South Carolina Department of Alcohol and Other Drug Abuse Services

HENRY McMASTER
Governor

SARA GOLDSBY
Director

January 13, 2020

Via E-mail
The Honorable Jay West, Chair
Healthcare and Regulatory Subcommittee
Legislative Oversight Committee
South Carolina House of Representatives
Post Office Box 11867
Columbia, South Carolina 29211

RE: Follow-up questions from the Subcommittee meetings with the agency on December 10 and 17, 2019

Dear Representative West:

Thank you for the opportunity to provide information on the Department of Alcohol and Other Drug Abuse Services' prevention and treatment activities during our meetings on December 10 and 17, 2019. As requested in your letter dated December 17, I am pleased to provide the following information:

1. How did you determine the targets for performance measure #9, "Increase Number of Individuals who Receive Prevention Services"? What strategies do you use to set appropriate performance targets in general?

   Because there is a main office or satellite office of an alcohol and drug abuse authority in every county, our provider system theoretically has the ability to touch and interact with every resident of South Carolina. Therefore, DAODAS set its targets for performance measure #9 to mirror state population growth (typically around 1%). The county authorities strive to directly or indirectly deliver environmental prevention services to everyone from youth (e.g., via school-based education that they can share with their parents) to adults (by exposing them to prevention messages that they can also share with their younger children, for example).

   To set appropriate performance targets in general, DAODAS takes an indicator-by-indicator approach. We examine data trends regarding specific performance measures and couple the quantitative information gleaned from this data with the input (i.e., qualitative information) from subject-matter experts based on their expertise and past experiences in the field, along with any new policy changes or interventions that could affect the measure moving forward. DAODAS then creates data-informed targets that our system can realistically attain and/or strive toward, to ensure better outcomes for the populations that we serve.

While each performance target is unique, targets for prevention performance measures are typically lower than current measures as we aim to lower incidence, rate, or overall negative impact on population health with prevention strategies (e.g., lowering rates of adolescent substance use, reducing alcohol-related car crashes). When it comes to intervention and treatment targets, DAODAS typically aims to increase interventions, increase efficiency of access, and increase the number of individuals admitted for services, because national research suggests very few people with substance use disorders receive the necessary evidence-based treatment. (See accompanying PDF titled *America's Need for and Receipt of Substance Use Treatment in 2015*.)

2. How many inspectors work on the U.S. Food and Drug Administration contract annually? What percentage of that contract's funding does DAODAS retain to cover administrative costs?

   The intent of the U.S. Food and Drug Administration's contract with DAODAS was to have 10 commissioned inspectors available at any given time. DAODAS employed 10 commissioned inspectors in Fiscal Year 2016 (FY16), 10 inspectors in Fiscal Year 2017 (FY17), and nine in Fiscal Year 2018 (FY18).

   During FY16, DAODAS retained less than 1% of the contract amount for administrative costs (i.e., salary support for two employees who oversaw the contract). As contract activities increased, the department retained 2% for administrative costs in FY17 and 3% in FY18.

3. How many fake IDs were confiscated in the 721 fake ID/bar sweeps completed as part of Project Safety Through Alcohol Responsibility?

   The number of bar sweeps (721) mentioned during Michelle Nienhius' presentation to the subcommittee was derived from the final report of Project Safety Through Alcohol Responsibility (STAR). When evaluator Michael George, Ph.D., with the Pacific Institute for Research and Evaluation revisited the report databases, he discovered an additional 52 bar sweeps (probably the result of STAR enforcement participants submitting reports after the final project report was published). The revised total of 753 bar sweeps resulted in the confiscation of 213 fake IDs.

4. Please provide more information about the criminal penalties for providing alcohol to minors in different ways, including purchasing it at a store and providing it at a party.

Fine *	**Jail**	**Statute Short Title & Penalty**	**Statute**
1st - $200 to $300, 2nd and subsequent - $400 to $500	or 30 days or both	**Sales to underage persons (***beer or wine***),** Completion of a Merchant Education Class, Minor must also be charged unless a confidential informant; 63-19-2440	61-4-50
1st - $200 to $300, 2nd and subsequent - $400 to $500	or 30 days or both	**Sale to person under the age of 21 years (***alcoholic liquors***),** Completion of a Merchant Education Class, Minor must also be charged unless a confidential informant; 63-19-2450	61-6-4080
1st - $200 to $300, 2nd or subsequent - $400 to $500	or 30 days or both	**Transfer of beer or wine for underage person's consumption**, Cannot be charged with this and 61-6-4070	61-4-90

Fine *	Jail	Statute Short Title & Penalty	Statute
1st - $200 to $300, 2nd or subsequent - $400 to $500	or 30 days or both	**Transfer to person under the age of 21 years** *(alcoholic liquors*), Cannot be charged with this and 61-4-90	61-6-4070
1st - $200 to $300, 2nd or subsequent - $400 to $500	or 30 days or both	**Purchase of beer or wine for a person to whom it cannot lawfully be sold** *(transfer to minor on alcohol outlet premises)*	61-4-80
1st - $200 to $300, 2nd or subsequent - $400 to $500	or 30 days or both	**Purchase of alcoholic beverage for minor**, *(transfer to minor on alcohol outlet premises)*	61-6-4075
Misdemeanor, Not more than $1,000	or 30 days or both	**Violations committed by person on premises or property of lodging establishment**, *(violates 63-19-2440, 63-19-2450, uses or possesses a controlled substance under Chapter 53, Title 44, or rents lodging for purposes of underage drinking party, **NOTE**: increases to felony if room is damaged & fine/penalty increases considerably)* Restitution for damage whether misdemeanor or felony.	45-2-40

** County-level courts may add state and local administrative costs to fines, which will increase the cost by over 100% to the individual convicted of violating the statute. The total cost can vary slightly by county, so it is difficult to list an amount for the total fine.*

5. Please provide the drunk driving enforcement survey referenced during the meeting on December 17, 2019.

   See the accompanying PDF titled *MADD South Carolina 2019 Law Enforcement Survey Report*.

6. Please provide the most recent Alcohol and Drug Safety Action Program report the agency provided to the Senate Finance and House Ways and Means Committees.

   See the accompanying PDFs titled *Goldsby-Leatherman FY19 ADSAP Report 1-10-20* and *Goldsby-Smith FY19 ADSAP Report 1-10-20*.

7. What opportunities do patients have to provide feedback about services provided by county authorities? Does DAODAS see that feedback?

   There is no standardized collection of feedback about services provided by the county authorities, although some of the local agencies utilize a patient satisfaction survey. However, DAODAS does not receive the feedback that is collected through these surveys.

   Because the county authorities use Substance Abuse Prevention and Treatment Block Grant funding, they are required to collect and report to DAODAS the Treatment Episode Data Set (TEDS), which is a compilation of data on the demographic and substance use characteristics of each individual patient. The information must be collected from the patient upon admission to services, at discharge from services, and at 90 days following discharge from services.

   See the accompanying PDF titled *TEDS-2017-R excerpt* to review the TEDS information collected from patients by the county authorities. The accompanying PDF titled *DAODAS Outcome Reports FY19 revised* is an example of the state's annual aggregate TEDS information.

8. Please provide any available estimates of the number of people living with opioid use disorder in South Carolina.

   The Substance Abuse and Mental Health Services Administration estimates that only 20% of United States residents with an opioid use disorder (OUD) receive specialty addictions treatment. Using this same benchmark – and based on the approximately 13,000 South Carolinians who receive OUD treatment from a county alcohol and drug abuse authority, some other Medicaid-eligible provider, or an opioid treatment program – DAODAS is able to estimate that over 98,000 South Carolina residents are living with an OUD. **NOTE:** This estimate does not include individuals who access treatment services from a private provider.

Please feel free to contact me if you have any questions about the information provided with this letter, and I look forward to our next meeting on January 15.

Sincerely,

Sara Goldsby
Director

cc: DAODAS Executive Management

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

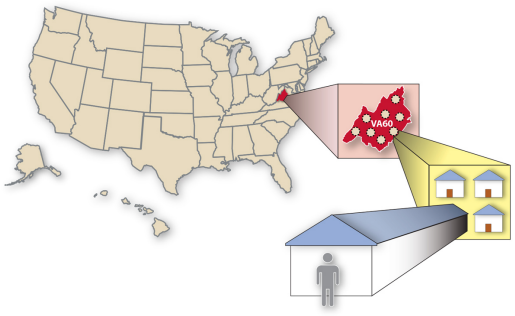
National Survey on Drug Use and Health

The CBHSQ Report

Short Report

September 29, 2016

AMERICA'S NEED FOR AND RECEIPT OF SUBSTANCE USE TREATMENT IN 2015



AUTHORS

Rachel N. Lipari, Ph.D, Eunice Park-Lee, Ph.D., and Struther Van Horn, M.A.

In Brief

- The 2015 National Survey on Drug Use and Health (NSDUH) data indicate that 8.1 percent or 21.7 million people aged 12 or older needed substance use treatment in the past year.
- In 2015, an estimated 2.3 million people aged 12 or older who needed substance use treatment received treatment at a specialty facility in the past year. This number represents 10.8 percent of the 21.7 million people who needed substance use treatment in the past year.
- Among the estimated 19.3 million people aged 12 or older who were classified as needing but not receiving substance use treatment at a specialty facility, about 18.4 million or 95.4 percent did not think that they needed treatment in the past year for their substance use.

INTRODUCTION

Substance use disorders (SUDs) represent clinically significant impairment caused by the recurrent use of alcohol or illicit drugs (or both), including health problems, disability, and failure to meet major responsibilities at work, school, or home.[1] The consequences of SUD can be costly to people and the nation as a whole because they are often associated with negative outcomes, such as involvement with the justice system,[2,3] occurrence of chronic health conditions,[4] and poorer health outcomes.[5]

People who experience SUDs can take many pathways to recovery. Many individuals may benefit from evidence-based substance use treatment that addresses their specific needs, which may include physical, psychosocial, and environmental issues. Although there are benefits to getting substance use treatment, recent research indicates that many people do not get the treatment they need.[1] According to the 2016 National Drug Control Strategy, a leading indicator of unmet substance use treatment need is the number of people who need substance use treatment but do not receive it at a specialty facility.[6] The overall health of the nation are improved by the extent to which the population has access to needed substance use treatment. Hence, the Substance Abuse and Mental Health Services Administration (SAMHSA) states that recovery is built on access to evidence-based clinical treatment and recovery support services for all populations.[7]
The National Survey on Drug Use and Health (NSDUH) is an annual survey of the civilian, noninstitutionalized population of the United States aged 12 years or older. NSDUH gathers information on substance use treatment need and service utilization. NSDUH respondents who used alcohol or illicit drugs[8] in their lifetime are asked whether they ever received substance use treatment. Those who received substance use treatment in their lifetime are asked whether they received treatment in the 12 months before the survey interview (i.e., the past year). Substance use treatment refers to treatment or counseling that was received for illicit drug or alcohol use, or for medical issues associated with illicit drug or alcohol use. NSDUH also collects information on the receipt of substance use treatment at a specialty facility (i.e., substance use treatment at a hospital [only as an inpatient], a drug or alcohol rehabilitation facility [as an inpatient or outpatient], or a mental health center).[9]

This issue of *The CBHSQ Report* also examines respondents' perception of their need for substance use treatment. This report uses 2015 NSDUH data to examine the need for and receipt of substance use treatment at a specialty facility among people aged 12 or older. Comparisons are made between adolescents aged 12 to 17, young adults aged 18 to 25, and adults aged 26 or older. All differences between age groups discussed in this report are statistically significant at the .05 level.

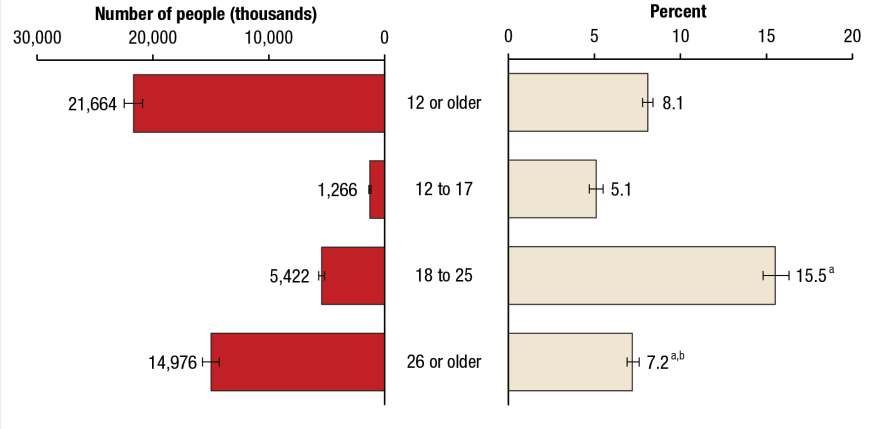
NEED FOR SUBSTANCE USE TREATMENT

NSDUH classifies people as needing substance use treatment if they met the criteria for having SUD[10] in the past year (based on symptoms they report) or if they received substance use treatment at a specialty facility in the past year.[11] In 2015, an estimated 21.7 million people aged 12 or older needed substance use treatment in the past year (Figure 1). Stated another way, about 8.1 percent of the population aged 12 or older

needed substance use treatment in the past year. SUD is defined as meeting criteria for illicit drug or alcohol dependence or abuse based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).[10]

The percentage of people identified as needing substance use treatment was highest among young adults aged 18 to 25 and was lowest among adolescents aged 12 to 17. In 2015, approximately 1.3 million adolescents (5.1 percent of this age group), 5.4 million young adults (15.5 percent of this age group), and 15.0 million adults aged 26 or older (7.2 percent of this age group) needed substance use treatment in the past year (Figure 1). Stated another way, about 1 in 20 adolescents, 1 in 6 young adults, and 1 in 14 adults aged 26 or older were classified to be in need of substance use treatment in the past year.

Figure 1. Need for substance use treatment in the past year among people aged 12 or older, by age group: 2015



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2015.

[a] Difference between this estimate and the 12 to 17 estimate is statistically significant at the .05 level.

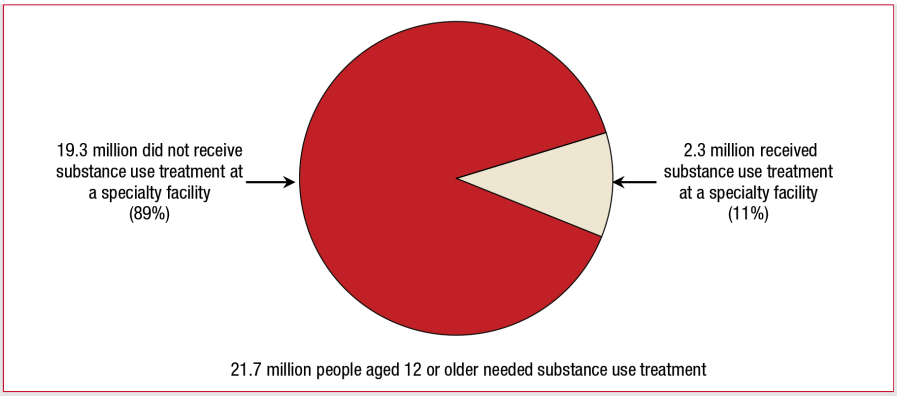
[b] Difference between this estimate and the 18 to 25 estimate is statistically significant at the .05 level.

