.98	120,656	511.28
Calhoun	3,891	264.82	3,400	234.16	3,130	215.08	2,992	205.58
Charleston	349,691	870.45	305,267	752.07	274,123	666.31	256,977	614.81
Cherokee	62,788	1103.00	56,329	986.88	50,710	884.99	47,121	822.13
Chester	28,757	890.72	24,498	759.60	23,045	714.71	22,612	701.54
Chesterfield	44,842	976.52	38,502	841.50	35,888	786.16	34,921	765.71
Clarendon	27,161	798.85	24,206	718.28	23,492	696.16	23,710	709.56
Colleton	41,342	1099.70	37,080	984.60	36,205	960.93	35,510	947.41
Darlington	96,158	1434.49	84,123	1259.29	79,067	1186.87	72,886	1095.88
Dillon	36,129	1182.58	32,013	1046.21	30,500	1000.69	29,458	970.07
Dorchester	146,023	919.07	128,715	801.23	120,694	741.32	114,958	693.62
Edgefield	14,379	537.09	12,324	455.57	10,870	398.75	10,421	384.26
Fairfield	10,563	467.14	9,293	414.83	8,677	388.28	8,417	381.57
Florence	180,148	1300.59	163,255	1181.65	158,693	1147.51	149,002	1082.96
Georgetown	55,303	894.28	47,208	758.37	50,394	803.99	48,596	767.07
Greenville	481,368	950.28	434,521	845.02	402,281	768.38	369,618	694.14
Greenwood	77,716	1101.00	67,397	952.73	61,798	872.72	56,779	798.87
Hampton	18,415	944.31	16,229	838.66	15,735	818.59	15,287	846.78
Horry	343,865	1033.71	311,772	905.93	291,907	824.41	281,437	770.11
Jasper	19,849	698.96	16,876	582.51	17,203	572.04	16,770	530.90
Kershaw	54,385	835.51	47,302	721.16	46,205	694.28	44,581	660.73

CHART E.1: (NUMBER OF PRESCRIPTIONS-CONTINUED)

COUNTY OF OCCURRENCE	2017		2018		2019		2020	
	NUMBER OF PRESCRIPTIONS	RATE PER 1,000	NUMBER OF PRESCRIPTIONS	RATE PER 1,000	NUMBER OF PRESCRIPTIONS	RATE PER 1,000	NUMBER OF PRESCRIPTIONS	RATE PER 1,000
Lancaster	71,882	776.06	62,935	659.83	60,775	620.08	59,483	589.37
Laurens	59,147	883.91	52,520	783.95	44,348	657.08	38,607	568.73
Lee	8,615	498.93	8,094	472.17	7,923	470.82	7,248	433.99
Lexington	252,623	868.66	227,583	771.38	231,590	775.20	225,513	741.95
Marion	33,638	1074.97	27,462	884.76	24,740	806.99	23,926	793.35
Marlboro	27,730	1038.50	25,493	965.72	22,963	879.20	21,386	836.01
McCormick	3,582	374.41	3,220	342.19	3,020	319.14	3,160	335.10
Newberry	38,357	998.15	32,853	852.88	29,590	769.77	29,089	756.64
Oconee	89,372	1154.13	78,333	999.48	72,746	914.51	70,025	875.15
Orangeburg	73,705	840.68	62,217	715.68	57,862	671.45	55,218	647.01
Pickens	124,037	1002.83	112,312	898.95	108,275	853.34	103,987	812.51
Richland	315,221	766.08	279,318	673.74	259,543	624.26	256,018	610.95
Saluda	6,791	332.50	5,682	276.58	5,001	244.27	4,444	218.75
Spartanburg	316,108	1030.90	282,359	899.55	291,986	913.07	271,391	831.96
Sumter	75,089	704.97	65,712	616.94	62,418	584.87	62,311	585.85
Union	30,811	1120.48	26,190	955.49	23,044	843.61	22,190	822.13
Williamsburg	23,046	739.01	20,621	673.76	18,965	624.51	19,145	641.91
York	181,847	683.26	157,079	573.03	143,458	510.56	135,723	469.46

Rate = For the calculation of prescribing rates, numerators are the total number of opioid prescriptions dispensed in a given year for the corresponding county of occurrence. Annual resident population denominator estimates were obtained from the U.S. Census Bureau. The rates are provided per 1,000 people.

Number = Total number of opioid prescriptions dispensed in a given year for the corresponding county of occurrence.

Source: DHEC, PMP- SCRIPTS; JUSTPLAINKILLERS.COM

CHART E.2: QUANTITY OF PRESCRIPTIONS

COUNTY OF OCCURRENCE	2017		2018		2019		2020	
	QUANTITY	QUANTITY PER CAPITA	QUANTITY	QUANTITY PER CAPITA	QUANTITY	QUANTITY PER CAPITA	QUANTITY	QUANTITY PER CAPITA
SOUTH CAROLINA	**298,518,126**	**59.45**	**254,681,711**	**50.09**	**228,888,238**	**44.46**	**216,346,927**	**41.46**
Abbeville	844,213	34.37	746,070	30.40	666,069	27.16	663,278	27.18
Aiken	8,673,479	51.55	7,414,826	43.77	6,819,728	39.91	6,585,645	38.09
Allendale	427,103	47.45	357,621	40.17	349,158	40.19	314,020	37.69
Anderson	13,638,496	68.79	11,889,591	59.31	10,446,370	51.57	9,937,366	48.63
Bamberg	836,061	58.07	726,822	50.92	687,489	48.88	659,362	47.42
Barnwell	1,365,513	63.94	1,150,905	54.51	1,082,903	51.90	1,118,846	53.78
Beaufort	6,790,184	36.41	6,019,841	31.90	5,575,482	29.02	5,557,166	28.40
Berkeley	8,315,418	38.77	7,219,341	32.65	7,046,335	30.92	6,640,472	28.14
Calhoun	233,736	15.91	194,655	13.41	175,650	12.07	165,991	11.41
Charleston	23,065,668	57.41	18,739,257	46.17	16,073,464	39.07	14,897,911	35.64
Cherokee	5,166,503	90.76	4,502,849	78.89	3,807,787	66.45	3,515,577	61.34
Chester	1,776,554	55.03	1,444,900	44.80	1,293,163	40.11	1,270,569	39.42
Chesterfield	3,119,343	67.93	2,646,102	57.83	2,335,291	51.16	2,259,906	49.55
Clarendon	1,945,205	57.21	1,714,000	50.86	1,606,965	47.62	1,599,064	47.85
Colleton	2,944,048	78.31	2,673,582	70.99	2,441,808	64.81	2,398,813	64.00
Darlington	7,682,004	114.60	6,518,350	97.58	5,841,099	87.68	5,339,637	80.28
Dillon	2,550,175	83.47	2,143,017	70.04	1,902,294	62.41	1,839,957	60.59
Dorchester	9,345,009	58.82	8,051,893	50.12	7,242,375	44.48	6,845,871	41.31
Edgefield	875,789	32.71	727,359	26.89	628,225	23.05	588,416	21.70
Fairfield	717,073	31.71	636,386	28.41	556,985	24.92	523,607	23.74
Florence	12,570,379	90.75	10,905,717	78.94	10,429,658	75.42	9,858,572	71.65
Georgetown	3,942,492	63.75	3,282,577	52.73	3,224,956	51.45	3,045,435	48.07
Greenville	32,655,237	64.47	27,968,199	54.39	24,006,464	45.85	21,713,574	40.78
Greenwood	4,917,955	69.67	4,188,316	59.21	3,586,821	50.65	3,346,472	47.08
Hampton	1,060,650	54.39	948,227	49.00	929,526	48.36	915,566	50.72
Horry	23,393,354	70.32	20,297,546	58.98	17,945,915	50.68	17,207,221	47.09
Jasper	993,838	35.00	825,959	28.51	804,456	26.75	795,778	25.19
Kershaw	3,484,595	53.53	2,959,885	45.13	2,748,734	41.30	2,619,764	38.83

CHART E.2: (QUANTITY OF PRESCRIPTIONS-CONTINUED)