RECEIPT OF SUBSTANCE USE TREATMENT AT A SPECIALTY FACILITY AMONG PEOPLE WHO NEEDED SUBSTANCE USE TREATMENT

The extent of the unmet substance use treatment need in the United States is measured by calculating the number of people aged 12 or older who were classified as needing substance use treatment but who did not receive substance use treatment at a specialty facility in the past year. This section focuses on the receipt (or lack of receipt) of treatment at a specialty facility among people who needed substance use treatment in the past year.

In 2015, an estimated 2.3 million people aged 12 or older who needed substance use treatment received treatment at a specialty facility in the past year (Figure 2). This number represents 0.9 percent of all people aged 12 or older and 10.8 percent of the 21.7 million people who needed substance use treatment. Conversely, there were about 19.3 million people aged 12 or older who needed substance use treatment but did not receive substance use treatment at a specialty facility; this represents 89.2 percent of people who needed substance use treatment in the past year.[12]

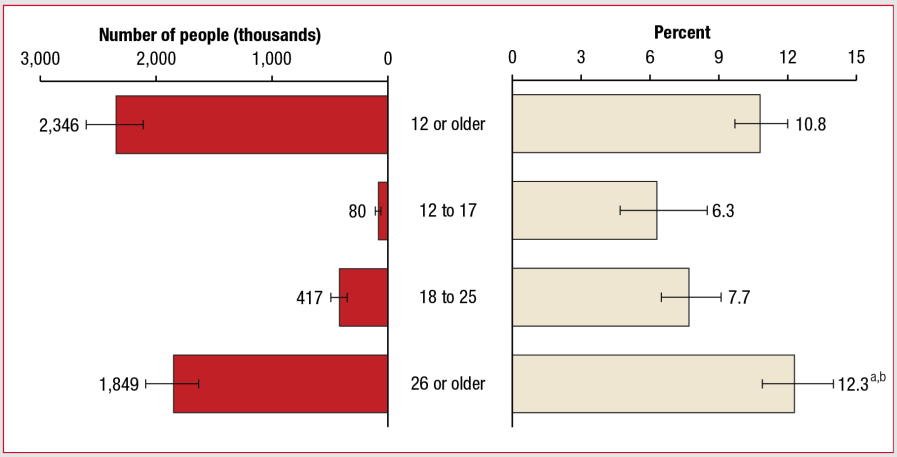
Figure 2. Receipt of substance use treatment at a specialty facility in the past year among people aged 12 or older who needed substance use treatment in the past year: 2015



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2015.

As shown earlier, in 2015, an estimated 1.3 million adolescents aged 12 to 17, 5.4 million young adults aged 18 to 25, and 15.0 million adults aged 26 or older needed substance use treatment in the past year. Of those who needed substance use treatment, about 80,000 adolescents (or 6.3 percent of this age group), 417,000 young adults (or 7.7 percent of this age group), and 1.8 million adults aged 26 or older (12.3 percent of this age group) received substance use treatment at a specialty facility in the past year. Among people who needed substance use treatment, adults aged 26 or older were more likely to have received treatment at a specialty facility in the past year than adolescents or young adults (12.3 vs. 6.3 and 7.7 percent, respectively). Conversely, among people in specific age groups who needed substance use treatment, 93.7 percent of adolescents, 92.3 percent of young adults, and 87.7 percent of adults aged 26 or older did not receive treatment at a specialty facility in the past year (Figure 3).

Figure 3. Receipt of substance use treatment at a specialty facility in the past year among people aged 12 or older who needed substance use treatment in the past year, by age group: 2015



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2015.

[a] Difference between this estimate and the 12 to 17 estimate is statistically significant at the .05 level.

[b] Difference between this estimate and the 18 to 25 estimate is statistically significant at the .05 level.

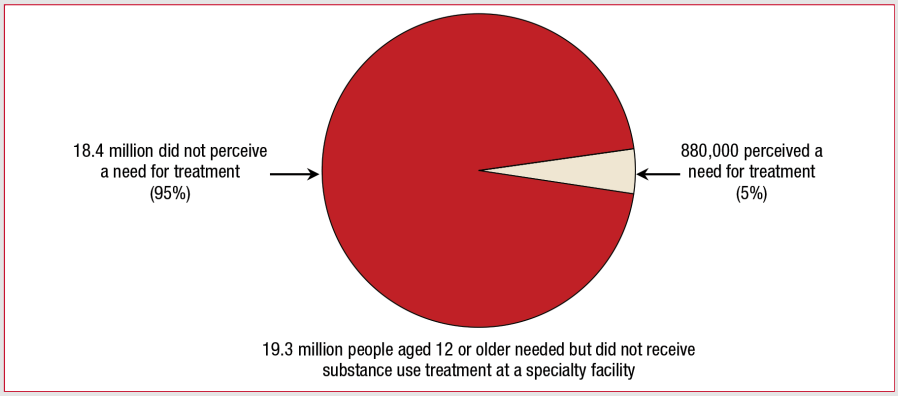
PERCEIVED NEED FOR SUBSTANCE USE TREATMENT AMONG PEOPLE WHO NEEDED BUT DID NOT RECEIVE SUBSTANCE USE TREATMENT AT A SPECIALTY FACILITY

In 2015, among the estimated 19.3 million people aged 12 or older who were classified as needing substance use treatment but who did not receive substance use treatment at a specialty facility in the past year, about 880,000 (or 4.6 percent of this population) perceived a need for

substance use treatment. The vast majority (95.4 percent), on the other hand, did not think that they needed treatment in the past year for their substance use (Figure 4).

Among those who needed but did not receive substance use treatment at a specialty facility in 2015, adolescents were less likely to have felt a need for treatment than young adults or adults aged 26 or older (data not shown). Of the estimated 1.2 million adolescents aged 12 to 17 who needed but did not receive substance use treatment at a specialty facility in the past year, 17,000 (1.4 percent) perceived a need for substance use treatment. Among the estimated 5.0 million young adults aged 18 to 25 who needed but did not receive substance use treatment at a specialty facility in the past year, about 138,000 (2.7 percent) perceived a need for substance use treatment. Of the estimated 13.1 million adults aged 26 or older who needed but did not receive substance use treatment at a specialty facility in the past year, approximately 725,000 (5.5 percent) perceived a need for substance use treatment.

Figure 4. Perceived need for substance use treatment among people aged 12 or older who needed but did not receive substance use treatment in the past year: 2015



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2015.

DISCUSSION

As previously stated, many people in need of substance use treatment may benefit from evidence-based substance use treatment that addresses their specific needs; however, the research suggests that few Americans receive any or adequate substance use treatment.[1] The 2015 NSDUH data presented in this report suggest that the majority of people aged 12 or older who needed substance use treatment in the United States do not receive treatment at a specialty facility. The report finds that about 21.7 million or 8.1 percent of people aged 12 or older needed substance use treatment in the past year. In addition, among the 19.3 million people aged 12 or older who were classified as needing substance use treatment because they either met the criteria for having a substance use disorder or they have been in substance use treatment at a specialty facility in the past year, a large proportion of this population indicated they did not perceive that they had a need for substance use treatment. In addition, receipt of substance use treatment at a specialty facility and perceived need for substance use treatment among those who needed substance use treatment varied by age group. For example, compared with adults aged 26 or older, lower percentages of adolescents and young adults who needed substance use treatment received treatment at a specialty facility. Similarly, lower percentages of adolescents and young adults who were classified as needing substance use treatment felt that they needed treatment for their substance use than adults aged 26 or older.

The substance use recovery process is highly personal and occurs via many pathways. For many Americans, this recovery process includes access to and use of substance use treatment at specialty facilities, such as a hospital (only as an inpatient), a drug or alcohol rehabilitation facility (as an inpatient or an outpatient), or a mental health center. Having access to substance use treatment and supportive services to address various needs associated with substance use disorders is critical for those who are in need of treatment. In order to aid individuals in need of treatment, SAMHSA provides information about where to find substance use and mental health treatment at https://findtreatment.samhsa.gov.

ENDNOTES

1. Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Retrieved from http://samhsa.gov/data/
2. Glasheen, C., Hedden, S. L., Kroutil, L. A., Pemberton, M. R., & Goldstrom, I. (2012, November). *CBHSQ Data Review: Past year arrest among adults in the United States: Characteristics of and association with mental illness and substance use*. Retrieved from http://samhsa.gov/data/

3. Feucht, T. E., & Gfroerer, J. (2011, May). *SAMHSA Data Review: Mental and substance use disorders among adult men on probation or parole: Some success against a persistent challenge* (NCJ 235637). Retrieved from http://samhsa.gov/data/
4. Clarke, D. M., & Currie, K. C. (2009). Depression, anxiety and their relationship with chronic diseases: A review of the epidemiology, risk and treatment evidence. *Medical Journal of Australia, 190*(7 Suppl.), S54–S60.
5. McCusker, J., Cole, M., Ciampi, A., Latimer, E., Windholz, S., & Belzile, E. (2007). Major depression in older medical inpatients predicts poor physical and mental health status over 12 months. *General Hospital Psychiatry, 29*(4), 340–348. doi:10.1016/j.genhosppsych.2007.03.007
6. Office of National Drug Control Policy. 2015. *2015 National Drug Control Strategy*. Retrieved from https://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/2015_national_drug_control_strategy_0.pdf
7. Substance Abuse and Mental Health Services Administration. (2015). *Recovery and recovery support* [Web page]. Retrieved from http://samhsa.gov/recovery
8. NSDUH estimates of "illicit drug use" include the data from 10 drug categories: the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine; or the misuse of prescription pain relievers, tranquilizers, stimulants, or sedatives.
9. Information on the receipt of substance use treatment at nonspecialty treatment facilities such as emergency rooms, private doctors' offices, prisons or jails, and self-help groups is reported elsewhere. For more information, see Park-Lee, E., Lipari, R. N., Hedden, S. L., Copello, E. A. P., & Kroutil, L. A. (2016, September). Receipt of services for substance use and mental health issues among adults: Results from the 2015 National Survey on Drug Use and Health. NSDUH Data Review. Retrieved from http://www.samhsa. gov/data/
10. NSDUH includes a series of questions about past year SUDs among respondents who used alcohol or illicit drugs in the past 12 months. These questions are used to classify people as having an SUD in the past 12 months based on criteria specified in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*. The criteria include symptoms such as withdrawal, tolerance, use in dangerous situations, trouble with the law, and interference with major obligations at work, school, or home during the past 12 months.
11. In 2015, about 96.0 percent of the adults who needed treatment for a substance use issue were defined as such because they had an SUD in the past year, regardless of whether they received substance use treatment at a specialty facility.
12. People who are classified as needing substance use treatment may receive treatment at a nonspecialty facility for their substance use issues; however, the majority of people who needed treatment do not receive any substance use treatment. For example, about 679,000 people aged 12 or older in 2015 who needed substance use treatment received nonspecialty treatment, whereas 18.6 million people did not receive any treatment.

SUGGESTED CITATION

Lipari, R. N., Park-Lee, E., and Van Horn, S. *America's need for and receipt of substance use treatment in 2015*. The CBHSQ Report: September 29, 2016. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD.

SUMMARY

Background: Substance use disorders (SUDs) affect people of all age groups and from different socioeconomic statuses. These disorders are common and recurrent, but people experiencing these disorders may benefit from treatment. The Substance Abuse and Mental Health Services Administration (SAMHSA) reports information from the National Survey on Drug Use and Health (NSDUH) on substance use treatment (i.e., treatment for problems related to the use of alcohol or illicit drugs) in the United States to help evaluate access to and use of substance use treatment. **Method**: This report uses 2015 NSDUH data to examine the need for and receipt of substance use treatment at a specialty facility among people aged 12 or older. **Results**: The findings in this report suggest that the majority of people aged 12 or older who needed substance use treatment in the United States do not receive treatment at a specialty facility. Also, a large proportion of those who need substance use treatment do not perceive a need for it. In addition, receipt of substance use treatment at a specialty facility and perceived need for treatment among those who needed substance use treatment varied by age group. Compared with adults aged 26 or older, lower percentages of adolescents and young adults who needed substance use treatment received treatment at a specialty facility, and lower percentages of adolescents and young adults felt they needed treatment for their substance use. **Conclusion**: This report provides the most current findings from NSDUH on the receipt of substance use treatment among people aged 12 or older in the United States. Findings presented in the report can be useful for monitoring the need for substance use treatment among all people aged 12 or older and assessing whether they receive treatment at a specialty facility for their substance use.

Keywords: National Survey on Drug Use and Health, NSDUH, treatment, substance use

AUTHOR INFORMATION

cbhsqrequest@samhsa.hhs.gov

KEYWORDS

Age Group, Short Report, Population Data, Public Officials, Substance Abuse, People with Substance Use or Abuse Problems as Population Group, Access to Care, Treatment, All US States Only, 2015

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The National Survey on Drug Use and Health (NSDUH) is an annual survey sponsored by The Substance Abuse and Mental Health Services Administration (SAMHSA). The data used in this report are based on information obtained from 68,073 people aged 12 or older in 2015. The Survey collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at their place of residence.

The NSDUH Report is prepared by The Center for Behavioral Health Statistics and Quality (CBHSQ), SAMHSA, and by RTI International in Research Triangle Park, North Carolina. (RTI International is a trade name of Research Triangle Institute.)

Information on the most recent NSDUH is available in the following publication:

Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Retrieved from http://samhsa.gov/data/

Also available online: http://www.samhsa.gov/data/population-data-nsduh.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Substance Abuse & Mental Health Services Administration
Center for Behavioral Health Statistics and Quality
www.samhsa.gov/data

MADD South Carolina 2019

Law Enforcement Survey Report

Executive Summary

Purpose of this Report

This report documents specific reasons as to why law enforcement officials across many levels (e.g., officers, troopers, supervisors, command staff, etc.) believe that DUI arrests and convictions are decreasing in South Carolina. A statewide sample of 323 respondents completed this anonymous, online survey about their perceptions of this downward trend. Specifically, in recent years there has been a 32% reduction in DUI arrests (2010 = 26,532 to 2018 = 17,969) and an even greater 45% reduction in DUI/DUAC convictions (2013 = 13,449 to 2018 = 7,357). State drunk driving fatality numbers have not decreased to any similar extent, which suggests these reductions are not due to less drinking and driving and that public safety is endangered by fewer arrests and convictions.

Because of the many comments we hear and observe about the ongoing challenges to adequate DUI enforcement, we chose to examine the most pressing concerns of law enforcement. MADD's strong collaborative relationships and support of law enforcement, victims, and criminal justice officials contributed to its interest in conducting this survey done in mid-summer 2019.

Survey Development and Distribution

To develop the final survey, MADD compiled a variety of reasons often mentioned as to why DUI arrests and convictions are decreasing. About 12-15 individuals reviewed the list and made suggestions for additions, edits, and deletions. The final list included 34 statements with respondents reporting "not a reason," "yes a reason but not in top 5," or "yes a top 5 reason." MADD created an online link that was emailed to law enforcement groups directly or by its partners (e.g., 16 Law Enforcement Networks, OHSJP grantees). Three additional questions were asked of the respondents including, 1) support for Senate Bill 18, 2) confidence in making a drugged driving arrest, and 3) knowledge of the DUI child endangerment statute and how to handle these situations. Summary results are provided below. The full report includes sample written comments by the respondents included in the appendix of the final report.

Summary Results

Data indicate that respondents perceive a variety of reasons for decreasing DUI enforcement and convictions. Specifically, 25 of the 34 items were endorsed as reasons for decreased DUI arrests by half or more of the respondents. The top two reasons relate to the slant of our current DUI laws favoring defense attorneys and

being created by defense attorneys. More than 70% of officers reported that these two reasons were among their top five. "Prosecutors are not prepared and/or motivated to take arrests to trial and are looking for any plea agreement " was another reason endorsed by 90% of law enforcement. Among the most common responses also included items that dealt with the complexity of the DUI law, the judiciary, prosecution support, and general frustrations.

Top Five Reasons For Decreasing Trends in DUI Enforcement	**Total Yes %**	**Top 5 %**
There are too many loopholes working in the favor of the defense.	97.9%	84.4%
SC DUI laws were largely written by defense attorneys.	94.4%	71.1%
Prosecutors are not prepared and/or motivated to take arrests to trial and are looking for a plea agreement.	90.8%	66.1%
I know my arrest will too often end up as a reckless driving or some other lesser charge.	89.2%	47.4%
Generally, DUI cases are too complex and time consuming.	83.7%	47.6%

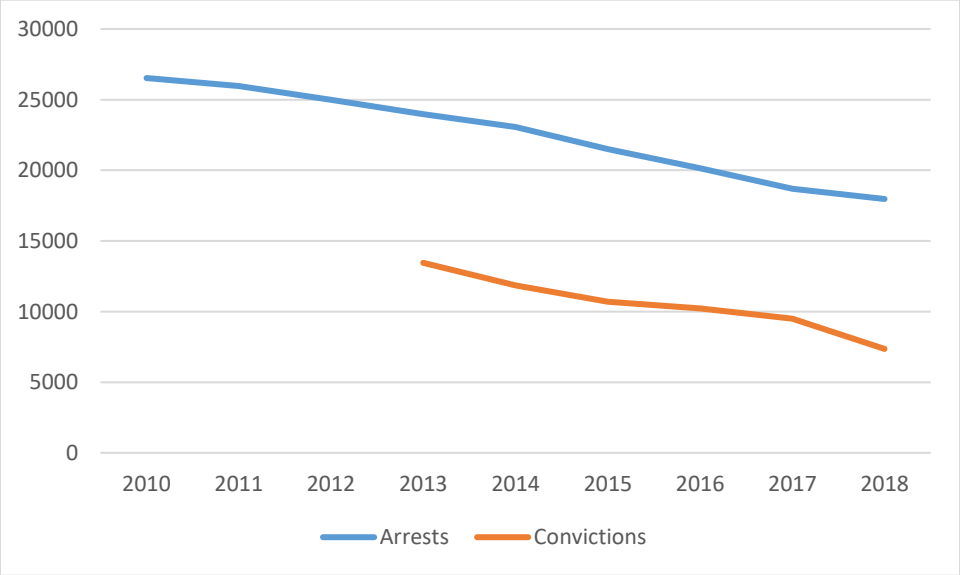
MADD will be sharing the full report with law enforcement and other officials to gather input and feedback on the results to garner support for system-level changes. Achieving safer roads for citizens requires sufficient enforcement of existing laws as well as adopting evidence-based strategies to support law enforcement's efforts and commitment to perform their job well.

Full Report

Background: Mothers Against Drunk Driving South Carolina, in an effort to better understand why DUI arrests are down in South Carolina, conducted an anonymous survey of law enforcement officers across the state between July 25th and August 17th, 2019.

According to DUI arrest data from the South Carolina Office of Highway Safety and Justice Programs (OHSJP), DUI arrests have been decreasing over the past several years, from 26,532 in 2010 to 17,969 in 2018. It should be noted that there is not full consistency in which agencies report from year to year.

There have also been concerning decreases in DUI convictions. According to South Carolina Department of Motor Vehicles data, convictions for DUI or Driving with an Unlawful Alcohol Concentration (DUAC) dropped from 13,449 in 2013 to 7,357 in 2018. This is a 45% decrease and even outpaces the 25% decrease in arrests that occurred in that same time span. When arrests and conviction rates are dropping simultaneously, it is truly a frightening situation for all of us to be safe on South Carolina roads.



It should be noted that South Carolina had the ninth-most drunk driving fatalities in the nation in 2017 with 313. For a state that is 23rd in population, that ranking is completely unacceptable.

MADD South Carolina felt compelled to get first-hand feedback from law enforcement officers on their perceptions of what have been the primary causes of the decrease in DUI arrests among so many frustrations

expressed. With these findings, we felt we could better focus our efforts to make positive change and to speak more confidently when sharing the frustrations expressed by officers.

Survey: The survey was primarily composed of a list of reasons on why DUI arrests have decreased. MADD staff generated the list based on issues discussed in our 2018 Court Monitoring Report ("A Lack of Conviction"), conversations MADD has hosted with officers and prosecutors over the past two years, and frequent complaints from officers shared with MADD staff directly or in larger group settings. Some items were also added based on responses from a similar survey that MADD Florida did in 2018.

In the end, 34 statements were included covering topics from the laws, prosecutors, judges/magistrates, resources, training, complexity of the arrest process, penalties, and more. There were also three statements included that related to the possibility that they believe drunk and drunk driving have decreased, which would explain fewer arrests. While the overall question was directed toward why arrests had decreased, the options also mirror some of the general frustrations officers face in enforcing DUI laws in South Carolina. Officers were invited to list additional reasons if the survey was missing an important one.

The list of reasons was edited several times during survey preparation as about 15 individuals reviewed our list and made suggestions for additions, edits, and deletions.

For each reason listed, officers were asked to indicate one of the three following options:

- Not a Reason (for decreased DUI arrests)
- YES, but not TOP 5 (reason for decreased DUI arrests)
- YES, a TOP 5 Reason (for decreased DUI arrests)

Other than this primary question, there were other questions included on:

- Support for strengthening our state's Ignition Interlock Device law (Emma's Law)
- Confidence in making a proper drugged driving arrest
- Understanding of the state's DUI child endangerment statute
- Judicial circuit the officer works in
- Role within the agency the officer holds
- Any other comments they wanted to share with MADD

Distribution Format: The survey was online and anonymous. MADD created a link that was emailed out to a number of law enforcement groups directly by MADD or by MADD's partners to include the 16 Law Enforcement Networks and OHSJP grantees. Many officers emailed it to their colleagues, and we know of multiple command staff that emailed the link to the officers within their agency. In some instances, MADD staff handed out the link directly. The survey period was July 25th through August 17th, 2019.

MADD SC thanks Dr. Michael George for assisting with the tools for the survey collection and MADD Florida for the basis for the survey and approach.

Results: There were 323 survey responses, though not every respondent gave an answer for every item. Participants represented those who do enforcement in every judicial circuit. The 9th Circuit had far more responses than any other circuit.

Survey Participation by Judicial Circuit of Enforcement			
1st	6	2nd	13
3rd	4	4th	24
5th	10	6th	8
7th	21	8th	9
9th	86	10th	6
11th	26	12th	7
13th	11	14th	27
15th	10	16th	5
Multiple Circuits	23	Unsure/Not Applicable	19

Participants also represented all levels of law enforcement.

Head of Agency	13
Command Staff	72
First-line Supervisor	81
Officer/Deputy/Trooper	139
None of the Above	12

Below are law enforcement officers' responses for various reasons that DUI arrests are down, in order of how often it was listed as a reason (a top 5 reason or a reason but not top 5). The final column shows the percentage that listed that reason as a top 5 reason.

Potential Reason	Total Yes %	Top 5 %
There are too many loopholes working in the favor of the defense.	97.9%	84.4%
SC DUI laws were largely written by defense attorneys.	94.4%	71.1%
Prosecutors are not prepared and/or motivated to take arrests to trial and are looking for any plea agreement.	90.8%	66.1%
I know my arrest will too often end up as a reckless driving or some other lesser charge.	89.2%	47.4%
Generally, DUI cases are too complex and time consuming.	83.7%	47.6%
Judges allow too many delays/continuances.	82.7%	35.2%
Defense attorneys who are legislators have too much influence in the courtroom.	82.7%	38.0%
The dash cam video statute makes arrests/convictions far too difficult.	82.3%	45.6%
Many officers have to prosecute their own cases and feel at a disadvantage or dislike that additional time to prep.	80.3%	41.5%
Other priorities, like calls for service or working crashes, have increased.	76.9%	24.1%
The increase in drugged driving has made enforcement/prosecution even more frustrating.	76.9%	23.5%
Officers dislike the time required and purpose of implied consent hearings.	75.1%	23.8%
Breath test refusals have increased so evidence is weaker.	71.6%	22.0%
Uber/Lyft specifically have led to less impaired driving.	71.2%	25.8%
The paperwork is excessive.	71.1%	27.9%
DUI penalties are not high enough to justify the time/complication of a DUI arrest.	68.4%	24.9%
We have fewer or no officers assigned to traffic.	67.6%	20.9%
Judges too often side with the defense/accused.	67.1%	29.0%
Laws around blood draws make arrests/convictions far too difficult.	65.0%	15.5%
There are too many conflicts of interest between judges and the defense or between the prosecution and defense that lead to "deals."	63.8%	22.3%
Delays in getting toxicology back are too long.	56.2%	12.7%
Initial DUI enforcement training for new officers is insufficient.	55.1%	8.8%
Judges are insufficiently educated on how to preside over DUI cases.	53.7%	16.4%
Opportunities for continued/advanced DUI enforcement training is missing or insufficient	52.3%	8.1%
The law enforcement workforce is generally younger and experience matters with DUI.	50.2%	9.5%
Protocols that apply to the breath testing site make arrests/convictions far too difficult.	49.5%	12.7%
Outside funding/resources, including grants, for DUI/traffic enforcement has decreased.	47.5%	9.2%
Officers today do not put the time/pride into their DUI arrest investigations/reports they once did.	43.9%	10.2%

Judges have said/shown they do not want trials for DUI cases.	39.9%	8.5%
Officers receive little to no recognition for all the hard work it takes to enforce DUI laws.	38.4%	7.0%
More enforcement and/or tougher penalties have led to less impaired driving	24.6%	9.0%
OTHER	22.9%	14.5%
Body cameras have led to law enforcement doing less proactive work.	19.6%	2.5%
Generally, impaired driving is less common now.	19.3%	5.6%
The Datamaster is an insufficient instrument.	14.2%	1.8%

Discussion: Of the 34 items included, 25 were believed to be a reason for decreased DUI arrests in the state by 50% or more of the responses. Only four items were listed as reason by less than 25% of respondents. This indicates that law enforcement believe there are a multitude of reasons for decreased arrests.

The top two reasons from the survey both relate to the slant of our current DUI laws favoring defense attorneys and being created by defense attorneys, in the opinion of law enforcement. More than 70% of the officers said these two reasons were among their top five. "Prosecutors are not prepared and/or motivated to take arrests to trial and are looking for any plea agreement" was the other reason that 90% or more of law enforcement considered a reason for decrease DUI arrests.

Among the most common responses also included items that dealt with complexity of the DUI law ("DUI cases are too complex and time consuming"), the judiciary ("Judges allow too many delays/continuances"), prosecution support ("Many officers have to prosecute their own cases and feel at a disadvantage or dislike that additional time to prep"), legislators who are defense attorneys ("Defense attorneys who are legislators have too much influence in the courtroom"), and general frustrations ("I know my arrest will too often end up as a reckless driving or some other lesser charge).

Two of the three items aimed at determining whether officers believe that decreased impaired driving is contributing to the decrease in arrests were among the lower responses, however "Uber/Lyft specifically have led to less impaired driving" was indicated by 71% of law enforcement to be a reason.

In addition to the responses to these items, officers were invited to write in "Other" reasons if there were any we missed. This led to 14 pages of written comments. However, the vast majority were echoing existing options on our survey or adding their own experiences to why they selected what

they did. In the Appendix of this report, we have included a number of direct quotes from written responses on the survey.

The most frequent item in the comments that were not already reflected in one of our options was the state's lack of use of portable breath test devices (PBTs) that could be used to better measure impairment at the time of the roadside arrest. There were about 10 comments reflecting the need for these devices, suggesting it might have had a good deal of support if it had been included. However, as these have not been used in the state for a long time, it may speak to a frustration more so than a reason for a decrease in arrests.

Another topic that came up with some frequency is the lack of dashboard cameras at some agencies. With no video, they have little chance of getting a DUI conviction.

There were also a troubling number of comments indicating that officers increasingly may be making Public Disorderly Conduct arrests rather than DUI because it is so much simpler to deal with.

Additional Questions: Aside from the lengthy question about why DUI arrests have declined, there were three other questions asked of law enforcement on the survey.

Senate Bill 18, which passed the Senate and awaits House action in January, would require ignition interlocks for some period of time for ALL individuals convicted of DUI AND would add ignition interlock requirements to getting driving privileges back after a breath test refusal suspension. How would you describe your support of S. 18?

Strongly Support	214	66%
Somewhat Support	54	16%
Neutral/Do Not Have Enough Information to Say	41	12%
Low Support or Do Not Support	13	4%

I feel comfortable in making a drugged driving arrest correctly.

Strongly Agree	60	18%
Agree	124	38%
Disagree	80	24%
Strongly Disagree	38	11%
Does Not Apply/I Do Not Make Those Types of Arrests	20	6%

I have a solid understanding of the DUI child endangerment statute and how to handle those situations.

Strongly Agree	103	32%
Agree	132	41%
Disagree	57	15%
Strongly Disagree	15	4%
Does Not Apply/I Do Not Make Those Types of Arrests	14	4%

Appendix: Direct Quotes From Law Enforcement

The comments below are just some of those taken directly from what was written by law enforcement on the two open responses items, one of which was asking what reasons we missed on our list and the other was an invitation to make any comments they wanted MADD to see. These comments were selected for the degree to which they were representative of other comments on a given topic or that they made the point particularly well, in our opinion.

Dissatisfaction with the Laws and Final Disposition of Cases

- The laws are for the defense and have no sympathy for the countless victims that DUI have made.
- Most officers learn that the wording on the DUI law is written in such a way that puts the law at a disadvantage and thus setting up cops to fail, even before they even think of looking for the dangerous and deadly impaired drivers that are out on the streets at any given time. If the law was written in a way that gave officers a level playing field, than maybe more officers would do work to lock up the drunk drivers.
- I have 28 years in law enforcement and have seen many revisions in the law. All of them have made it more difficult to enforce.
- No matter how motivated an officer is to do DUI arrests, taking 4 hours to do an arrest and constantly having those arrests thrown out or plead down is going to take its toll and lead to a lack of motivation to make DUI arrests.
- In the last 5 1/2 years as a Law Enforcement Officer I have less than 5 DUI convictions and have arrested over 150 people for DUI. The convictions that I have been able to secure were individuals that have come to court and plead guilty.

Prosecutors

- Officers would not complain about the amount of time needed to make a quality DUI arrest IF they believed prosecutors would follow through in court.
- Until the lack of prosecution is questioned in my area, nothing will change and cases will continue to vanish. Law enforcement puts a lot of time into making the DUI case and see their case go away with no explanation. This is why the numbers of cases have declined with our agency.
- If anything, I applaud the defense for being that good at their job. I wish that the prosecutors took as much pride and passion into their job to want to get a conviction on these charges. I heard way too

many times that these cases are hard, maybe we should just plea it. It makes all the hard work that has been put into the DUI seem like it was all for nothing.
- Prosecutors not willing to assist. In (redacted), many are plead to reckless before any chance in court is given. Many dropped completely. It's a huge morale killer.