COUNTY OF OCCURRENCE	2017		2018		2019		2020	
	QUANTITY	QUANTITY PER CAPITA	QUANTITY	QUANTITY PER CAPITA	QUANTITY	QUANTITY PER CAPITA	QUANTITY	QUANTITY PER CAPITA
Lancaster	4,483,113	48.40	3,858,418	40.45	3,578,781	36.51	3,454,404	34.23
Laurens	4,402,069	65.79	3,769,103	56.26	2,903,782	43.02	2,515,147	37.05
Lee	577,644	33.45	530,359	30.94	500,861	29.76	471,113	28.21
Lexington	14,939,079	51.37	13,154,970	44.59	12,820,463	42.91	12,306,737	40.49
Marion	2,447,772	78.22	1,802,711	58.08	1,534,579	50.06	1,452,105	48.15
Marlboro	1,987,181	74.42	1,791,030	67.85	1,616,092	61.88	1,529,762	59.80
McCormick	238,055	24.88	196,175	20.85	168,694	17.83	180,675	19.16
Newberry	2,250,608	58.57	1,894,912	49.19	1,652,631	42.99	1,593,189	41.44
Oconee	7,351,116	94.93	5,987,214	76.39	5,234,326	65.80	4,953,209	61.90
Orangeburg	4,549,653	51.89	3,705,605	42.63	3,377,470	39.19	3,248,935	38.07
Pickens	8,611,043	69.62	7,559,225	60.50	6,969,301	54.93	6,737,512	52.64
Richland	19,394,447	47.13	16,726,931	40.35	15,050,637	36.20	14,844,887	35.43
Saluda	359,493	17.60	293,956	14.31	245,313	11.98	223,380	11.00
Spartanburg	23,996,501	78.26	20,336,433	64.79	18,692,786	58.45	17,346,704	53.18
Sumter	4,619,382	43.37	4,009,199	37.64	3,696,495	34.64	3,643,895	34.26
Union	2,468,370	89.77	1,875,483	68.42	1,507,760	55.20	1,470,697	54.49
Williamsburg	1,532,166	49.13	1,253,944	40.97	1,112,191	36.62	1,083,464	36.33
York	10,588,894	39.79	8,614,734	31.43	7,473,332	26.60	7,058,078	24.41

Quantity per capita = Numerators are the total quantity of opioids dispensed in a given year for the corresponding county of occurrence. Annual resident population denominator estimates were obtained from the U.S. Census Bureau.

Quantity = Total number of pills, capsules, liquids, patches, and units dispensed in a given year for the corresponding county of occurrence.

Source: DHEC, PMP- SCRIPTS; JUSTPLAINKILLERS.COM

CHART E.3: DAYS SUPPLY

COUNTY OF OCCURRENCE	2017		2018		2019		2020	
	DAYS SUPPLY	DAYS SUPPLY PER CAPITA	DAYS SUPPLY	DAYS SUPPLY PER CAPITA	DAYS SUPPLY	DAYS SUPPLY PER CAPITA	DAYS SUPPLY	DAYS SUPPLY PER CAPITA
SOUTH CAROLINA	**82,695,637**	**16.47**	**73,225,715**	**14.40**	**67,986,478**	**13.20**	**65,407,843**	**12.53**
Abbeville	247,586	10.08	222,375	9.06	201,376	8.21	201,577	8.26
Aiken	2,542,588	15.11	2,223,820	13.13	2,079,726	12.17	2,051,025	11.86
Allendale	119,261	13.25	99,776	11.21	92,251	10.62	88,906	10.67
Anderson	3,656,281	18.44	3,340,913	16.66	3,050,004	15.06	2,926,889	14.32
Bamberg	254,498	17.68	224,010	15.69	211,274	15.02	206,327	14.84
Barnwell	394,295	18.46	334,989	15.87	320,653	15.37	340,622	16.37
Beaufort	1,972,533	10.58	1,805,571	9.57	1,703,796	8.87	1,710,047	8.74
Berkeley	2,399,401	11.19	2,153,846	9.74	2,165,247	9.50	2,081,421	8.82
Calhoun	65,474	4.46	55,785	3.84	51,748	3.56	48,660	3.34
Charleston	5,809,392	14.46	5,000,130	12.32	4,414,049	10.73	4,193,647	10.03
Cherokee	1,410,143	24.77	1,273,391	22.31	1,121,939	19.58	1,044,328	18.22
Chester	519,147	16.08	435,425	13.50	399,891	12.40	388,988	12.07
Chesterfield	917,543	19.98	795,964	17.40	714,537	15.65	699,332	15.33
Clarendon	541,714	15.93	488,035	14.48	469,860	13.92	477,793	14.30
Colleton	794,132	21.12	732,795	19.46	692,310	18.37	692,083	18.46
Darlington	2,196,077	32.76	1,926,252	28.84	1,766,110	26.51	1,643,223	24.71
Dillon	719,212	23.54	637,016	20.82	588,981	19.32	581,395	19.15
Dorchester	2,676,223	16.84	2,358,472	14.68	2,194,425	13.48	2,100,547	12.67
Edgefield	253,042	9.45	212,701	7.86	187,999	6.90	178,296	6.57
Fairfield	193,805	8.57	172,038	7.68	153,048	6.85	149,335	6.77
Florence	3,351,428	24.20	3,035,956	21.97	2,976,817	21.53	2,864,917	20.82
Georgetown	1,067,884	17.27	929,771	14.94	951,456	15.18	915,698	14.45
Greenville	8,986,459	17.74	8,014,860	15.59	7,216,871	13.78	6,638,937	12.47
Greenwood	1,377,189	19.51	1,203,540	17.01	1,071,632	15.13	1,013,720	14.26
Hampton	326,085	16.72	291,428	15.06	286,736	14.92	288,772	16.00
Horry	6,525,463	19.62	5,893,375	17.12	5,407,086	15.27	5,286,522	14.47
Jasper	304,573	10.73	254,303	8.78	245,570	8.17	251,873	7.97
Kershaw	973,518	14.96	871,181	13.28	841,542	12.65	822,368	12.19

CHART E.3: (DAYS SUPPLY-CONTINUED)

COUNTY OF OCCURRENCE	2017		2018		2019		2020	
	DAYS SUPPLY	DAYS SUPPLY PER CAPITA	DAYS SUPPLY	DAYS SUPPLY PER CAPITA	DAYS SUPPLY	DAYS SUPPLY PER CAPITA	DAYS SUPPLY	DAYS SUPPLY PER CAPITA
Lancaster	1,305,657	14.10	1,157,039	12.13	1,104,279	11.27	1,074,376	10.65
Laurens	1,230,826	18.39	1,106,577	16.52	884,189	13.10	769,084	11.33
Lee	163,508	9.47	159,379	9.30	153,996	9.15	143,984	8.62
Lexington	4,145,451	14.25	3,745,418	12.69	3,717,839	12.44	3,632,424	11.95
Marion	684,240	21.87	521,011	16.79	455,046	14.84	442,406	14.67
Marlboro	571,460	21.40	530,008	20.08	479,198	18.35	459,183	17.95
McCormick	66,892	6.99	58,898	6.26	52,799	5.58	56,799	6.02
Newberry	650,617	16.93	561,760	14.58	500,068	13.01	489,266	12.73
Oconee	1,929,775	24.92	1,672,656	21.34	1,492,589	18.76	1,436,917	17.96
Orangeburg	1,305,189	14.89	1,091,863	12.56	1,001,713	11.62	968,232	11.35
Pickens	2,464,443	19.92	2,268,935	18.16	2,154,134	16.98	2,113,505	16.51
Richland	5,262,119	12.79	4,700,449	11.34	4,365,411	10.50	4,411,097	10.53
Saluda	107,287	5.25	88,410	4.30	77,439	3.78	69,445	3.42
Spartanburg	6,765,438	22.06	5,918,088	18.85	5,707,075	17.85	5,391,602	16.53
Sumter	1,272,164	11.94	1,122,558	10.54	1,061,882	9.95	1,075,245	10.11
Union	666,151	24.23	545,058	19.89	460,357	16.85	454,899	16.85
Williamsburg	427,618	13.71	373,919	12.22	340,469	11.21	338,362	11.34
York	2,975,633	11.18	2,501,171	9.12	2,266,404	8.07	2,191,297	7.58

Days Supply per capita = Numerators are the total number of all dispensed opioid days on every opioid prescription in a given year for the corresponding county of occurrence. Annual resident population denominator estimates were obtained from the U.S. Census Bureau.

Days Supply = Sum of all dispensed opioid days on every opioid prescription.