Judges/Magistrates

- More concern is given to how it will affect the defendant's livelihood then the lives they could have affected by driving impaired.

Officers as Prosecutors

- Another issue is that it is absolutely ridiculous that in the State of South Carolina, a Police Officer with only the training he has had at the academy (too little) and whatever experience he or she has gained while working as an Officer is expected to successfully prosecute a DUI case in which the defendant hires a defense attorney who has gone to law school and practiced for years defending people against DUI charges.
- Officers do not make Attorney salaries! They SHOULD NOT be handling all the attorney duties. In all surrounding states, officers have representation. Not so much in SC. Yes, this is expensive, but it is necessary to bring both the arrest and conviction rate up in SC.

Manpower/Resources

- All together a DUI is very time consuming (SFST, vehicle inventory, vehicle tow, DMT-observation period and operation, booking into jail and paperwork). This ties up an officer for a long time during peak hours when our staffing is already low.

Training

- Only a few trained officers make the bulk of DUI arrests. New officers don't have the training and confidence to make arrests

Portable Breath Test Devices

- I believe that the average officer is not confident enough to take someone's freedom without that solid "ah-ha!" evidence. And I believe it's not fair to expect officers to conduct their job without a tool (PBT) that nearly every other state in the union allows their officers to use.

General

- Most of the time DUI arrests do not get charged. Instead they get arrested on other charges like PDC, open container, Reckless Driving, etc.
- Proactivity has dropped off in my area due to poor job satisfaction, poor pay, fear of becoming the next media spectacle, and high call volume, just to name a few reasons.

South Carolina Department of Alcohol and Other Drug Abuse Services

HENRY McMASTER
Governor

SARA GOLDSBY
Director

January 10, 2020

The Honorable Hugh K. Leatherman
Chairman
Senate Finance Committee
South Carolina Senate
111 Gressette Building
Columbia, South Carolina 29201

Dear Senator Leatherman:

Pursuant to Section 56-5-2990 of the 1976 Code of Laws of South Carolina, as amended, the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) is required to report to the Senate Finance Committee and the House Ways and Means Committee the following information on the Alcohol and Drug Safety Action Program (ADSAP):

1. The number of first-time and repeat driving under the influence offenders who completed ADSAP during fiscal year 2019 (SFY19):
   - First-time offenders who successfully completed ADSAP: 5,827
   - Repeat offenders who successfully completed ADSAP: 1,457

   (Source: Discharges Occurring in FY19. CareLogic Clinical Record Data Warehouse)

2. The amount of fees collected and other revenue and expenses incurred by each provider during SFY19:
   - Aggregate fees and other revenue collected from clients referred into ADSAP services: $7,138,657.00
   - Aggregate expenses incurred: $7,920,245.00

     SFY19 Expenses over Revenue: $(781,588.00)

   (Source: Provider audits and unaudited information submitted directly from providers to DAODAS)

3. The number of community-service hours performed in lieu of payment in SFY19:
   - Community-service hours performed: 11,234.35
   - Fees offset by community service: $290,813.00

   (Source: Information submitted by providers)

Please feel free to contact me if you have any questions.

Sincerely,

Sara Goldsby
Director

SG/sp

DAODAS

mailing: Post Office Box 8268 • Columbia, South Carolina 29202
location: 1801 Main Street, 4th Floor • Columbia, South Carolina 29201
telephone: 803-896-5555 • *fax*: 803-896-5557 • www.daodas.sc.gov

South Carolina Department of Alcohol and Other Drug Abuse Services

HENRY McMASTER
Governor

SARA GOLDSBY
Director

January 10, 2020

The Honorable Murrell Smith
Chairman
Ways and Means Committee
South Carolina House of Representatives
525 Blatt Building
Columbia, South Carolina 29201

Dear Representative Smith:

Pursuant to Section 56-5-2990 of the 1976 Code of Laws of South Carolina, as amended, the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) is required to report to the Senate Finance Committee and the House Ways and Means Committee the following information on the Alcohol and Drug Safety Action Program (ADSAP):

1. The number of first-time and repeat driving under the influence offenders who completed ADSAP during fiscal year 2019 (SFY19):
   - First-time offenders who successfully completed ADSAP: 5,827
   - Repeat offenders who successfully completed ADSAP: 1,457

   (Source: Discharges Occurring in FY19. CareLogic Clinical Record Data Warehouse)

2. The amount of fees collected and other revenue and expenses incurred by each provider during SFY19:
   - Aggregate fees and other revenue collected from clients referred into ADSAP services: $7,138,657.00
   - Aggregate expenses incurred: $7,920,245.00

   SFY19 Expenses over Revenue: $(781,588.00)

   (Source: Provider audits and unaudited information submitted directly from providers to DAODAS)

3. The number of community-service hours performed in lieu of payment in SFY19:
   - Community-service hours performed: 11,234.35
   - Fees offset by community service: $290,813.00

   (Source: Information submitted by providers)

Please feel free to contact me if you have any questions.

Sincerely,

Sara Goldsby
Director

SG/sp

DAODAS

mailing: Post Office Box 8268 • Columbia, South Carolina 29202
location: 1801 Main Street, 4th Floor • Columbia, South Carolina 29201
telephone: 803-896-5555 • *fax*: 803-896-5557 • www.daodas.sc.gov

Appendix B.
TEDS Data Elements

TEDS Minimum Data Set

Age of first use (primary, secondary, and tertiary substance)

For drugs other than alcohol, these fields identify the age at which the client first used the respective substance. For alcohol, these fields record the age of first intoxication.

- 0—Indicates a newborn with a substance dependency problem
- 1–95—Indicates the age at first use

Client or codependent/collateral

Specifies whether the admission record is for a substance use treatment client, or a person being treated for his/her codependency or collateral relationship with a substance user.

- Client—Must meet all of the following criteria:
  - Has an alcohol or drug related disorder
  - Has completed the screening and intake process
  - Has been formally admitted for treatment or recovery service in an alcohol or drug treatment unit
  - Has his or her own client record

A person is not a client if he or she has completed only a screening or intake process or has been placed on a waiting list.

- Codependent/collateral—Must meet all of the following criteria:
  - Has no alcohol or drug related disorder
  - Is seeking services because of concerns arising from his or her relationship with an alcohol or drug user
  - Has been formally admitted for service to a treatment unit
  - Has his or her own client record or has a record within a primary client record

Guidelines: Reporting of data for *Codependent/collaterals* is optional. If the state opts to report codependent/collateral clients, the mandatory fields are *State code, Provider identifier, Client identifier, Client transaction type, Codependent/collateral*, and *Date of admission*. Reporting of the remaining fields in the TEDS Minimum and Supplemental Data Sets is optional. For all items not reported, the data field should be coded with the appropriate "Not collected" or "Not applicable" code.

If a substance use client with an existing record in TEDS becomes a codependent, a new client record should be submitted indicating that the client has been admitted as a codependent, and vice versa.

If a record does not include a value for this field, it is assumed to be a substance use client record.

Date of admission

The day when the client receives his or her first direct treatment or recovery service. For transfers, this is the date when the client receives his or her first direct treatment after the transfer has occurred.

Demographics

Age

Identifies the client's age at admission. Derived from client's date of birth and date of admission.

- 0—Indicates a newborn with a substance dependency problem
- 1–95—Indicates the age at admission

Education

Specifies the highest school grade (number of school years) completed by the client.

- 0—Less than one grade completed
- 1–25—Years of school (highest grade) completed. For General Equivalency Degree, use 12.

Guidelines: States that use specific categories for designating education level should map their codes to a logical number of years of school completed. For Associate's Degree, use 14. For Bachelor's degree, use 16.

Employment status

Identifies the client's employment status at the time of admission or transfer.

- Full time—Working 35 hours or more each week, including active duty members of the uniformed services
- Part time—Working fewer than 35 hours each week
- Unemployed—Looking for work during the past 30 days, or on layoff from a job
- Not in labor force—Not looking for work during the past 30 days, or a student, homemaker, disabled, retired, or an inmate of an institution. Clients in this category are further defined in the TEDS Supplemental Data Set item Detailed not in labor force.

Guidelines: Seasonal workers are coded in this category based on their employment status at admission.

Ethnicity

Identifies the client's specific Hispanic origin.

- Cuban—Of Cuban origin, regardless of race
- Hispanic (specific origin not specified)—Of Hispanic origin, but specific origin not known or not specified
- Mexican—Of Mexican origin, regardless of race
- Not of Hispanic origin
- Other specific Hispanic—Of known Central or South American or any other Spanish cultural origin (including Spain), other than Puerto Rican, Mexican, or Cuban, regardless of race
- Puerto Rican—Of Puerto Rican origin, regardless of race

Guidelines: If a state does not collect specific Hispanic detail, code *Ethnicity* for Hispanics as *Hispanic (specific origin not specified)*.

Race

Specifies the client's race.

- Alaska Native (Aleut, Eskimo, Indian)—Origins in any of the original people of Alaska
- American Indian (other than Alaska Native)—Origins in any of the original people of North America and South America (including Central America) and who maintains cultural identification through tribal affiliation or community attachment
- Asian or Pacific Islander—Origins in any of the original people of the Far East, the Indian subcontinent, Southeast Asia, or the Pacific islands
- Asian—Origins in any of the original people of the Far East, the Indian subcontinent, or Southeast Asia, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Philippine Islands, Thailand, and Vietnam
- Native Hawaiian or Other Pacific Islander—Origins in any of the original people of Hawaii, Guam, Samoa, or other Pacific islands
- Black or African American—Origins in any of the black racial groups of Africa
- White—Origins in any of the original people of Europe, North Africa, or the Middle East
- Other single race—Client is not classified in any category above or whose origin group, because of area custom, is regarded as a racial class distinct from the above categories
- Two or more races—For use when the state data system allows multiple race selection and more than one race is indicated

Guidelines: If a state does not distinguish between American Indian and Alaska Native, both should be coded as American Indian. If a state does not distinguish between Asian and Native Hawaiian or other Pacific Islander, both should be coded as Asian or Pacific Islander. For states that collect multiple races: (a) when a single race is designated, the specific race code should be used; (b) if the state collects a primary or preferred race along with additional races, the code for the primary/preferred race should be used; (c) if the state uses a system such as an algorithm to select a single

race when multiple races have been designated, the same system may be used to determine the race code for TEDS. When two or more races have been designated and neither (b) nor (c) above apply, the TEDS code for *Two or more races* should be used.

Sex

Identifies the client's gender.

- Male
- Female

Substance Use and Treatment Characteristics

Frequency of use (primary, secondary, and tertiary substances)

Identifies the frequency of use for the client's primary, secondary, and tertiary *substance use*.

- No use in the past month
- 1–3 times in the past month
- 1–2 times in the past week
- 3–6 times in the past week
- Daily

Medication-assisted opioid therapy

Identifies whether the use of methadone, naltrexone or buprenorphine is part of the client's treatment plan.

- Yes
- No

Number of prior treatment episodes

Indicates the number of previous treatment episodes the client has received in any drug or alcohol program. Changes in service for the same episode (transfers) should not be counted as separate prior episodes.

- 0 previous episodes
- 1 previous episode
- 2 previous episodes
- 3 previous episodes
- 4 previous episodes
- 5 or more previous episodes

Guidelines: It is preferred that the number of prior treatments be a self-reporting field collected at the time of client intake. However, this data item may be derived from the state data system if the system has that capability and episodes can be counted for at least several years.

Principal source of referral

Describes the person or agency referring the client to the alcohol or drug use treatment program.

- Alcohol/drug use care provider—Any program, clinic, or other health care provider whose principal objective is treating clients with substance use disorder, or a program whose activities are related to alcohol or other drug use prevention, education, or treatment
- Court/criminal justice referral/DUI/DWI—Any police official, judge, prosecutor, probation officer, or other person affiliated with a federal, state, or county judicial system. Includes referral by a court for DWI/DUI, clients referred in lieu of or for deferred prosecution, or during pretrial release, or before or after official adjudication. Includes clients on pre-parole, pre-release, work or home furlough, or TASC. Client need not be officially designated as "on parole." Includes clients referred through civil commitment. Client referrals on this category are further defined in the TEDS Supplemental Data Set item Detailed criminal justice referral.
- Employer/EAP—A supervisor or an employee counselor
- Individual (includes self-referral)—Includes the client, a family member, friend, or any other individual who would not be included in any of the following categories; includes self-referral due to pending DWI/DUI
- Other community referral—Community or religious organization or any federal, state, or local agency that provides aid in the areas of poverty relief, unemployment, shelter, or social welfare. Self-help groups such as Alcoholics Anonymous (AA), Al-Anon, and Narcotics Anonymous (NA) are also included in this category. Defense attorneys are included in this category.
- Other health care provider—A physician, psychiatrist, or other licensed health care professional; or a general hospital, psychiatric hospital, mental health program, or nursing home
- School (educational)—A school principal, counselor, or teacher; or a student assistance program (SAP), the school system, or an educational agency

Substance use (primary, secondary, or tertiary)

Identifies the client's primary, secondary, and tertiary substance use. Each *Substance use* (primary, secondary, and tertiary) has associated fields for *Route of administration, Frequency of use, Age at first use*, and the TEDS Supplemental Data Set item *Detailed drug code*.

- Alcohol
- Barbiturates—Amobarbital, pentobarbital, phenobarbital, secobarbital, etc.
- Benzodiazepines—Includes alprazolam, chlordiazepoxide, clonazepam, clorazepate, diazepam, flunitrazepam, flurazepam, halazepam, lorazepam, oxazepam, prazepam, temazepam, triazolam, and other unspecified benzodiazepines
- Cocaine/crack

- Heroin
- Inhalants—Includes chloroform, ether, gasoline, glue, nitrous oxide, paint thinner, etc.
- Marijuana/hashish—Includes THC and any other cannabis sativa preparations
- Methamphetamine
- Non-prescription methadone
- Other amphetamines—Includes amphetamines, MDMA, phenmetrazine, and other unspecified amines and related drugs
- Other hallucinogens—Includes LSD, DMT, STP, hallucinogens, mescaline, peyote, psilocybin, etc.
- Other non-barbiturate sedatives or hypnotics—Includes chloral hydrate, ethchlorvynol, glutethimide, methaqualone, and other non-barbiturate sedatives or hypnotics
- Other non-benzodiazepine tranquilizers—Includes meprobamate and other non-benzodiazepine tranquilizers
- Other opiates and synthetics—Includes buprenorphine, codeine, hydrocodone, hydromorphone, meperidine, morphine, opium, oxycodone, pentazocine, propoxyphene, tramadol, and any other drug with morphine-like effects
- Other stimulants—Includes methylphenidate and any other stimulants
- Over-the-counter medications—Includes aspirin, cough syrup, diphenhydramine and other antihistamines, sleep aids, and any other legally obtained nonprescription medication
- PCP—Phencyclidine
- Other—Includes diphenylhydantoin/phenytoin, GHB/GBL, ketamine, etc.
- None

Guidelines: Substance use is further defined in the TEDS Supplemental Data Set item *Detailed drug code*. For guidance on which specific substances to include in the substance categories, please refer to the detailed drug categories listed for Detailed drug code.

Data set considerations for *Substance use* and *Route of administration*:

For states that do collect *Detailed drug code*—Records may have duplicate *Substance use* and identical *Route of administration* if the corresponding *Detailed drug codes* are different or are ‘‘multiple’’ drug codes.

For states that do not collect *Detailed drug code*—A record may not have duplicate *Substance use* with identical *Routes of administration*.

Transaction type

Identifies whether a record is for an initial admission or a transfer/change in service. Note: Some states may use other terminology such as "initial admission" and "transfer admission" in place of "admission" and "transfer."

- A—Admission
- T—Transfer/change in service

Guidelines: For TEDS, a treatment episode is defined as that period of service between the beginning of treatment for drug or alcohol use and the termination of services for the prescribed treatment plan. The episode includes one admission (when services begin) and at least one discharge (when services end). Within a treatment episode, a client may transfer to a different service, facility, provider, program, or location. Each admission and transfer record should have an associated discharge record.

When it is feasible for the state to identify transfers, they should be reported as transfers in admissions data submissions. When admissions and transfers cannot be differentiated in a state data system, such changes in service or facility should be reported to TEDS as admissions.

Data set considerations for transfers:

- All fields from the transfer record should be updated to reflect values at the time of transfer except the following fields, which must have the same values as in the associated (preceding) admission record: *Client ID, Codependent/collateral, Date of birth, Sex, Race,* and *Ethnicity*. If a field cannot be updated, it should be transmitted to TEDS with its value from the associated (preceding) admission record.
- *Date of admission* is defined as the date services begin after the transfer to another service or facility.

Type of treatment service

Describes the type of service and treatment setting in which the client is placed at the time of admission or transfer.

- Ambulatory, detoxification—Outpatient treatment services providing for safe withdrawal in an ambulatory setting (pharmacological or non-pharmacological)
- Ambulatory, intensive outpatient—As a minimum, the client must receive treatment lasting two or more hours per day for three or more days per week
- Ambulatory, non-intensive outpatient—Ambulatory treatment services including individual, family, and/or group services, and may include pharmacological therapies
- Detoxification, 24-hour service, free-standing residential—24-hour per day services in a non-hospital setting providing for safe withdrawal and transition to ongoing treatment
- Detoxification, 24-hour service, hospital inpatient—24-hour per day medical acute care services in a hospital setting for detoxification of persons with severe medical complications associated with withdrawal

- Rehabilitation/residential, hospital (other than detoxification)—24-hour per day medical care in a hospital facility in conjunction with treatment services for alcohol and other drug use and dependency
- Rehabilitation/residential, short-term (30 days or fewer)—Typically, 30 days or less of non-acute care in a setting with treatment services for alcohol and other drug use and dependency
- Rehabilitation/residential, long-term (more than 30 days)—Typically, more than 30 days of non-acute care in a setting with treatment services for alcohol and other drug use and dependency; this may include transitional living arrangements such as halfway houses

Usual route of administration (primary, secondary, and tertiary substances)

Identifies the usual route of administration of the respective *substance use*.

- Inhalation
- Injection (IV or intramuscular)
- Oral
- Smoking
- Other

TEDS Linked Discharge Data Set

Date of discharge

The date when the client was formally discharged from the treatment facility or service. The date may be the same as the date of last contact. In the event of a change of service or provider within an episode of treatment, it is the date the service terminated or the date the treatment ended at a particular provider.

Date of last contact

The date when the client was last seen for a treatment. The date may be the same as the date of discharge. In the event of a change of service or provider within an episode of treatment, it is the date the client transferred to another service or provider.

Detailed not in labor force at admission/discharge

Records more detailed information about those clients who are coded as *Not in labor force* in the TEDS Minimum Data Set item *Employment status*.

- Disabled
- Homemaker
- Inmate of institution (prison or institution that keeps a person, otherwise able, from entering the labor force)
- Other
- Retired
- Student

Employment status at discharge

See TEDS Minimum Data Set item *Employment status* for definitions.

Frequency of attendance at self-help programs in 30 days prior to admission/discharge

Records the number of times the client has attended a self-help program in the 30 days preceding the date of admission to and discharge from treatment services.

- No attendance in the past month
- 1–3 times in the past month
- 4–7 times in the past month
- 8–15 times in the past month
- 16–30 times in the past month
- Some attendance in the past month, but frequency unknown

Frequency of use at discharge (primary, secondary, and tertiary substances)

See TEDS Minimum Data Set item *Frequency of use* for definitions.

Living arrangements at admission/discharge

Records whether the client is homeless, living with parents, in a supervised setting, or living on his or her own at the time of admission and discharge.

- Dependent living—Clients living in a supervised setting such as a residential institution, halfway house, or group home, and children (under age 18) living with parents, relatives, or guardians or in foster care
- Homeless—Clients with no fixed address; includes shelters
- Independent living—Clients living alone or with others without supervision

Number of arrests in 30 days prior to admission/discharge

Records the number of arrests in the 30 days preceding the date of admission to and discharge from treatment services.

- 0–96—Number of arrests

Reason for discharge, transfer, or discontinuance of treatment

Indicates the outcome of treatment or the reason for transfer or discontinuance of treatment.

- Death
- Incarcerated—Jail, prison, house confinement
- Left against professional advice (dropped out)—Client chose not to complete treatment program, with or without specific advice to continue treatment; includes clients who dropped out for unknown reasons and clients who did not receive a treatment service for some time and were discharged for administrative reasons
- Terminated by facility—Treatment terminated by action of facility, generally because of client non-compliance or violation of rules, laws, or procedures (excludes client drop-out, incarceration, or client-motivated reason for discontinuance)
- Transferred to another substance use program or facility—Client was transferred to another substance use treatment service type, program, provider, or facility; client may or may not have reported to the new program or facility
- Treatment completed—All parts of the treatment plan or program were completed.
- Other—Client moved, became ill, was hospitalized, or other reason somewhat out of client's control
- Unknown—Client status at discharge not known (e.g., record incomplete or lost); not to be used for clients who dropped out of treatment

PUBLIC SUBSTANCE USE DISORDER TREATMENT INFORMATION

CLINICAL INFORMATION FOR FINAL DISCHARGE EPISODES IN STATE FISCAL YEAR 2019

PATIENT DEMOGRAPHICS
SUBSTANCE USE PROFILES
TREATMENT UTILIZATION
STATE- AND COUNTY-LEVEL OUTCOMES
EMPLOYMENT
LIVING SITUATION
ARRESTS
ALCOHOL AND OTHER SUBSTANCE USE

Run Date = September 5, 2019

SOURCE: This report was produced from Clinical Data Extracts Provided by the County Alcohol and Drug Abuse Authorities' Electronic Clinical Record

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

REPORT NOTES

The Discharged Episodes Report is intended to assist our county providers in monitoring and reporting patient substance use disorder treatment outcomes in South Carolina. The latest report covers **32,453** patient episode discharges during the period of **FY2019** (July 1, 2018 – June 30, 2019).

To build the dataset, we utilize the following CareLogic data tables:

Rpt_TED_NOM_Combined
Rpt_Client
Rpt_Programs
Rpt_Client_Episodes

The report is basically organized into three sections:

Patient Demographics and Substance Abuse Profiles (Pages 1-6)
Treatment Utilization (Pages 7-9)
Patient Outcomes (Pages 10-12)

Definitions

Final Episode Discharge: The final episode discharge record is obtained by selecting records in the TED_NOM_Combined table where the data field TYPE_TRAN_DIS_REQUEST = “Discharge from Episode/Organization."

Run Date: This is the date we extracted the dataset for analysis and reporting.

Length of Stay (LOS) includes time spent in all programs accessed during an episode of care (initial admission to final discharge).

Dominant Program: Dominant program status is determined by assigning discharges to highest level of care accessed during an episode of care.

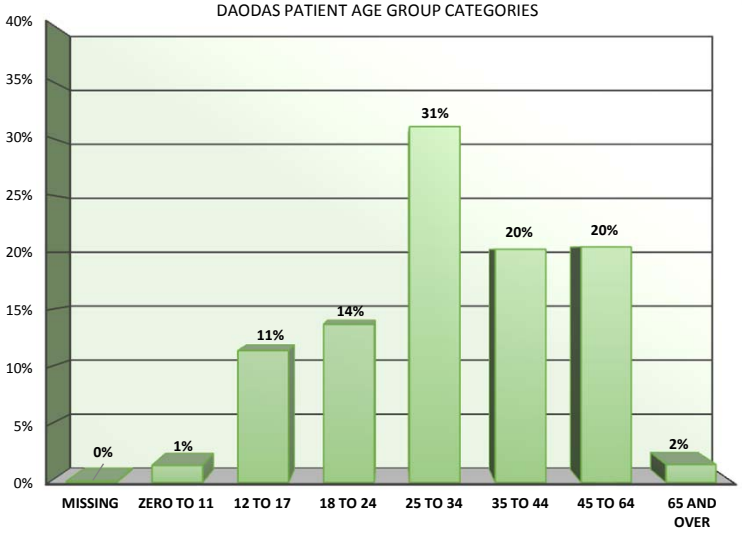
Outcomes: These data elements are required by SAMHSA for their National Outcome Measures (NOMs). Note that each outcome domain contains its own criteria (e.g., Employment Status is limited to clients age 18 and older). We measure outcomes at three points: Admission – Discharge – Follow-up Survey so only records where the patient provided a response to the question are included.

Feedback

The work of creating and refining statistical reports based on the CareLogic system is an ongoing process, so we welcome your suggestions and feedback on how we can provide you with the most useful information.

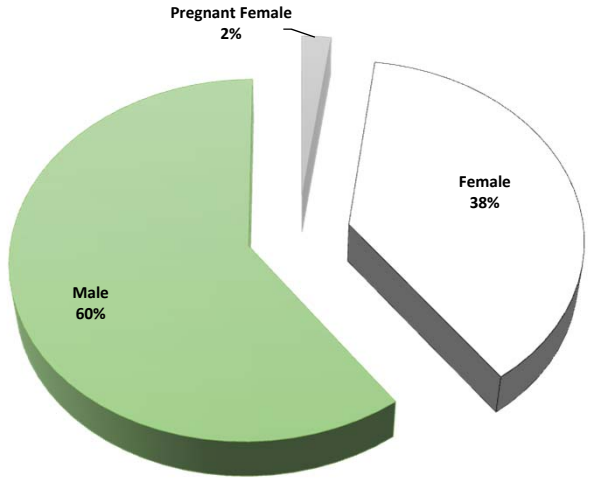
Jim Maxwell, Statistician
DAODAS
jmaxwell@daodas.sc.gov
(803) 896-1198

DAODAS PATIENT AGE GROUP CATEGORIES



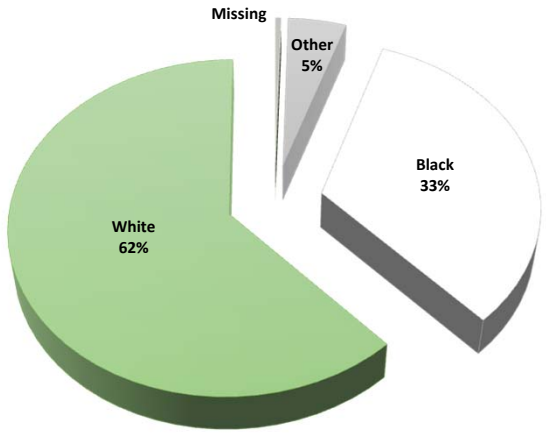
Total Discharges = 32,453

DAODAS PATIENT GENDER AND PREGNANCY STATUS DISTRIBUTION



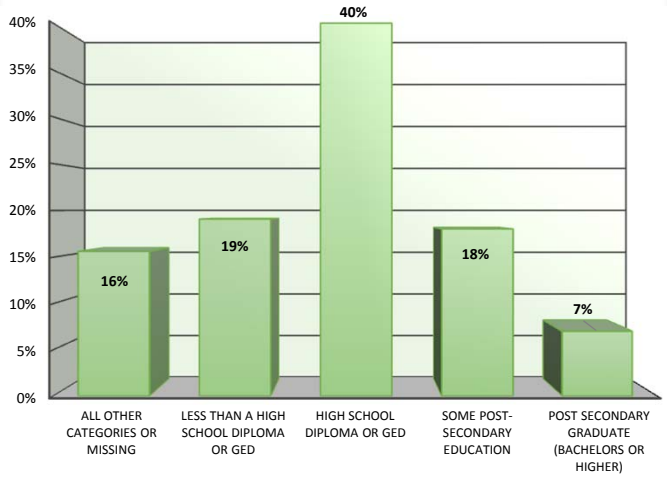
Male = 19,481 Female = 12,265 Pregnant Female = 707

DAODAS PATIENT RACE GROUP DISTRIBUTION



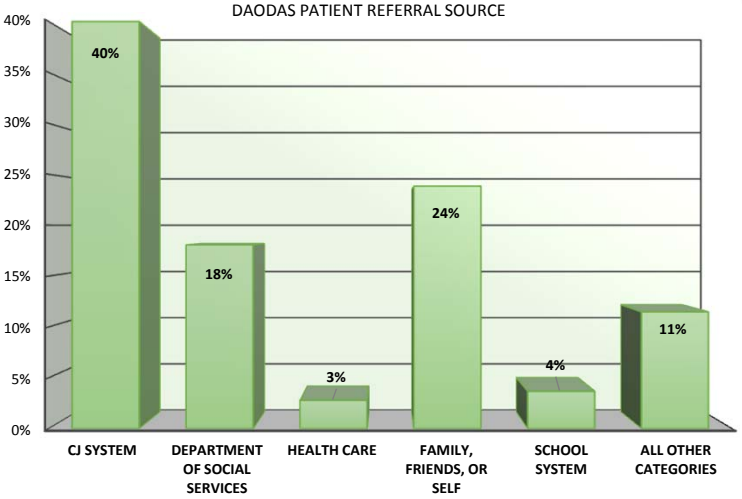
White = 20,114 Black = 10,660 All Other Categories = 1,524

DAODAS PATIENT EDUCATION STATUS



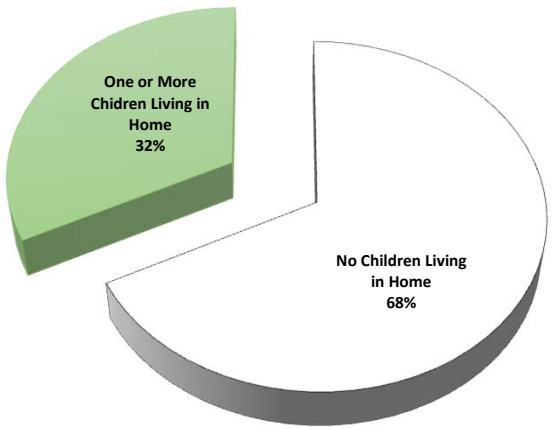
Total Discharges = 32,453

DAODAS PATIENT REFERRAL SOURCE



Total Discharges = 32,453

DAODAS PATIENT HOUSEHOLD COMPOSITION (CHILDREN LIVING IN HOME)