Source: DHEC, PMP- SCRIPTS; JUSTPLAINKILLERS.COM

Opioid Deaths in South Carolina, CY 2017 – CY 2020

Chart F.1: TOTAL Drug Overdose Deaths

County of Occurrence	2017		2018		2019		2020	
	Number of Deaths	Adjusted Rate per 100,000	Number of Deaths	Adjusted Rate per 100,000	Number of Deaths	Adjusted Rate per 100,000	Number of Deaths	Adjusted Rate per 100,000
South Carolina	**1001**	**16.00**	**1103**	**22.00**	**1131**	**22.72**	**1734**	**34.76**
Abbeville	8	35.00	3	12.00	0	0.00	6	26.09
Aiken	40	25.00	34	21.00	29	17.58	71	44.34
Allendale	0	0.00	1	16.00	0	0.00	0	0.00
Anderson	32	17.00	28	13.00	36	18.91	75	37.07
Bamberg	0	0.00	0	0.00	0	0.00	4	28.64
Barnwell	4	20.00	4	16.00	1	5.24	2	5.81
Beaufort	25	16.00	16	10.00	26	16.42	34	22.22
Berkeley	27	13.00	32	14.00	36	15.53	48	21.20
Calhoun	0	0.00	2	18.00	1	7.27	1	9.31
Charleston	118	28.00	121	29.00	123	28.20	197	44.27
Cherokee	1	2.00	4	7.00	7	15.48	7	12.65
Chester	5	16.00	3	11.00	4	12.11	11	44.05
Chesterfield	4	9.00	3	4.00	8	18.31	8	17.94
Clarendon	4	10.00	4	13.00	6	17.72	2	8.27
Colleton	6	15.00	10	27.00	5	15.92	7	17.74
Darlington	9	14.00	6	10.00	7	12.37	7	10.72
Dillon	6	24.00	4	14.00	5	19.34	19	71.22
Dorchester	28	17.00	36	23.00	20	12.28	36	21.90
Edgefield	2	8.00	0	0.00	1	3.65	5	18.14
Fairfield	3	19.00	1	5.00	3	11.59	10	49.48
Florence	31	24.00	37	26.00	28	22.37	52	42.31
Georgetown	18	36.00	23	44.00	15	27.20	28	56.70
Greenville	107	21.00	172	34.00	140	27.02	181	34.78
Greenwood	16	24.00	25	37.00	12	19.78	37	56.69
Hampton	1	5.00	1	7.00	2	10.81	5	30.01
Horry	103	35.00	105	35.00	153	49.23	197	63.73
Jasper	6	24.00	8	27.00	9	35.94	24	88.62
Kershaw	7	11.00	13	23.00	11	17.12	30	50.23

CHART F.1: (TOTAL DRUG OVERDOSE DEATHS-CONTINUED)

COUNTY OF OCCURRENCE	2017		2018		2019		2020	
	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000
Lancaster	24	29.00	14	17.00	35	37.66	47	50.65
Laurens	12	16.00	16	24.00	11	17.76	32	54.62
Lee	1	6.00	0	0.00	4	24.68	3	22.46
Lexington	49	17.00	55	19.00	65	22.48	112	38.33
Marion	2	7.00	1	4.00	4	11.48	8	29.82
Marlboro	0	0.00	1	4.00	2	8.31	4	18.79
McCormick	0	0.00	2	26.00	2	31.38	2	31.83
Newberry	2	6.00	2	6.00	2	4.38	9	26.10
Oconee	22	30.00	17	22.00	26	37.47	13	18.85
Orangeburg	9	10.00	10	12.00	21	26.60	19	25.08
Pickens	27	22.00	34	32.00	36	28.59	40	31.07
Richland	93	23.00	85	21.00	69	16.75	99	23.58
Saluda	2	6.00	0	0.00	1	5.07	2	11.82
Spartanburg	69	22.00	82	27.00	75	23.90	113	34.22
Sumter	7	6.00	29	28.00	27	27.34	30	29.22
Union	4	12.00	0	0.00	2	8.55	9	36.73
Williamsburg	7	24.00	4	17.00	4	16.84	10	31.28
York	60	22.00	55	20.00	57	20.27	78	27.12

Rate = Age adjusted rate per 100,000 people for the corresponding county of occurrence and year.

Number = Total number of drug overdose deaths for the corresponding county of occurrence and year.

NOTE: Rates based on numbers smaller than 20 are unstable and should be used with caution.

Source: DHEC, Vital Statistics; JUSTPLAINKILLERS.COM

CHART F.2: FENTANYL DEATHS

COUNTY OF OCCURRENCE	2017		2018		2019		2020	
	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000
SOUTH CAROLINA	**362**	**8.00**	**460**	**10.00**	**537**	**11.18**	**1100**	**22.74**
Abbeville	0	0.00	0	0.00	0	0.00	2	11.54
Aiken	19	13.00	9	6.00	16	9.00	41	26.01
Allendale	0	0.00	0	0.00	0	0.00	0	0.00
Anderson	4	2.00	2	1.00	9	5.09	29	15.26
Bamberg	0	0.00	0	0.00	0	0.00	3	24.30
Barnwell	3	15.00	1	3.00	0	0.00	1	2.90
Beaufort	12	8.00	7	5.00	8	4.84	24	15.76
Berkeley	7	3.00	9	4.00	17	7.37	33	14.57
Calhoun	0	0.00	2	18.00	0	0.00	0	0.00
Charleston	59	14.00	51	12.00	71	16.45	144	33.18
Cherokee	0	0.00	1	2.00	2	4.96	3	6.08
Chester	1	3.00	3	11.00	4	12.11	3	9.07
Chesterfield	2	5.00	0	0.00	2	5.70	5	13.07
Clarendon	1	5.00	2	8.00	1	3.61	0	0.00
Colleton	1	2.00	2	4.00	0	0.00	3	6.22
Darlington	4	7.00	4	6.00	3	4.81	5	7.47
Dillon	1	4.00	1	4.00	3	12.70	12	44.99
Dorchester	7	4.00	16	10.00	5	3.05	22	13.69
Edgefield	0	0.00	0	0.00	1	3.65	4	13.41
Fairfield	1	7.00	0	0.00	1	7.23	6	26.62
Florence	9	7.00	11	8.00	17	13.68	36	29.25
Georgetown	6	11.00	11	23.00	7	16.01	20	41.17
Greenville	39	8.00	101	21.00	70	14.36	114	22.48
Greenwood	9	15.00	15	22.00	8	14.31	26	41.50
Hampton	0	0.00	0	0.00	0	0.00	2	12.29
Horry	36	13.00	50	17.00	91	31.26	130	42.54
Jasper	3	13.00	3	12.00	7	28.25	18	68.40
Kershaw	2	3.00	6	11.00	8	12.59	22	38.57

CHART F.2: (FENTANYL DEATHS-CONTINUED)

COUNTY OF OCCURRENCE	2017		2018		2019		2020	
	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000
Lancaster	16	19.00	11	14.00	24	26.53	38	42.96
Laurens	3	4.00	7	12.00	8	13.76	25	44.28
Lee	1	6.00	0	0.00	2	10.33	1	8.33
Lexington	14	5.00	23	8.00	27	9.48	78	27.02
Marion	1	3.00	0	0.00	2	5.81	4	15.47
Marlboro	0	0.00	0	0.00	2	8.31	2	9.39
McCormick	0	0.00	1	20.00	0	0.00	2	31.83
Newberry	0	0.00	1	4.00	1	1.59	5	17.42
Oconee	5	6.00	2	4.00	7	10.97	6	10.67
Orangeburg	3	3.00	2	3.00	9	12.07	9	12.67
Pickens	5	5.00	11	10.00	8	6.63	23	19.23
Richland	38	9.00	24	6.00	29	6.91	61	14.90
Saluda	1	3.00	0	0.00	0	0.00	2	11.82
Spartanburg	23	8.00	36	12.00	26	8.08	61	19.81
Sumter	1	1.00	7	7.00	10	10.05	18	17.11
Union	1	5.00	0	0.00	1	4.27	5	22.71
Williamsburg	0	0.00	2	8.00	2	9.58	5	16.49
York	24	9.00	26	10.00	28	10.31	47	17.11

Rate = Age adjusted rate per 100,000 people for the corresponding county of occurrence and year.

Number = Total number of deaths involving fentanyl for the corresponding county of occurrence and year.

NOTE: Rates based on numbers smaller than 20 are unstable and should be used with caution.

Source: DHEC, Vital Statistics; JUSTPLAINKILLERS.COM

CHART F.3: OPIOID DEATHS

COUNTY OF OCCURRENCE	2017		2018		2019		2020	
	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000
SOUTH CAROLINA	**748**	**15.00**	**816**	**17.00**	**876**	**17.83**	**1400**	**28.45**
Abbeville	6	26.00	1	4.00	0	0.00	2	11.54
Aiken	31	20.00	27	16.00	21	12.26	57	35.92
Allendale	0	0.00	0	0.00	0	0.00	0	0.00
Anderson	22	12.00	15	7.00	27	14.45	47	24.52
Bamberg	0	0.00	0	0.00	0	0.00	4	28.64
Barnwell	3	15.00	2	6.00	1	5.24	1	2.90
Beaufort	18	12.00	14	9.00	16	9.81	30	20.06
Berkeley	23	11.00	24	10.00	31	13.14	41	17.75
Calhoun	0	0.00	2	18.00	1	7.27	1	9.31
Charleston	94	22.00	100	24.00	107	24.84	168	38.01
Cherokee	1	2.00	2	4.00	3	6.80	4	7.23
Chester	5	16.00	3	11.00	4	12.11	7	26.48
Chesterfield	3	7.00	1	1.00	3	8.93	7	15.76
Clarendon	2	6.00	3	9.00	2	5.31	1	3.55
Colleton	5	13.00	6	16.00	3	9.95	4	10.28
Darlington	8	13.00	5	8.00	6	10.16	6	9.10
Dillon	4	16.00	3	11.00	5	19.34	16	60.04
Dorchester	20	13.00	30	19.00	14	8.41	34	20.56
Edgefield	1	5.00	0	0.00	1	3.65	4	13.41
Fairfield	2	14.00	0	0.00	2	9.31	8	37.26
Florence	26	20.00	26	19.00	24	19.18	44	35.38
Georgetown	14	28.00	16	29.00	13	25.30	26	51.67
Greenville	73	15.00	131	26.00	102	20.31	144	28.06
Greenwood	14	22.00	19	28.00	9	15.83	29	47.77
Hampton	0	0.00	1	7.00	0	0.00	4	26.50
Horry	77	27.00	85	29.00	131	42.95	170	54.96
Jasper	3	13.00	7	25.00	8	32.21	21	77.60
Kershaw	4	6.00	11	19.00	9	14.18	27	45.07

CHART F.3: (OPIOID DEATHS-CONTINUED)

COUNTY OF OCCURRENCE	2017		2018		2019		2020	
	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000
Lancaster	23	28.00	12	15.00	32	35.11	42	46.61
Laurens	7	9.00	12	19.00	10	16.84	26	45.84
Lee	1	6.00	0	0.00	4	24.68	2	16.66
Lexington	36	13.00	42	15.00	48	16.72	95	32.63
Marion	2	7.00	0	0.00	2	5.81	5	19.24
Marlboro	0	0.00	0	0.00	2	8.31	2	9.39
McCormick	0	0.00	1	20.00	1	12.16	2	31.83
Newberry	0	0.00	1	4.00	1	1.59	8	23.26
Oconee	18	23.00	15	20.00	16	24.09	10	16.10
Orangeburg	5	5.00	8	10.00	15	19.48	13	17.56
Pickens	19	17.00	22	19.00	22	17.12	26	20.82
Richland	71	18.00	51	12.00	52	12.77	73	17.83
Saluda	1	3.00	0	0.00	0	0.00	2	11.82
Spartanburg	47	15.00	56	18.00	55	17.52	91	28.06
Sumter	6	6.00	17	17.00	19	19.08	23	22.55
Union	3	9.00	0	0.00	1	4.27	5	22.71
Williamsburg	5	20.00	2	8.00	4	16.84	7	23.47
York	45	17.00	43	16.00	49	17.54	61	21.41

Rate = Age adjusted rate per 100,000 people for the corresponding county of occurrence and year.

Number = Total number of deaths involving opioids for the corresponding county of occurrence and year.

NOTE: Rates based on numbers smaller than 20 are unstable and should be used with caution.

Source: DHEC, Vital Statistics; JUSTPLAINKILLERS.COM

CHART F.4: PRESCRIPTION DRUG DEATHS

COUNTY OF OCCURRENCE	2017		2018		2019		2020	
	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000
SOUTH CAROLINA	**782**	**16.00**	**863**	**17.00**	**923**	**18.56**	**1463**	**29.44**
Abbeville	7	31.00	1	4.00	0	0.00	2	11.54
Aiken	31	19.00	29	18.00	24	13.88	56	34.49
Allendale	0	0.00	0	0.00	0	0.00	0	0.00
Anderson	22	12.00	16	7.00	26	14.02	49	25.05
Bamberg	0	0.00	0	0.00	0	0.00	4	28.64
Barnwell	4	20.00	2	6.00	1	5.24	2	5.81
Beaufort	23	15.00	14	9.00	22	13.37	30	19.53
Berkeley	25	12.00	23	9.00	34	14.46	44	19.19
Calhoun	0	0.00	2	18.00	1	7.27	0	0.00
Charleston	99	23.00	100	24.00	106	24.40	177	40.10
Cherokee	0	0.00	2	4.00	5	11.17	5	9.03
Chester	5	16.00	3	11.00	4	12.11	6	21.74
Chesterfield	2	5.00	2	3.00	6	15.62	6	14.41
Clarendon	2	6.00	3	9.00	1	3.61	1	3.55
Colleton	4	11.00	9	26.00	3	9.95	3	6.22
Darlington	9	14.00	6	10.00	6	10.16	6	9.10
Dillon	4	16.00	3	11.00	5	19.34	16	60.04
Dorchester	22	14.00	28	18.00	13	7.81	36	21.90
Edgefield	1	5.00	0	0.00	1	3.65	4	13.41
Fairfield	1	7.00	0	0.00	3	11.59	8	37.26
Florence	25	19.00	30	21.00	22	17.44	46	36.45
Georgetown	14	28.00	15	27.00	15	27.20	24	48.06
Greenville	79	16.00	140	28.00	109	21.21	145	28.03
Greenwood	14	21.00	23	34.00	9	14.73	32	50.15
Hampton	0	0.00	1	7.00	1	4.11	3	20.28
Horry	84	28.00	84	28.00	138	44.60	181	58.15
Jasper	4	17.00	4	16.00	8	32.21	21	77.60
Kershaw	2	3.00	10	18.00	8	12.59	27	45.07

CHART F.4: (PRESCRIPTION DRUG DEATHS-CONTINUED)

COUNTY OF OCCURRENCE	2017		2018		2019		2020	
	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000
Lancaster	20	24.00	12	15.00	31	33.58	44	48.24
Laurens	10	14.00	14	21.00	11	17.76	27	48.00
Lee	1	6.00	0	0.00	3	18.74	2	16.66
Lexington	43	15.00	48	17.00	58	19.91	99	33.57
Marion	2	7.00	0	0.00	4	11.48	6	23.99
Marlboro	0	0.00	0	0.00	2	8.31	2	9.39
McCormick	0	0.00	1	20.00	1	12.16	2	31.83
Newberry	1	3.00	2	6.00	1	1.59	8	23.26
Oconee	18	23.00	16	20.00	17	26.09	11	15.36
Orangeburg	6	6.00	6	7.00	14	17.54	14	18.33
Pickens	23	18.00	24	21.00	26	20.39	30	23.76
Richland	69	18.00	60	14.00	52	12.82	82	19.80
Saluda	1	3.00	0	0.00	0	0.00	2	11.82
Spartanburg	45	15.00	61	20.00	56	17.76	96	29.20
Sumter	3	3.00	16	15.00	18	18.36	24	22.99
Union	3	9.00	0	0.00	2	8.55	6	24.89
Williamsburg	2	9.00	4	17.00	2	9.58	7	23.47
York	52	19.00	49	18.00	54	19.12	67	23.25

Rate = Age adjusted rate per 100,000 people for the corresponding county of occurrence and year.

Number = Total number of deaths involving prescription drugs for the corresponding county of occurrence and year.

NOTE: Rates based on numbers smaller than 20 are unstable and should be used with caution.

Source: DHEC, Vital Statistics; JUSTPLAINKILLERS.COM

CHART F.5: PSYCHOSTIMULANT DEATHS

COUNTY OF OCCURRENCE	2020	
	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000
SOUTH CAROLINA	**551**	**11.49**
Abbeville	0	0.00
Aiken	29	18.33
Allendale	0	0.00
Anderson	34	16.97
Bamberg	0	0.00
Barnwell	0	0.00
Beaufort	4	2.13
Berkeley	17	7.40
Calhoun	0	0.00
Charleston	33	7.82
Cherokee	3	5.42
Chester	3	9.99
Chesterfield	2	4.63
Clarendon	1	3.55
Colleton	4	11.73
Darlington	2	2.57
Dillon	5	17.56
Dorchester	9	5.82
Edgefield	2	6.89
Fairfield	4	22.00
Florence	15	12.78
Georgetown	6	13.81
Greenville	60	11.90
Greenwood	13	19.18
Hampton	1	6.22
Horry	79	26.99
Jasper	7	28.21
Kershaw	8	13.36

CHART F.5: (PSYCHOSTIMULANT DEATHS-CONTINUED)

COUNTY OF OCCURRENCE	2020	
	NUMBER OF DEATHS	ADJUSTED RATE PER 100,000
Lancaster	5	5.87
Laurens	17	30.90
Lee	2	14.13
Lexington	48	16.79
Marion	2	7.84
Marlboro	0	0.00
McCormick	0	0.00
Newberry	2	6.90
Oconee	4	6.34
Orangeburg	7	10.43
Pickens	22	18.19
Richland	22	5.36
Saluda	1	5.91
Spartanburg	43	13.56
Sumter	11	10.87
Union	3	13.70
Williamsburg	2	5.75
York	19	6.97

Rate = Age adjusted rate per 100,000 people for the corresponding county of occurrence and year.