ONE OR MORE CHILDREN = 10,514 NO CHILDREN = 21,939

DAODAS PATIENT DEMOGRAPHICS FOR ALL DISCHARGED EPISODES OCCURRING IN SFY 2019
BY PROVIDER

Agency	Total Discharge Count	Unique Discharge Count	Age Groups							Race			Gender*			Referral Source**					
			Zero to 11	12 to 17	18 to 24	25 to 34	35 to 44	45 to 64	65 and over	Other Categ.	Black	White	Preg. Female	Female	Male	CJ System	DSS	Health Care	Self	School	Other Categ.
Aiken Center	794	768	1	59	141	264	163	141	24	42	255	497	13	287	494	540	136	5	60	0	25
Anderson Oconee	1,313	1,250	5	95	219	429	297	247	21	47	265	1,000	33	559	721	591	424	35	156	9	48
Barnwell	186	178	0	21	33	49	31	47	4	1	91	94	1	60	125	80	33	0	56	0	1
Beaufort	862	837	0	121	134	250	155	170	31	101	253	504	7	240	615	578	61	12	80	59	15
Berkeley	894	868	3	192	112	257	145	166	18	48	295	551	14	323	557	377	110	13	182	105	20
Charleston	2,614	2,418	36	129	314	904	594	603	30	108	867	1,635	81	915	1,618	851	355	65	1,049	13	103
Cherokee	478	445	0	22	83	162	115	92	4	9	109	360	8	197	273	305	109	0	39	4	7
Chester	304	300	0	9	33	95	73	87	7	3	112	189	4	99	201	134	41	2	31	0	12
Clarendon	367	359	31	64	45	87	66	69	5	6	186	175	9	165	193	119	73	7	105	21	1
Colleton	291	279	0	15	58	87	62	63	6	7	102	176	6	107	178	117	61	7	50	8	4
Darlington	323	319	10	36	48	90	79	55	5	4	132	186	8	167	148	86	116	5	80	4	7
Dorchester	1,410	1,378	14	363	189	371	245	201	25	111	438	794	16	534	860	534	212	20	218	219	18
Fairfield	182	178	3	14	22	55	41	46	1	2	118	62	4	73	105	97	49	4	16	7	3
Florence	1,123	1,089	32	54	150	380	246	244	17	15	509	598	55	452	616	439	200	26	281	4	39
Georgetown	410	390	0	50	57	114	94	86	7	17	166	227	4	146	260	203	76	14	82	1	7
Greenville	4,284	3,846	72	530	462	1,340	893	941	43	291	1,087	2,906	110	1,526	2,648	1,701	633	280	1,151	185	53
Allendale-Hampton-Jasper	175	174	0	12	26	53	43	36	4	7	99	69	2	67	106	82	31	2	27	3	3
Horry	1,626	1,598	11	167	218	550	347	313	20	78	337	1,210	46	717	863	663	506	24	351	14	11
Lancaster	504	496	0	21	90	175	95	112	11	21	171	311	19	203	282	212	151	13	55	0	7
Laurens	560	526	0	64	77	163	120	119	16	11	150	399	15	211	334	240	122	14	74	3	83
Newberry and Saluda	430	423	26	50	64	126	66	83	15	26	167	237	11	146	273	191	79	6	104	26	5
Orangeburg-Bamberg-Calhoun	985	954	9	194	145	270	160	192	10	20	613	346	14	314	657	394	129	26	254	26	6
Pickens	1,223	1,188	146	269	150	312	196	136	11	53	106	1,046	33	532	658	321	324	61	222	182	70
LRADAC	4,003	3,665	10	410	516	1,265	808	941	49	170	1,543	2,289	43	1,435	2,525	1,289	471	112	1,165	229	318
Spartanburg	1,350	1,284	0	202	196	420	260	250	20	108	382	859	30	555	765	636	334	17	259	41	16
Sumter	638	619	3	50	105	194	129	147	8	16	349	272	11	260	367	272	102	4	195	0	25
Union	298	294	0	94	30	61	56	51	6	6	142	150	5	72	221	204	30	1	18	0	4
Williamsburg	277	268	0	30	33	80	65	61	8	0	189	88	4	85	188	134	51	0	42	0	10
York	1,949	1,768	0	108	325	659	385	428	40	98	455	1,394	45	776	1,128	722	344	86	614	16	89
Cornerstone - GEMA	699	683	1	48	118	193	163	155	21	11	262	426	10	262	427	384	101	7	95	7	13
Kershaw-Chesterfield-Lee	1,174	1,128	62	98	144	351	257	246	16	54	373	741	23	478	673	361	213	17	474	3	59
Marion-Dillon-Marlboro	727	717	11	126	119	224	125	113	8	33	337	323	23	302	402	183	182	14	153	1	18
Total	32,453	30,687	486	3,717	4,456	10,030	6,574	6,641	511	1,524	10,660	20,114	707	12,265	19,481	13,040	5,859	899	7,738	1,190	1,100

* Pregnancy status determined from responses at admission, transfer, or discharge

** Self category includes referrals from family and friends

** CJ system referrals include referrals due to driving under the influence charges/convictions

RUN DATE=09/05/2019

DAODAS PATIENT DEMOGRAPHICS FOR ALL DISCHARGED EPISODES OCCURRING IN SFY 2019
PERCENT DISTRIBUTION BASED ON TOTAL DISCHARGES BY PROVIDER

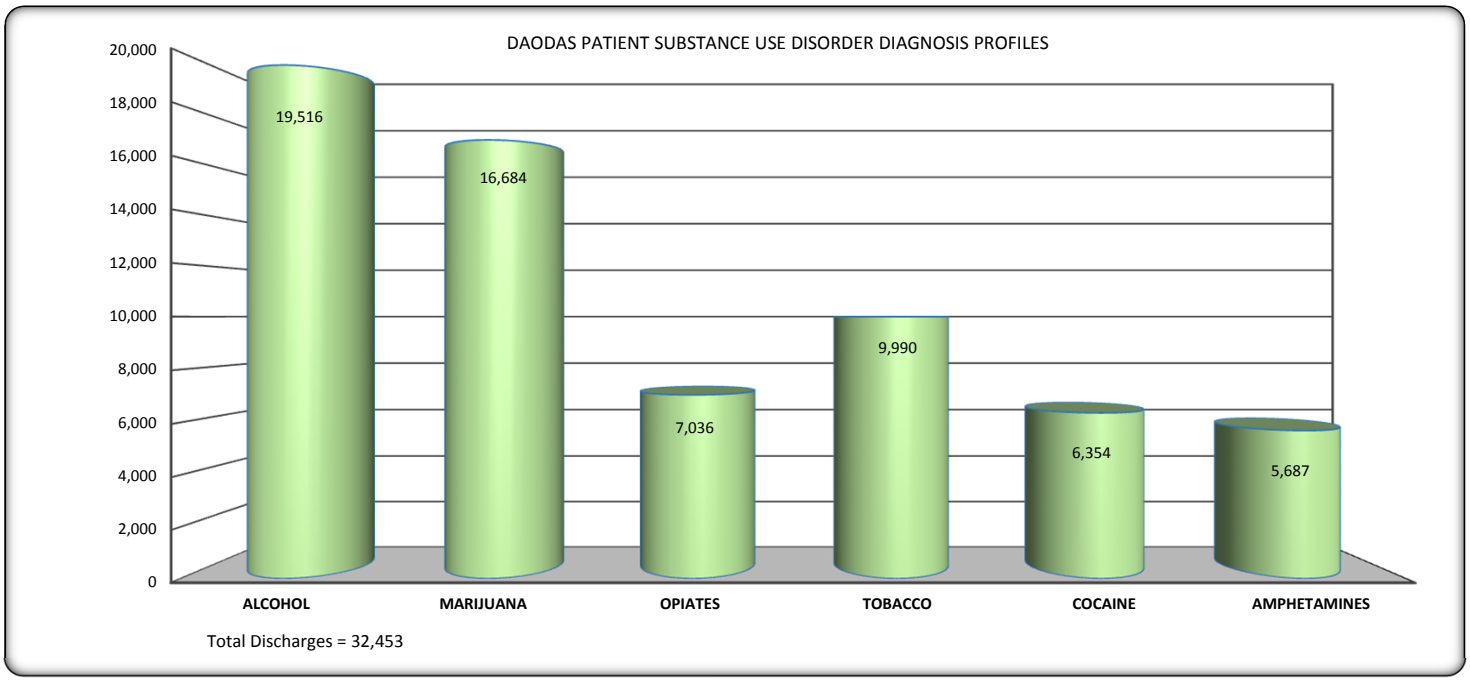
Agency	Total Discharge Count	Unique Discharge Count	Age Groups							Race			Gender*			Referral Source**					
			Zero to 11	12 to 17	18 to 24	25 to 34	35 to 44	45 to 64	65 and over	Other Categ.	Black	White	Preg. Female	Female	Male	CJ System	DSS	Health Care	Self	School	Other Categ.
Aiken Center	794	97%	0%	7%	18%	33%	21%	18%	3%	5%	32%	63%	2%	36%	62%	68%	17%	1%	8%	0%	3%
Anderson Oconee	1,313	95%	0%	7%	17%	33%	23%	19%	2%	4%	20%	76%	3%	43%	55%	45%	32%	3%	12%	1%	4%
Barnwell	186	96%	0%	11%	18%	26%	17%	25%	2%	1%	49%	51%	1%	32%	67%	43%	18%	0%	30%	0%	1%
Beaufort	862	97%	0%	14%	16%	29%	18%	20%	4%	12%	29%	58%	1%	28%	71%	67%	7%	1%	9%	7%	2%
Berkeley	894	97%	0%	21%	13%	29%	16%	19%	2%	5%	33%	62%	2%	36%	62%	42%	12%	1%	20%	12%	2%
Charleston	2,614	93%	1%	5%	12%	35%	23%	23%	1%	4%	33%	63%	3%	35%	62%	33%	14%	2%	40%	0%	4%
Cherokee	478	93%	0%	5%	17%	34%	24%	19%	1%	2%	23%	75%	2%	41%	57%	64%	23%	0%	8%	1%	1%
Chester	304	99%	0%	3%	11%	31%	24%	29%	2%	1%	37%	62%	1%	33%	66%	44%	13%	1%	10%	0%	4%
Clarendon	367	98%	8%	17%	12%	24%	18%	19%	1%	2%	51%	48%	2%	45%	53%	32%	20%	2%	29%	6%	0%
Colleton	291	96%	0%	5%	20%	30%	21%	22%	2%	2%	35%	60%	2%	37%	61%	40%	21%	2%	17%	3%	1%
Darlington	323	99%	3%	11%	15%	28%	24%	17%	2%	1%	41%	58%	2%	52%	46%	27%	36%	2%	25%	1%	2%
Dorchester	1,410	98%	1%	26%	13%	26%	17%	14%	2%	8%	31%	56%	1%	38%	61%	38%	15%	1%	15%	16%	1%
Fairfield	182	98%	2%	8%	12%	30%	23%	25%	1%	1%	65%	34%	2%	40%	58%	53%	27%	2%	9%	4%	2%
Florence	1,123	97%	3%	5%	13%	34%	22%	22%	2%	1%	45%	53%	5%	40%	55%	39%	18%	2%	25%	0%	3%
Georgetown	410	95%	0%	12%	14%	28%	23%	21%	2%	4%	40%	55%	1%	36%	63%	50%	19%	3%	20%	0%	2%
Greenville	4,284	90%	2%	12%	11%	31%	21%	22%	1%	7%	25%	68%	3%	36%	62%	40%	15%	7%	27%	4%	1%
Allendale-Hampton-Jasper	175	99%	0%	7%	15%	30%	25%	21%	2%	4%	57%	39%	1%	38%	61%	47%	18%	1%	15%	2%	2%
Horry	1,626	98%	1%	10%	13%	34%	21%	19%	1%	5%	21%	74%	3%	44%	53%	41%	31%	1%	22%	1%	1%
Lancaster	504	98%	0%	4%	18%	35%	19%	22%	2%	4%	34%	62%	4%	40%	56%	42%	30%	3%	11%	0%	1%
Laurens	560	94%	0%	11%	14%	29%	21%	21%	3%	2%	27%	71%	3%	38%	60%	43%	22%	3%	13%	1%	15%
Newberry and Saluda	430	98%	6%	12%	15%	29%	15%	19%	3%	6%	39%	55%	3%	34%	63%	44%	18%	1%	24%	6%	1%
Orangeburg-Bamberg-Calhoun	985	97%	1%	20%	15%	27%	16%	19%	1%	2%	62%	35%	1%	32%	67%	40%	13%	3%	26%	3%	1%
Pickens	1,223	97%	12%	22%	12%	26%	16%	11%	1%	4%	9%	86%	3%	43%	54%	26%	26%	5%	18%	15%	6%
LRADAC	4,003	92%	0%	10%	13%	32%	20%	24%	1%	4%	39%	57%	1%	36%	63%	32%	12%	3%	29%	6%	8%
Spartanburg	1,350	95%	0%	15%	15%	31%	19%	19%	1%	8%	28%	64%	2%	41%	57%	47%	25%	1%	19%	3%	1%
Sumter	638	97%	0%	8%	16%	30%	20%	23%	1%	3%	55%	43%	2%	41%	58%	43%	16%	1%	31%	0%	4%
Union	298	99%	0%	32%	10%	20%	19%	17%	2%	2%	48%	50%	2%	24%	74%	68%	10%	0%	6%	0%	1%
Williamsburg	277	97%	0%	11%	12%	29%	23%	22%	3%	0%	68%	32%	1%	31%	68%	48%	18%	0%	15%	0%	4%
York	1,949	91%	0%	6%	17%	34%	20%	22%	2%	5%	23%	72%	2%	40%	58%	37%	18%	4%	32%	1%	5%
Cornerstone - GEMA	699	98%	0%	7%	17%	28%	23%	22%	3%	2%	37%	61%	1%	37%	61%	55%	14%	1%	14%	1%	2%
Kershaw-Chesterfield-Lee	1,174	96%	5%	8%	12%	30%	22%	21%	1%	5%	32%	63%	2%	41%	57%	31%	18%	1%	40%	0%	5%
Marion-Dillon-Marlboro	727	99%	2%	17%	16%	31%	17%	16%	1%	5%	46%	44%	3%	42%	55%	25%	25%	2%	21%	0%	2%
Total	32,453	95%	1%	11%	14%	31%	20%	20%	2%	5%	33%	62%	2%	38%	60%	40%	18%	3%	24%	4%	3%

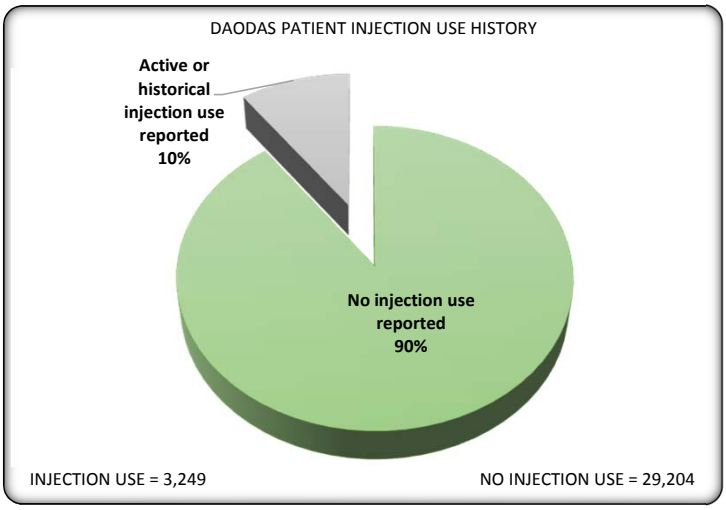
* Pregnancy status determined from responses at admission, transfer, or discharge