Number = Total number of deaths involving psychostimulants for the corresponding county of occurrence and year.

NOTES: Rates based on numbers smaller than 20 are unstable and should be used with caution.
Psychostimulants were not included in prior years' reports.

Source: DHEC, Vital Statistics; JUSTPLAINKILLERS.COM

Inmate Opioid Use in South Carolina, CY 2017 – CY 2020

Chart G.1: Inmate Opioid Use During Most Recent Screening

County of Occurrence	2017		2018		2019		2020	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
South Carolina	1,776	9%	1,798	9%	1,818	10%	1,597	9%
Abbeville	8	7%	11	8%	11	9%	11	10%
Aiken	68	10%	66	10%	64	10%	57	9%
Allendale	0	0%	0	0%	<5	-	0	0%
Anderson	34	6%	39	7%	40	7%	36	7%
Bamberg	5	6%	7	9%	5	8%	5	8%
Barnwell	16	14%	11	10%	8	7%	7	7%
Beaufort	21	6%	23	6%	21	6%	23	7%
Berkeley	43	8%	64	12%	63	12%	45	9%
Calhoun	<5	-	<5	-	<5	-	<5	-
Charleston	107	7%	117	8%	117	8%	92	7%
Cherokee	40	9%	36	9%	47	10%	45	9%
Chester	12	9%	12	11%	14	13%	13	12%
Chesterfield	17	13%	21	16%	17	14%	15	15%
Clarendon	7	5%	9	6%	10	7%	5	4%
Colleton	13	8%	14	9%	13	9%	13	10%
Darlington	26	12%	19	10%	17	8%	17	9%
Dillon	11	8%	10	7%	8	6%	8	7%
Dorchester	33	8%	39	10%	35	9%	35	10%
Edgefield	11	11%	13	14%	11	12%	6	7%
Fairfield	<5	-	6	6%	6	7%	6	9%
Florence	62	8%	72	10%	62	8%	55	8%
Georgetown	24	9%	24	10%	21	9%	20	9%
Greenville	224	12%	205	11%	224	12%	198	11%
Greenwood	27	8%	32	9%	35	11%	33	11%
Hampton	5	6%	<5	-	5	7%	<5	-
Horry	145	13%	173	16%	157	14%	142	14%
Jasper	5	5%	10	9%	6	6%	6	6%
Kershaw	16	8%	14	8%	15	8%	18	10%

CHART G.1: (DURING MOST RECENT SCREENING -CONTINUED)

COUNTY OF OCCURRENCE	2017		2018		2019		2020	
	NUMBER	PERCENTAGE	NUMBER	PERCENTAGE	NUMBER	PERCENTAGE	NUMBER	PERCENTAGE
Lancaster	28	11%	23	10%	32	13%	38	14%
Laurens	25	9%	25	9%	34	11%	25	9%
Lee	<5	-	<5	-	<5	-	<5	-
Lexington	104	11%	96	11%	92	11%	85	10%
Marion	11	6%	6	4%	14	8%	7	4%
Marlboro	5	5%	5	5%	5	6%	6	7%
McCormick	0	0%	<5	-	<5	-	<5	-
Newberry	10	6%	12	7%	14	8%	7	5%
Oconee	33	13%	29	11%	30	12%	28	10%
Orangeburg	26	5%	27	5%	25	5%	23	5%
Pickens	63	14%	75	14%	73	14%	58	13%
Richland	86	5%	80	5%	74	5%	65	5%
Saluda	<5	-	<5	-	5	5%	<5	-
Spartanburg	202	10%	176	10%	183	11%	161	10%
Sumter	34	6%	35	6%	39	7%	34	7%
Union	26	12%	23	11%	26	13%	21	12%
Williamsburg	13	7%	14	9%	9	6%	9	7%
York	116	12%	110	12%	122	13%	105	11%

Percentage = Percentage of inmates who have indicated opioid use during their most recent screening within a given year for the corresponding county of occurrence.

Number = Total number of inmates who have indicated opioid use during their most recent screening within a given year for the corresponding county of occurrence.

NOTE: Non-zero numbers less than 5 are censored due to confidentiality restrictions.

Source: S.C. Department of Corrections; JUSTPLAINKILLERS.COM

Chart G.2: Inmate Opioid Use During Any Screening

County of Occurrence	2017		2018		2019		2020	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
South Carolina	**2,071**	**10%**	**2,097**	**11%**	**2,203**	**12%**	**1,996**	**12%**
Abbeville	9	8%	11	8%	13	11%	12	11%
Aiken	79	11%	80	12%	77	11%	71	11%
Allendale	0	0%	0	0%	<5	-	0	0%
Anderson	47	8%	46	8%	53	9%	56	11%
Bamberg	8	9%	9	12%	6	9%	6	10%
Barnwell	16	14%	11	10%	8	7%	7	7%
Beaufort	22	6%	24	6%	25	7%	25	7%
Berkeley	49	9%	70	13%	74	14%	60	12%
Calhoun	<5	-	<5	-	<5	-	<5	-
Charleston	123	8%	128	9%	132	10%	113	9%
Cherokee	51	11%	49	12%	60	12%	60	13%
Chester	14	11%	14	13%	16	15%	14	13%
Chesterfield	18	13%	22	17%	20	17%	19	18%
Clarendon	8	6%	9	6%	10	7%	7	6%
Colleton	15	9%	19	12%	16	11%	15	11%
Darlington	29	13%	22	11%	23	11%	19	10%
Dillon	12	9%	13	10%	8	6%	10	9%
Dorchester	37	9%	41	11%	40	10%	38	11%
Edgefield	12	12%	14	15%	11	12%	7	8%
Fairfield	6	6%	8	9%	10	11%	8	11%
Florence	74	9%	87	12%	83	11%	73	11%
Georgetown	29	11%	31	13%	27	11%	27	12%
Greenville	262	14%	240	13%	276	14%	246	14%
Greenwood	29	8%	35	10%	42	14%	41	13%
Hampton	5	6%	<5	-	6	9%	<5	-
Horry	157	14%	189	17%	179	16%	160	16%
Jasper	8	8%	10	9%	8	8%	7	7%
Kershaw	18	9%	16	9%	21	11%	23	13%

CHART G.2: (DURING ANY SCREENING-CONTINUED)

COUNTY OF OCCURRENCE	2017		2018		2019		2020	
	NUMBER	PERCENTAGE	NUMBER	PERCENTAGE	NUMBER	PERCENTAGE	NUMBER	PERCENTAGE
Lancaster	30	12%	29	12%	35	14%	44	16%
Laurens	32	11%	34	12%	45	15%	34	12%
Lee	<5	-	<5	-	<5	-	<5	-
Lexington	115	12%	108	13%	106	12%	101	12%
Marion	12	6%	9	5%	16	9%	10	6%
Marlboro	6	6%	6	6%	7	8%	8	9%
McCormick	0	0%	<5	-	<5	-	<5	-
Newberry	12	7%	13	8%	15	9%	11	7%
Oconee	40	15%	41	16%	41	16%	36	13%
Orangeburg	27	5%	28	6%	27	6%	25	5%
Pickens	77	17%	94	18%	98	19%	78	18%
Richland	94	6%	89	6%	88	6%	79	6%
Saluda	<5	-	<5	-	5	5%	5	5%
Spartanburg	262	14%	224	13%	234	14%	221	14%
Sumter	41	7%	41	7%	46	9%	41	9%
Union	36	17%	33	16%	39	19%	29	17%
Williamsburg	15	8%	14	9%	10	6%	12	9%
York	123	12%	120	13%	136	14%	125	13%

Percentage = Percentage of inmates who have indicated opioid use during any screening that occurred within a given year for the corresponding county of occurrence.

Number = Total number of inmates who have indicated opioid use during any screening that occurred within a given year for the corresponding county of occurrence.

NOTE: Non-zero numbers less than 5 are censored due to confidentiality restrictions.