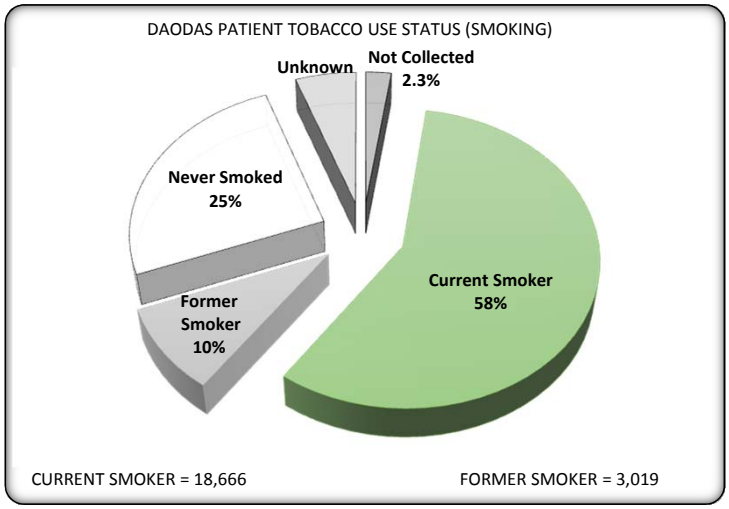
** Self category includes referrals from family and friends

** CJ system referrals include referrals due to driving under the influence charges/convictions

RUN DATE=09/05/2019


DAODAS PATIENT SUBSTANCE USE DISORDER DIAGNOSIS PROFILES
20,000
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
19,516
16,684
7,036
9,990
6,354
5,687
ALCOHOL
MARIJUANA
OPIATES
TOBACCO
COCAINE
AMPHETAMINES
Total Discharges = 32,453


DAODAS PATIENT INJECTION USE HISTORY
Active or historical injection use reported 10%
No injection use reported 90%
INJECTION USE = 3,249
NO INJECTION USE = 29,204


DAODAS PATIENT TOBACCO USE STATUS (SMOKING)
Unknown
Not Collected 2.3%
Never Smoked 25%
Former Smoker 10%
Current Smoker 58%
CURRENT SMOKER = 18,666
FORMER SMOKER = 3,019

DAODAS PATIENT SUBSTANCE USE PROFILES FOR ALL DISCHARGED EPISODES OCCURRING IN SFY 2019
BY PROVIDER

Agency	Total Discharge Count	Unique Discharge Count	Substance Use Profiles (Primary or Secondary Diagnosis/Problem)						Injection Use		Tobacco Use		
			Alcohol	Marijuana	Opiates	Tobacco	Cocaine	Amphet-amines	No Use	Current or Past Use	Current Smoker	Former Smoker	Never Smoked
Aiken Center	794	768	531	424	116	422	106	170	746	48	474	146	171
Anderson Oconee	1,313	1,250	928	820	210	878	234	452	1,228	85	852	185	270
Barnwell	186	178	109	114	30	22	49	27	169	17	102	20	35
Beaufort	862	837	696	422	83	87	156	38	828	34	385	73	157
Berkeley	894	868	602	539	94	74	147	119	856	38	452	121	284
Charleston	2,614	2,418	1,679	1,305	793	1,705	763	391	2,156	458	1,621	189	706
Cherokee	478	445	176	271	57	231	26	169	452	26	265	31	43
Chester	304	300	255	155	37	95	42	37	293	11	203	42	58
Clarendon	367	359	199	183	52	158	62	37	349	18	177	15	162
Colleton	291	279	175	195	82	52	84	74	263	28	181	28	49
Darlington	323	319	145	134	79	52	67	27	315	8	191	23	90
Dorchester	1,410	1,378	775	747	159	282	171	161	1,366	44	513	289	420
Fairfield	182	178	123	96	10	115	44	6	182	0	115	17	47
Florence	1,123	1,089	671	562	309	548	302	122	1,023	100	706	74	313
Georgetown	410	390	219	202	100	14	86	21	372	38	220	91	66
Greenville	4,284	3,846	2,451	1,971	1,089	124	673	960	3,657	627	2,723	174	1,248
Allendale-Hampton-Jasper	175	174	120	88	16	69	25	6	173	2	99	18	43
Horry	1,626	1,598	966	912	450	1,019	427	158	1,418	208	1,053	107	412
Lancaster	504	496	287	239	104	82	83	60	476	28	305	58	118
Laurens	560	526	285	303	160	191	70	168	515	45	406	34	96
Newberry and Saluda	430	423	244	184	39	226	47	54	416	14	236	70	120
Orangeburg-Bamberg-Calhoun	985	954	593	547	110	454	201	124	948	37	509	56	249
Pickens	1,223	1,188	342	465	193	582	98	362	1,129	94	542	132	496
LRADAC	4,003	3,665	2,597	2,136	960	1,341	1,006	777	3,396	607	2,515	281	1,024
Spartanburg	1,350	1,284	1,029	869	326	381	226	300	1,271	79	773	70	488
Sumter	638	619	398	276	91	30	105	46	589	49	362	129	124
Union	298	294	160	198	30	34	42	46	288	10	129	14	50
Williamsburg	277	268	209	161	49	123	75	15	257	20	182	28	58
York	1,949	1,768	1,322	1,034	636	405	463	422	1,651	298	1,278	269	391
Cornerstone - GEMA	699	683	439	389	106	77	143	158	643	56	410	153	123
Kershaw-Chesterfield-Lee	1,174	1,128	526	447	307	19	206	154	1,080	94	447	63	198
Marion-Dillon-Marlboro	727	717	265	296	159	98	125	26	699	28	240	19	119
Total	32,453	30,687	19,516	16,684	7,036	9,990	6,354	5,687	29,204	3,249	18,666	3,019	8,228

* Selected categories displayed here. Fields displayed will not equal total discharges

** Substance use categories are not mutually exclusive

RUN DATE=09/05/2019

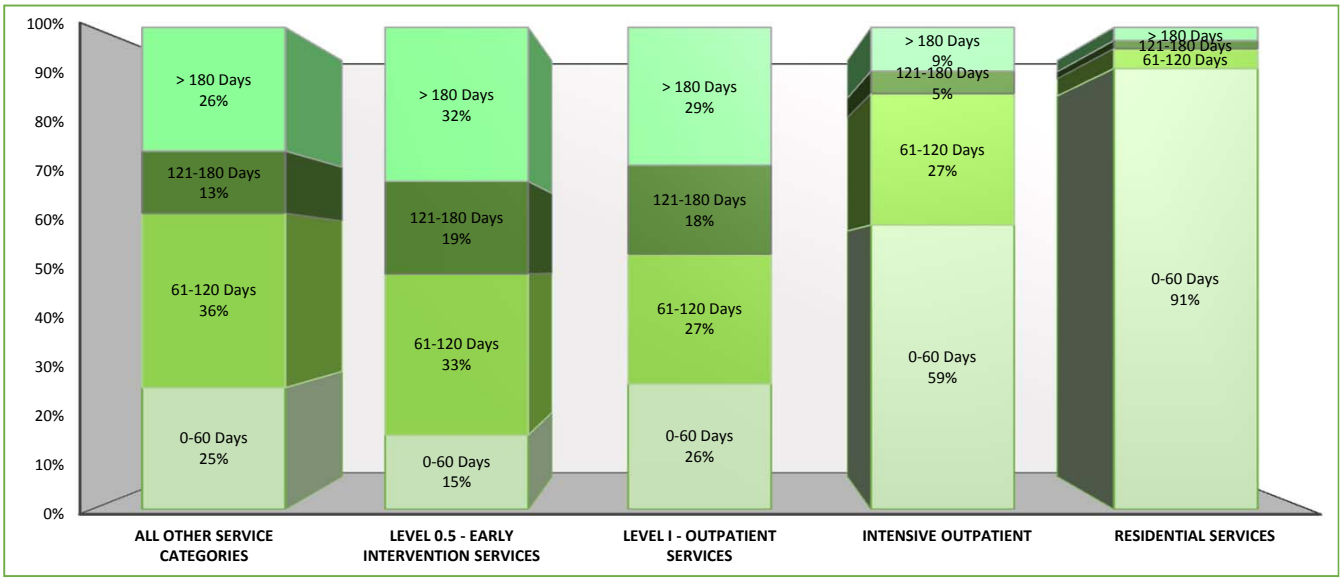
DAODAS PATIENT SUBSTANCE USE PROFILES FOR ALL DISCHARGED EPISODES OCCURRING IN SFY 2019
PERCENT DISTRIBUTION BASED ON TOTAL DISCHARGES BY PROVIDER

Agency	Total Discharge Count	Unique Discharge Count	Substance Use Profiles (Primary or Secondary Diagnosis/Problem)						Injection Use		Tobacco Use		
			Alcohol	Marijuana	Opiates	Tobacco	Cocaine	Amphet-amines	No Use	Current or Past Use	Current Smoker	Former Smoker	Never Smoked
Aiken Center	794	97%	67%	53%	15%	53%	13%	21%	94%	6%	60%	18%	22%
Anderson Oconee	1,313	95%	71%	62%	16%	67%	18%	34%	94%	6%	65%	14%	21%
Barnwell	186	96%	59%	61%	16%	12%	26%	15%	91%	9%	55%	11%	19%
Beaufort	862	97%	81%	49%	10%	10%	18%	4%	96%	4%	45%	8%	18%
Berkeley	894	97%	67%	60%	11%	8%	16%	13%	96%	4%	51%	14%	32%
Charleston	2,614	93%	64%	50%	30%	65%	29%	15%	82%	18%	62%	7%	27%
Cherokee	478	93%	37%	57%	12%	48%	5%	35%	95%	5%	55%	6%	9%
Chester	304	99%	84%	51%	12%	31%	14%	12%	96%	4%	67%	14%	19%
Clarendon	367	98%	54%	50%	14%	43%	17%	10%	95%	5%	48%	4%	44%
Colleton	291	96%	60%	67%	28%	18%	29%	25%	90%	10%	62%	10%	17%
Darlington	323	99%	45%	41%	24%	16%	21%	8%	98%	2%	59%	7%	28%
Dorchester	1,410	98%	55%	53%	11%	20%	12%	11%	97%	3%	36%	20%	30%
Fairfield	182	98%	68%	53%	5%	63%	24%	3%	100%	0%	63%	9%	26%
Florence	1,123	97%	60%	50%	28%	49%	27%	11%	91%	9%	63%	7%	28%
Georgetown	410	95%	53%	49%	24%	3%	21%	5%	91%	9%	54%	22%	16%
Greenville	4,284	90%	57%	46%	25%	3%	16%	22%	85%	15%	64%	4%	29%
Allendale-Hampton-Jasper	175	99%	69%	50%	9%	39%	14%	3%	99%	1%	57%	10%	25%
Horry	1,626	98%	59%	56%	28%	63%	26%	10%	87%	13%	65%	7%	25%
Lancaster	504	98%	57%	47%	21%	16%	16%	12%	94%	6%	61%	12%	23%
Laurens	560	94%	51%	54%	29%	34%	13%	30%	92%	8%	73%	6%	17%
Newberry and Saluda	430	98%	57%	43%	9%	53%	11%	13%	97%	3%	55%	16%	28%
Orangeburg-Bamberg-Calhoun	985	97%	60%	56%	11%	46%	20%	13%	96%	4%	52%	6%	25%
Pickens	1,223	97%	28%	38%	16%	48%	8%	30%	92%	8%	44%	11%	41%
LRADAC	4,003	92%	65%	53%	24%	33%	25%	19%	85%	15%	63%	7%	26%
Spartanburg	1,350	95%	76%	64%	24%	28%	17%	22%	94%	6%	57%	5%	36%
Sumter	638	97%	62%	43%	14%	5%	16%	7%	92%	8%	57%	20%	19%
Union	298	99%	54%	66%	10%	11%	14%	15%	97%	3%	43%	5%	17%
Williamsburg	277	97%	75%	58%	18%	44%	27%	5%	93%	7%	66%	10%	21%
York	1,949	91%	68%	53%	33%	21%	24%	22%	85%	15%	66%	14%	20%
Cornerstone - GEMA	699	98%	63%	56%	15%	11%	20%	23%	92%	8%	59%	22%	18%
Kershaw-Chesterfield-Lee	1,174	96%	45%	38%	26%	2%	18%	13%	92%	8%	38%	5%	17%
Marion-Dillon-Marlboro	727	99%	36%	41%	22%	13%	17%	4%	96%	4%	33%	3%	16%
Total	32,453	95%	60%	51%	22%	31%	20%	18%	90%	10%	58%	9%	25%

* Selected categories displayed here. Fields displayed will not equal total discharges

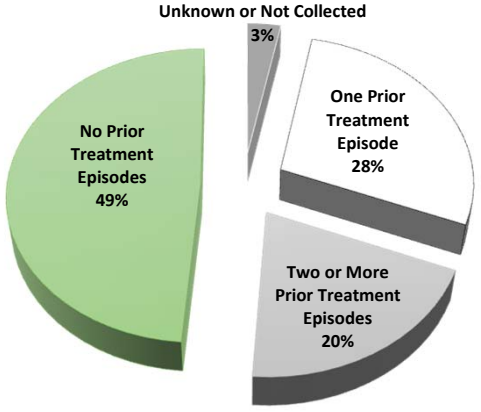
** Substance use categories are not mutually exclusive

DAODAS PATIENT EPISODE LENGTH OF STAY BY DOMINANT PROGRAM (HIGHEST LEVEL OF CARE ACCESSED DURING EPISODE)



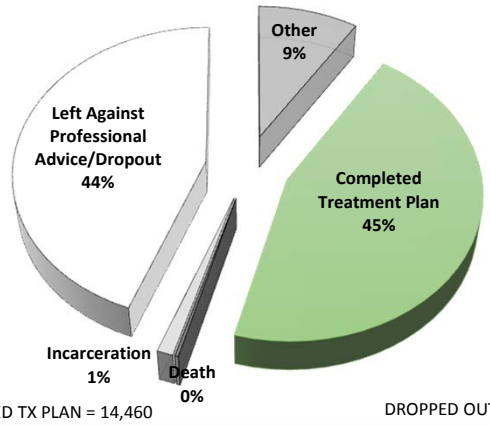
N= 2,170 | N = 4,626 | N = 16,250 | N = 5,706 | N = 474