Source: SC Department of Corrections; JUSTPLAINKILLERS.COM

Agency Comments

Appendix H
Agency Comments

South Carolina Department of Alcohol and Other Drug Abuse Services

HENRY McMASTER
Governor

SARA GOLDSBY
Director

August 31, 2022

K. Earle Powell
Director
South Carolina Legislative Audit Council
1331 Elmwood Avenue, Suite 315
Columbia, South Carolina 29201

Dear Director Powell:

On behalf of the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS), I would like to thank you for the opportunity to respond to the report by the Legislative Audit Council (LAC) titled *A Limited Review of the Department of Alcohol and Other Drug Abuse Services.*

Due to our daily work with those who serve on the front lines of South Carolina's efforts to combat the opioid epidemic, the staff of DAODAS keenly feel the impact of overdose deaths in our state, and we agree with the report's findings and recommendations regarding the challenges posed by opioid misuse, including the impact of counterfeit pills and fentanyl. In the following pages, we have noted the progress we are already making to address the LAC's recommendations in this and other areas. You will see that our work on 70% of the recommendations is complete or in progress.

Two key issues related to the core operations of our agency and the publicly funded system on which we are in full agreement are the heavy reliance on federal funding, and challenges in staffing. Without exception, DAODAS has felt the impact of the nationwide workforce shift, and we agree that analysis should be conducted to identify the agency's current staffing needs. Additionally, examination of the numerous services and programs dependent on short-term federal grants should continue.

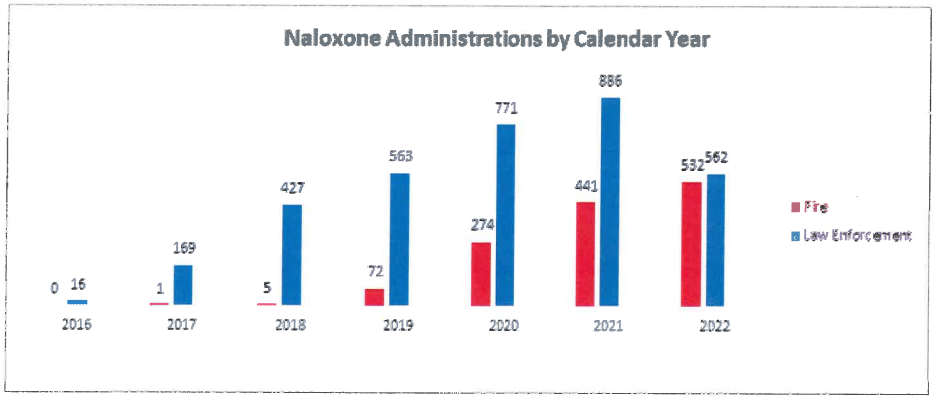
We are also taking this opportunity to note and correct the misinterpretation of information that was provided to your auditors. Despite these inaccuracies, we would like to express our appreciation for the courtesy and professionalism demonstrated by the LAC staff who conducted this review. We admired the dedication they exhibited as they strove to navigate the complexities of substance use disorder service provision, which we acknowledge can be challenging to the layperson.

While the purpose of the audit was to evaluate the agency's response to the opioid crisis and other efforts, we wish the evaluation had taken a balanced approach to the department's strengths and deficits. Overall, we disagree that the Summary is an accurate reflection of the full report, or that the report is an accurate reflection of assets

and attributes of DAODAS' work comprehensively. We are appreciative of the opportunity to provide our responses to the items highlighted in the report summary and the recommendations in the report itself, while also observing the restricted response length of 10 pages:

First Responders in Rural Areas Lack Training on Use of Overdose Reversal Medication

DAODAS received a new Preventing Drug Overdose Deaths (PDO) grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) in August 2021. This grant will continue to fund the Law Enforcement Officer Naloxone (LEON) and Reducing Opioid Loss of Life (ROLL) programs through August 31, 2026. The grant will also concentrate on providing training in areas of the state where there currently are no firefighters trained to administer naloxone and in areas where fewer than 50% of law enforcement officers have been trained across the departments that have received training.



The first PDO grant received by DAODAS ran from September 2016 through August 2021. The data in the above chart represents administrations by calendar year. In 2016, it took a few months for the first agencies to begin receiving training and naloxone through the LEON program, which explains why there were few administrations that year between September and December. In 2017, the focus was mainly on the LEON program, as the ROLL program did not enter the initial phases of development until late in the calendar year, with only one ROLL pilot site from late 2017 until mid-2018. By the end of 2018, a few more fire departments had been trained in the ROLL program, but the program did not go into full effect until 2019. The data reflected for 2022 is from January through August 28, 2022. This chart presents an accurate picture of the notable growth in naloxone administrations by the first responders connected to the DAODAS-funded LEON and ROLL programs, as opposed to the chart presented on Page 2 of the LAC report summary and Page 15 of the full report, which includes administrations by emergency medical services professionals, thereby creating a misperception of limited growth in the first responder administrations made possible by DAODAS funding.

Funding for Opioid Related Services

With the significant investments the state has received to address the opioid crisis, DAODAS does stratify many data indicators related to geographic and population opioid use for targeted sub-grants and contracted work. When applied to county population, rates of incidence of suspected overdose, overdose deaths, hospitalizations, treatment episodes, and prescription dispensation cumulatively indicate burden by

county. This data along with local asset availability is considered for opioid-specific funding allocations.

Prevention Funding Formula for Opioid-Related Services

The federal Substance Abuse Prevention and Treatment Block Grant (SABG) is the cornerstone of the state's addiction service system. Authorized by Congress and administered by SAMHSA, its purpose is to support the planning, implementation, and evaluation of activities that prevent and treat all substance use disorders. A weighted Population-at-Risk Index without mortality data is a one of the key elements of the funding formula used by SAMHSA in its grant allotment methodology to states and territories, and South Carolina has adopted this element in formula funding methodology to allocate dollars for prevention and treatment services in our state, basing funding allocations on county population rates. DAODAS respectfully disagrees that the funding formula for SABG distribution in South Carolina should consider the mortality from only one substance use disorder when it would skew funding away from addressing the prevalence of other addictive diseases. Our position on this key finding aligns with the LAC's recommendation #38 in the report.

Review of Opioid Treatment Programs (OTPs)

DAODAS agrees strongly that gaps in access to OTPs should be filled for universal accessibility around the state. While mobile OTP units could be a solution for increased access where services are not available, and while the federal government has authorized the use of grant funds to states for this purpose, an abundance of policy challenges must first be overcome, including federal and state statutes, regulations, and guidelines for the addition of a "mobile component" to any OTP. DAODAS and its OTP partners are committed to continuing to explore possibilities.

Monitoring Process and Effectiveness for Opioid Services

DAODAS maintains a contract with the S.C. Department of Health and Human Services (DHHS) that only applies to OTP services provided to Medicaid patients. Known as the Medicaid Contract, it does not require DAODAS to conduct the 10 chart reviews – or any onsite clinical quality assurance – that the Treatment Services Manual requires for county alcohol and drug abuse authorities. The LAC auditors confused the requirements of the Medicaid Contract with the requirements of the Treatment Services Manual, which does call for the review of 10 charts for any county authority being audited.

Furthermore, regulation of all OTPs falls under the jurisdiction of the U.S. Drug Enforcement Administration and the S.C. Department of Health and Environmental Control (DHEC). DHEC enforces both federal and state regulations applicable to OTPs. S.C. Regulation 61-93 (et seq) (Standards for Licensing Facilities That Treat Individuals for Psychoactive Substance Abuse or Dependence) is the oversight document used by DHEC to track service delivery by OTPs. Section 903 (A)(2) directs that an OTP refer individuals for outside services based on their need, and OTPs are not required to treat co-occurring disorders at their facilities.

DAODAS respectfully disagrees with the statement that it has not completed onsite visits to the OTPs. The State Opioid Response Coordinator completed site visits during 2021, while the OTP Compliance Manager has led trainings, conducted visits to the OTPs, and ensured clinical quality through chart reviews.

Regarding the recommendation that DAODAS track which OTPs treat co-occurring mental health disorders, while the agency can do this, it should be clarified that –

nationwide – the role of an OTP is that of a specialist treating opioid use disorder. Very few take on a dual role, particularly in treating severe and persistent mental illnesses. They do, however, refer patients to other specialty providers as routinely as other healthcare sub-specialties refer for unique specialty care.

Opioid Emergency Response Team (OERT)

DAODAS respectfully disagrees that meetings of the OERT have been infrequent. The report outlines three periods when citing "infrequent" meetings but does not account for the many subgroup meetings that were held during those time spans. With as many as 200 stakeholders and regular participants, the OERT is broken down into Primary and Supporting Agencies under leadership of Coordinating Agencies with particular focus areas. These subgroups, along with a Data Team, Overdose Rapid Response Team, and COVID-19 Coordinating Agency Team, all met with frequency during the periods of note. The main two-hour meetings of the full OERT occur every other month, the Data Team meets quarterly, and the Overdose Rapid Response Team meets weekly.

DAODAS is also now in compliance with state law regarding recordkeeping of a public body.

Alcohol and Drug Safety Action Program (ADSAP)

DAODAS agrees that ADSAP runs a deficit each year, and the agency would support legislation to increase fees for the program.

Additionally, DAODAS agrees that the Prime for Life curriculum needs to be evaluated for effectiveness. However, the auditors' statement that "The same curriculum is used for first-time and repeat offenders..." is misleading. ADSAP is an assessment-based program, and it is extremely rare for a repeat DUI offender to be assessed as appropriate for another course of the educational Prime for Life curriculum. In an overwhelming majority of cases, repeat offenders are referred directly to treatment services. As part of the intended effectiveness evaluation of Prime for Life, DAODAS will instruct the evaluator to consider whether a separate curriculum is warranted for those rare instances when a repeat offender is assessed as appropriate for the education component instead of treatment services.

Gambling Services

DAODAS' enabling legislation does not grant express authority to the agency to provide for the delivery of gambling services. However, that authority is found with the establishment of the state lottery in Section 59-150-230(I) of the South Carolina Education Lottery Act, which directs that a portion of unclaimed prize money be appropriated to DAODAS for the prevention and treatment of compulsive gambling and educational programs related to gambling disorders. These activities are to include a gambling "hotline," prevention programming and, in part or in total, mass communications efforts. DAODAS has legislative guidance to recommend policies aimed at responding to gambling disorders in South Carolina.

Effectiveness of Non-Opioid Services

Regarding the statement that DAODAS "uses the number of individuals served as the measure for effectiveness" of prevention programs, the LAC auditors overlooked information provided on the qualitative data that is used for evaluation. The Strategic Prevention Framework (SPF) is an approach to prevention that embraces and promotes outcomes-based prevention and data-driven decision making. Outcome evaluation demonstrates changes in consumption behaviors and consequences of substance use.

By identifying, addressing, and changing factors – such as access and availability of substances, social/community norms and perception of risk associated with use – population-level changes in substance use and the effects of use will decrease. In the SPF, prevention planners consider two types of evaluation: process and outcome. Process evaluation answers the question, "Did we do what we said we would do?" Prevention planners use process evaluation extensively to assess the quality of implementation, keep implementation on track, and inform adjustments that can strengthen the effectiveness of their prevention efforts. Outcome evaluation measures the direct effects of a program or practice following implementation, that is, it determines whether the program or practice made a difference and, if so, what changed.

Monitoring Process for Non-Opioid Services

DAODAS agrees that monitoring processes for non-opioid services should improve and is at work to implement all six recommendations from the report. Currently the new DAODAS Grant Management System is rolling out for end-to-end processes improvement of sub-grant and sub-contract execution, document completion and retention, deliverable monitoring, and payment approval. The system will transform the functional transactional relationship between DAODAS and sub-contractors, eliminating duplicative data entry points and storage for a more centralized and at-a-glance location of expectations and reporting dashboards.

Work with the Local Alcohol and Drug Abuse Authorities

Staff at DAODAS work relentlessly to cultivate strong working relationships with the local alcohol and drug abuse authorities and other contracted providers. The connection is critical given the increased pressures on those delivering direct services and the increased expectations of managing public funds with integrity. While the summary notes select negative themes from interviews with providers, we appreciate the positive comments from interviews with local directors about their interactions with DAODAS that can be found in the full report.

Regarding the desire for grant funding to be more flexible for specific needs, we align in agreement and continue to make our grant funding as flexible as possible while adhering to the federal regulations, restrictions, and intent of grant programs and awards. We continue to advocate to Congressional leaders that funding flexibility is essential to addressing local needs.

Administrative Costs and Carry-Forward Dollars

One finding states that "DAODAS allowed carry-forward dollars to lapse." In fact, no carry-forward dollars were allowed to lapse. As allowed by Proviso 37.4, the agency did carry forward State funds intentionally and in preparation for a federal funding "fiscal cliff" resulting from the expiration of congressional grant funding for medications and treatment related to the opioid epidemic. These state funds were tracked by internal order numbers and used for medication and treatment services as intended.

Reimbursements to Local Alcohol and Drug Abuse Authorities

DAODAS disagrees that variation in reimbursement is a flawed finding, as is conveyed in the statement that payments to the local alcohol and drug abuse authorities vary "depending on the authority," and we believe that the auditors misinterpreted the agency's reimbursement methods. Reimbursement can vary depending on the funding mechanism, such as specific grant awards or funding for unique programs or services that only certain local authorities are qualified or eligible to provide. DAODAS has

established internal controls that govern processing of payments to the local authorities. These controls require a signed contract and approval of deliverables by programmatic staff before a payment is processed. Various tracking methods include the establishment of subgrants and internal order numbers, monthly reconciliations through the S.C. Enterprise Information System, and disbursement schedules that are sent to local authorities. DAODAS has also worked in collaboration with the owners of the Carelogic electronic health record system to ensure reimbursement rates are updated.

P-Card Purchases and Assignments

The assertion that "DAODAS does not consistently obtain approval from the Comptroller General's office before making purchases at vendors with blocked merchant category codes" is incorrect. When agency staff encounter blocked merchant category codes, transactions are literally unable to be completed. In those cases, they either use a different procurement method or request that the Comptroller General's office temporarily remove the block. DAODAS has only submitted such a request to the Comptroller General twice during the past five fiscal years.

All P-Card purchases by staff are reviewed and approved by their supervisors and the Manager of Finance & Operations. DAODAS has revised its P-Card policies and procedures and has obtained approval from the Comptroller General's office for employees who hold more than one P-Card.

Internal Audit Function

Prior to fiscal year 2021 (FY21), DAODAS had never employed an internal auditor. During FY21, DAODAS hired a Certified Public Accountant to serve as its auditor, developed an Internal Auditing Charter, and received technical assistance from the South Carolina Office of the State Auditor regarding the development of a Risk-Based Internal Auditing (RBIA) program. Due to temporary staff shortages, the auditor was given the additional duties of subgrantee monitoring. However, they were able to conduct several internal tests and examinations of the DAODAS Division of Finance & Operations, which helped improve processes and reduce risk. DAODAS looks forward to continuing the development and deployment of a robust RBIA program.

TABLE 1: Progress on Recommendations

REC. #	STATUS	COMMENTS
#1	In Progress	DAODAS' new Preventing Drug Overdose Deaths grant will support the Department of Health & Environmental Control in complying with this recommendation.
#2	Completed	Addressed through completion of recommendation #73.
#3	Pending	
#4	N/A	DAODAS is supportive of this recommendation but does not have the authority to execute it.
#5	In Progress	Although the updating of public data on the Just Plain Killers website is typically accompanied by a press announcement, labels will be placed on the relevant web pages identifying data that is "new" or has been "revised/updated."
#6	In Progress	Data analysis is underway.
#7	Disagree	See *Prevention Funding Formula for Opioid-Related Services* on Page 3 of this letter.

REC. #	STATUS	COMMENTS
#8	Disagree	The agency will continue considering submission of grant applications for as many federal opportunities as possible, while also considering the support of the best eligible applicants outside DAODAS.
#9	Pending	
#10	Completed	A number of on-site visits have occurred in recent months.
#11	Completed	A number of clinical quality assurance reviews have been completed, and more are underway.
#12	Pending	
#13	Completed	DAODAS' new Grants Management System provides updated capability for demographic data entry. This information will be used for targeted decision making.
#14	Completed	A letter has been sent to the Chairperson of the S.C. Association for the Treatment of Opioid Dependence requesting that the association's member opioid treatment programs (OTPs) be encouraged to refer patients seeking injectable extended-release naltrexone to another provider if the OTP does not offer this service.
#15	Pending	
#16	Completed	The two opioid treatment programs (OTPs) that were missing from the interactive map when the LAC conducted its review have been added, and the DAODAS webmaster compares the agency's list of OTPs to the interactive map each time the list is updated.
#17	In Progress	DAODAS' new Grants Management System provides updated capability for specific data entry from subgrantees for optimal analysis.
#18	In Progress	Annual financial reviews are complete. Clinical chart reviews and programmatic reviews are underway.
#19	In Progress	Clinical chart reviews are underway.
#20	In Progress	DAODAS' new Grants Management System provides updated capability for complete recordkeeping.
#21	Pending	
#22	In Progress	DAODAS' new Grants Management System is designed to capture timeliness of deliverable submissions and compliance with requirements.
#23	In Progress	DAODAS has full-time staff to support subgrantee use of the GPRA tool.
#24	In Progress	Chart reviews for financial assessment completion are underway.
#25	In Progress	Discussions with the Department of Mental Health are underway regarding co-located mobile outreach.
#26	Completed	Unmet transportation needs are being supported financially, but through a different funding source.
#27	Completed	Routine OERT meetings are scheduled through the remainder of 2022.
#28	Completed	Detailed written minutes and attendance details of OERT meetings are being taken and kept on file.
#29	Completed	Detailed written minutes and attendance details of OERT meetings are being taken and kept on file.
#30	N/A	DAODAS is supportive of this recommendation but does not have the authority to execute it.
#31	Pending	
#32	Pending	

REC. #	STATUS	COMMENTS
#33	Pending	
#34	Disagree	See *Alcohol and Drug Safety Action Program* on Page 4 of this letter.
#35	Pending	
#36	In Progress	DAODAS staff are prioritizing the local alcohol and drug abuse authorities for daily communication.
#37	Completed	Funding for patient transportation needs was expanded this year.
#38	Completed	Most of the patients treated with federal SABG funds this year had primary diagnoses of alcohol and/or marijuana addictions.
#39	Completed	Conversations with local alcohol and drug abuse authorities on the development of policies and programs occur on most days.
#40	In Progress	A bill will be re-introduced to address this issue during the next legislative session.
#41	Completed	DAODAS will continue to make grant funding as flexible as possible while adhering to the federal regulations, restrictions, and intent of grant programs and awards.
#42	N/A	DAODAS is supportive of this recommendation but does not have the authority to execute it.
#43	N/A	DAODAS is supportive of this recommendation but does not have the authority to execute it.
#44	Completed	See *Effectiveness of Non-Opioid Services* on Page 4 of this letter.
#45	In Progress	See *Effectiveness of Non-Opioid Services* on Page 4 of this letter. In addition, DAODAS' new Grants Management System is designed to capture improved evaluation data.
#46	Pending	
#47	In Progress	DAODAS' new Grants Management System provides updated capability for complete recordkeeping.
#48	In Progress	DAODAS' new Grants Management System is designed to capture and track all contract deliverables.
#49	In Progress	At-a-glance dashboards in the new Grants Management System will give grant managers information on late or missing deliverables for withholding of payment.
#50	In Progress	The agency's new Grants Management System will eliminate the need for these tracking logs.
#51	In Progress	DAODAS' new Grants Management System is designed to capture and track all contract deliverables.
#52	In Progress	Real-time monitoring and analysis of deliverables using DAODAS' new Grants Management System will allow for continuous program improvement.
#53	In Progress	The process for reclassification is underway.
#54	In Progress	Reclassification will allow this recommendation to be executed.
#55	Disagree	See *Administrative Costs and Carry-Forward Dollars* on Page 5 of this letter.
#56	Completed	The Treatment Services Manual has been updated.
#57	In Progress	A search for inconsistencies is underway.
#58	Completed	This evaluation was completed in July 2022.
#59	Completed	Completion of the evaluation referenced in recommendation #58 made execution of this recommendation possible.

REC. #	STATUS	COMMENTS
#60	Completed	One vendor number is assigned per provider.
#61	Completed	DAODAS has streamlined its tracking process to ensure that all data is classified and recoverable.
#62	Pending	
#63	Completed	DAODAS has completed background checks on all current employees and implemented background checks as part of our new-hire onboarding process.
#64	Pending	
#65	Pending	
#66	Pending	
#67	Pending	
#68	Pending	
#69	Completed	The Comptroller General's office has approved DAODAS' allocation of P-Cards to employees, and the agency's relevant policies and procedures have been updated.
#70	Disagree	See *P-Card Purchases and Assignments* on Page 6 of this letter.
#71	Completed	The Comptroller General's office has approved specified DAODAS employees to hold more than one P-Card.
#72	Completed	DAODAS policies and procedures have been updated to reflect internal controls and recordkeeping.
#73	Completed	Text has been added to the "button" link to JustPlainKillers.com that advertises the availability of fentanyl-related information.
#74	Completed	Consideration was given to carrying over old links when developing the current website.
#75	Pending	
#76	Completed	Consideration was given to including more images when developing the current website.
#77	Completed	DAODAS is now contracting with a website monitoring service for notification of accessibility issues that need to be addressed.
#78	Completed	The websites of numerous state treatment authorities were reviewed during the development of the current website.

Thank you again for the diligent work of the LAC staff in preparing this report.

Sincerely,

Sara Goldsby

Sara Goldsby, MPH, MSW
Director

SG/jmm

Healthy People. Healthy Communities.
Edward D. Simmer, MD, MPH, DFAPA
Director

August 31, 2022

VIA EMAIL JKresslein@lac.sc.gov
AND HAND DELIVERY
K. Earle Powell, Director
South Carolina General Assembly
Legislative Audit Council
1331 Elmwood Avenue, Suite 315
Columbia, South Carolina 29201

RE: Agency Response to the final draft of *A Limited Review of the Department of Alcohol and Other Drug Abuse Services*

Dear Director Powell:

Thank you for the opportunity to review the information related to the South Carolina Department of Health and Environmental Control's ("Department's") excerpts of the Legislative Audit Council's ("LAC's") final draft report entitled *A Limited Review of the Department of Alcohol and Other Drug Abuse Services*. The Department appreciates the work undertaken by LAC and the detailed analysis and thoughtful recommendations presented in LAC's report. The Department will implement LAC's recommendations that are within the Department's authority to achieve.

In particular, the Department plans to implement LAC's recommendations as follows:

- **Recommendation 1:** The S.C. Department of Health and Environmental Control should take steps to ensure all first responders across the state have been trained to administer naloxone.

    - The Department will continue to make every effort to ensure first responders across the state have been trained to administer naloxone. Thus far, and to make all first responders aware of the training program, including smaller agencies, the Department has paid individual visits to first responder agencies, attended the fire and law enforcement annual meetings and chief association meetings, and have specifically targeted other areas. To better meet the training needs of individual agencies, the Department offers the training in various formats (including video assisted, train-the-trainer, staff led, combined groups,

etc.) and venues. DHEC shares local data through ODMAP so that local agencies can see and understand the opioid problem in their own communities. And the Department has worked with the law enforcement and fire academies to conduct naloxone training with new recruits before they go back to their respective agencies.

- DHEC's efforts to this point have produced positive results, The Department has made naloxone training and protocols available to all certified members of the EMS community. With the law enforcement community, the Department has trained over 11,400 officers since 2016 and continues offering LEON training for officers as new officers replace retiring officers and those who left the service. With the fire service, the Department has trained over 4,000 firefighters since 2017 and continues its training endeavors to ensure that the ROLL training is available to all firefighters in the state.

- **Recommendation 4:** The S.C. Department of Health and Environmental Control should review the rates per 100,000 for mortality data for 2015 through 2017 and revise the data if necessary.

    - The Department has reviewed and updated this information.

- **Recommendation 42:** The S.C. Department of Health and Environmental Control should ensure that the locations of all outpatient CDAP treatment licensees and their satellites are included in the Find a Facility table listing and map on its website.

    - The Department is in the process of implementing this recommendation. The process will involve creating a report of the requested information, coordinating with program administrators to ensure the report captures complete information that is displayed in a manner compatible with the website, and rewriting the program to change a script for the Find a Facility application. This project will require collaboration of various program areas within DHEC; therefore, a specific date has not been identified for completion of the project.

- **Recommendation 43:** The S.C. Department of Health and Environmental Control should ensure that its published information for healthcare treatment licensees included on the Find a Facility webpage is timely, accurate, and complete.

    - The Department will ensure that its published information for licensed facilities is timely, accurate, and complete. Information is transferred from a DHEC database to the Find a Facility application daily. Administrative assistants, which process CDAP facilities, input the satellite location information into the database when processing applications. The manager of the program area monitors processed applications to ensure accuracy. The Quality Management section of the Office of Training & Compliance conducts quarterly audits of the processed applications as well as systems and software.

The same quality assurance measures apply to information transferred from the database to the Find a Facility application. In the event an error or deficiency is detected, Quality Management conducts a root cause analysis and resolves the issue.

We appreciate the opportunity to present this response to LAC's draft report concerning *A Limited Review of the Department of Alcohol and Other Drug Abuse Services*. Should you have any questions, please do not hesitate to contact my office.

Sincerely,

Edward D. Simmer

cc: Jack Kresslein, Senior Auditor, LAC

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