DAODAS PATIENT SUBSTANCE USE DISORDER TREATMENT HISTORY



NO PRIOR TX = 15,842 | ANY PRIOR TX = 15,613

DAODAS PATIENT TREATMENT EPISODE DISCHARGE STATUS



COMPLETED TX PLAN = 14,460 | DROPPED OUT = 14,354

DAODAS LENGTH OF STAY BY DOMINANT PROGRAM FOR ALL DISCHARGED EPISODES OCCURRING IN SFY 2019

Agency	Total Discharge Count	Intervention				General Outpatient				Intensive Outpatient				Residential			
		0-120 Days	121 or More Days	% 121 or More Days	Total Program Count	0-120 Days	121 or More Days	% 121 or More Days	Total Program Count	0-120 Days	121 or More Days	% 121 or More Days	Total Program Count	0-60 Days	61 or More Days	% 61 or More Days	Total Program Count
Aiken Center	794	70	105	46%	230	300	147	33%	447	68	41	38%	109				
Anderson Oconee	1,313	65	15	8%	184	421	271	39%	692	124	222	64%	346				
Barnwell	186	2	16	59%	27	54	95	64%	149	0	0		0				
Beaufort	862	55	105	39%	270	210	150	42%	360	56	108	66%	164				
Berkeley	894	9	3	10%	31	423	320	43%	743	18	80	82%	98				
Charleston	2,614	25	35	16%	225	416	705	63%	1,121	51	52	50%	103	83	29	26%	112
Cherokee	478	12	36	43%	83	287	62	18%	349	26	20	43%	46				
Chester	304	3	62	85%	73	42	86	67%	128	10	82	89%	92				
Clarendon	367	7	13	46%	28	121	202	63%	323	0	1	100%	1				
Colleton	291	10	8	24%	33	84	113	57%	197	13	5	28%	18				
Darlington	323	0	0		0	15	247	94%	262	3	13	81%	16				
Dorchester	1,410	61	197	60%	330	306	458	60%	764	59	133	69%	193				
Fairfield	182	0	10	100%	10	8	155	95%	163	0	9	100%	9				
Florence	1,123	3	40	51%	79	188	369	66%	557	103	176	63%	279	35	21	38%	56
Georgetown	410	20	37	47%	79	155	103	40%	258	37	10	21%	47				
Greenville	4,284	215	26	7%	379	1,306	318	20%	1,624	551	335	38%	886	46	76	62%	122
Allendale-Hampton-Jasper	175	16	32	48%	67	25	58	70%	83	0	0		0				
Horry	1,626	10	129	70%	184	226	618	73%	844	107	369	78%	476	11	31	74%	42
Lancaster	504	14	38	42%	91	78	121	61%	199	33	118	78%	151				
Laurens	560	10	15	27%	55	335	86	20%	421	0	0		0				
Newberry and Saluda	430	19	21	38%	56	131	243	65%	374	0	0		0				
Orangeburg-Bamberg-Calhoun	985	18	88	59%	150	265	328	55%	593	48	63	57%	111	77	9	10%	86
Pickens	1,223	1	5	50%	10	227	564	71%	791	150	164	52%	314				
LRADAC	4,003	22	388	73%	533	760	678	47%	1,438	487	268	35%	755				
Spartanburg	1,350	141	20	7%	294	518	185	26%	703	213	140	40%	353				
Sumter	638	36	81	43%	187	125	141	53%	266	48	26	35%	74	21	21	50%	42
Union	298	5	37	69%	54	84	131	61%	215	0	1	100%	1				
Williamsburg	277	12	6	19%	32	100	116	54%	216	0	0		0				
York	1,949	220	47	9%	496	24	5	17%	29	758	160	17%	918	7	7	50%	14
Cornerstone - GEMA	699	6	53	58%	91	194	271	58%	465	58	71	55%	129				
Kershaw-Chesterfield-Lee	1,174	85	34	20%	174	441	531	55%	972	0	0		0				
Marion-Dillon-Marlboro	727	1	80	88%	91	81	423	84%	504	5	12	71%	17				
Total	32,453	1,173	1,782	39%	4,626	7,950	8,300	51%	16,250	3,026	2,679	47%	5,706	280	194	41%	474

* Dominant program status determined by assigning discharges to highest level of care accessed during an episode of care

** Length of stay includes time spent in all programs accessed during an episode of care (initial admission to final discharge)

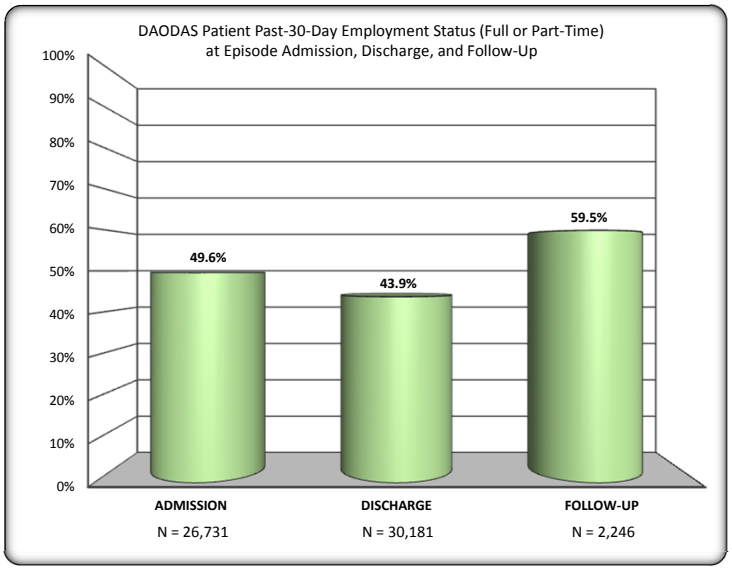
RUN DATE=09/05/2019

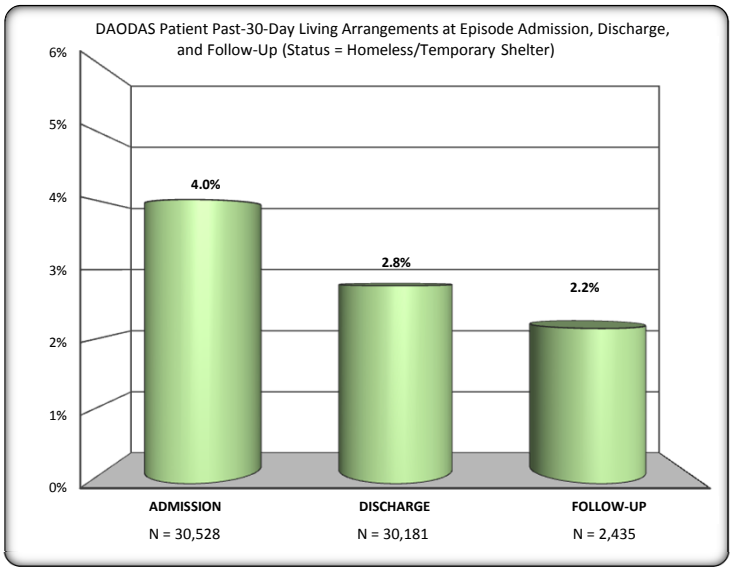
DAODAS PATIENT PRIOR PARTICIPATION IN TREATMENT AND EPISODE DISCHARGE STATUS FOR ALL DISCHARGED EPISODES OCCURRING IN SFY 2019

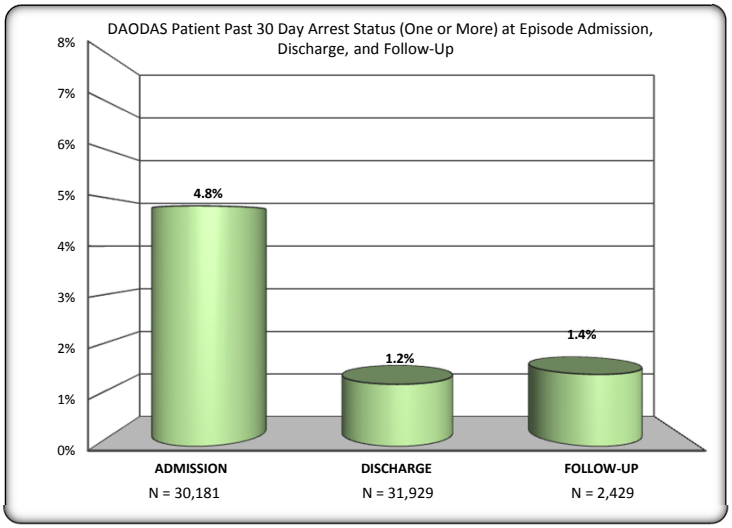
Agency	Total Discharge Count	Prior Participation in Substance Use Disorder Treatment							Treatment Episode Discharge Status						
		Unknown or Not Collected	One Prior Treatment Episode	Two or More Prior TX Episodes	No Prior Treatment Episodes	% No Prior Treatment	% Two or More Prior Treatment Episodes	Total With Valid Response	All Other Dispositions	Completed Treatment Plan	Death	Incarceration	Left Against Professional Advice or Dropout	% Completed Treatment Plan	Total
Aiken Center	794	9	237	135	413	53%	17%	785	31	461	2	12	288	58%	794
Anderson Oconee	1,313	12	445	261	595	46%	20%	1,301	120	595	3	9	586	45%	1,313
Barnwell	186	11	56	24	95	54%	14%	175	22	81	0	6	77	44%	186
Beaufort	862	14	217	132	499	59%	16%	848	99	476	0	15	272	55%	862
Berkeley	894	45	244	140	465	55%	16%	849	45	450	3	17	379	50%	894
Charleston	2,614	107	738	777	992	40%	31%	2,507	155	1,128	12	37	1,282	43%	2,614
Cherokee	478	0	159	76	243	51%	16%	478	31	240	1	1	205	50%	478
Chester	304	76	71	35	122	54%	15%	228	23	121	2	6	152	40%	304
Clarendon	367	4	108	66	189	52%	18%	363	24	166	5	7	165	45%	367
Colleton	291	12	97	59	123	44%	21%	279	34	83	0	5	169	29%	291
Darlington	323	23	91	39	170	57%	13%	300	37	110	0	2	174	34%	323
Dorchester	1,410	130	379	166	735	57%	13%	1,280	132	690	3	12	573	49%	1,410
Fairfield	182	0	48	24	110	60%	13%	182	6	98	0	0	78	54%	182
Florence	1,123	35	340	273	475	44%	25%	1,088	110	277	5	5	726	25%	1,123
Georgetown	410	4	130	56	220	54%	14%	406	48	103	2	6	251	25%	410
Greenville	4,284	76	1,169	1,365	1,674	40%	32%	4,208	228	2,424	2	42	1,588	57%	4,284
Allendale-Hampton-Jasper	175	20	37	17	101	65%	11%	155	12	107	2	0	54	61%	175
Horry	1,626	23	466	175	962	60%	11%	1,603	84	549	10	7	976	34%	1,626
Lancaster	504	46	139	70	249	54%	15%	458	51	267	2	6	178	53%	504
Laurens	560	1	133	93	333	60%	17%	559	66	278	5	14	197	50%	560
Newberry and Saluda	430	1	131	43	255	59%	10%	429	40	231	0	3	156	54%	430
Orangeburg-Bamberg-Calhoun	985	48	294	154	489	52%	16%	937	131	367	2	10	475	37%	985
Pickens	1,223	33	315	195	680	57%	16%	1,190	224	311	4	16	668	25%	1,223
LRADAC	4,003	20	1,073	969	1,941	49%	24%	3,983	290	1,894	8	67	1,744	47%	4,003
Spartanburg	1,350	5	370	143	832	62%	11%	1,345	41	681	1	24	603	50%	1,350
Sumter	638	12	177	111	338	54%	18%	626	73	310	0	7	248	49%	638
Union	298	29	67	24	178	66%	9%	269	12	143	0	7	136	48%	298
Williamsburg	277	25	72	49	131	52%	19%	252	25	105	1	1	145	38%	277
York	1,949	6	592	539	812	42%	28%	1,943	383	848	3	27	688	44%	1,949
Cornerstone - GEMA	699	0	206	118	375	54%	17%	699	35	326	5	12	321	47%	699
Kershaw-Chesterfield-Lee	1,174	19	331	123	701	61%	11%	1,155	123	504	4	15	528	43%	1,174
Marion-Dillon-Marlboro	727	152	166	64	345	60%	11%	575	233	216	1	5	272	30%	727
Total	32,453	998	9,098	6,515	15,842	50%	21%	31,455	2,968	14,640	88	403	14,354	45%	32,453

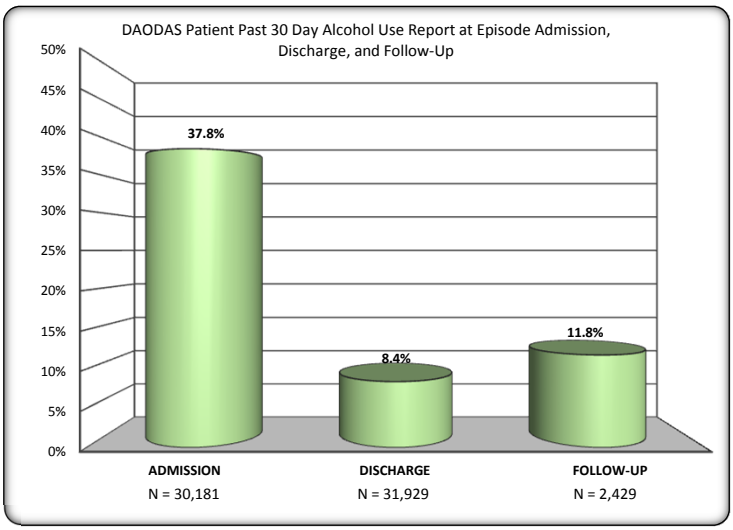
* Percent distribution of prior treatment is limited to episodes with a valid response for this question

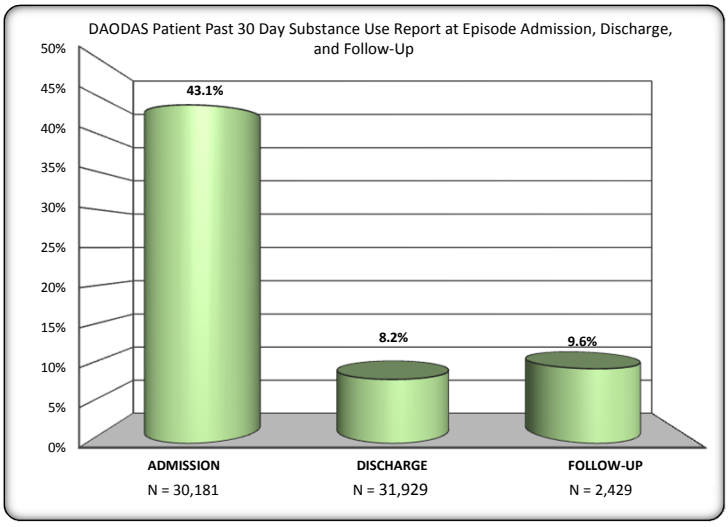
RUN DATE=09/05/2019











Additional Details

Employment outcome limited to clients 18 and older.

Arrest, Alcohol, and Substance use outcomes limited to patients 12 and older.

DAODAS PATIENT OUTCOMES FOR ALL DISCHARGED EPISODES OCCURRING IN SFY 2019
BY PROVIDER

Agency	Past 30 Day Employment Status (Full or Part-Time)						Past 30 Day Living Arrangements (Homeless or Temporary Shelter)						Past 30 Day Arrest Status (One or More)					
	Admission		Discharge		Outcome		Admission		Discharge		Outcome		Admission		Discharge		Outcome	
	% Employed at Admission	Total Admissions	% Employed at Discharge	Total Discharges	% Employed at Outcome	Total Outcomes	% Homeless at Admission	Total Admissions	% Homeless at Discharge	Total Discharges	% Homeless at Outcome	Total Outcomes	% With Arrests at Admission	Total Admissions	% With Arrests at Discharges	Total Discharges	% With Arrests at Outcome	Total Outcomes
Aiken Center	56%	726	54%	785	70%	142	2%	787	1%	785	0%	146	3%	785	0%	792	1%	146
Anderson Oconee	52%	1,141	50%	1,229	50%	2	2%	1,234	1%	1,229	0%	2	5%	1,229	1%	1,308	0%	2
Barnwell	47%	150	42%	171	33%	6	1%	172	0%	171	0%	9	6%	171	1%	185	11%	9
Beaufort	74%	687	67%	808	87%	105	0%	809	0%	808	0%	116	2%	808	1%	861	0%	116
Berkeley	61%	662	53%	849	67%	55	1%	852	0%	849	1%	78	2%	849	1%	890	3%	78
Charleston	48%	2,330	46%	2,447	46%	74	8%	2,450	6%	2,447	1%	78	5%	2,447	1%	2,574	8%	77
Cherokee	55%	456	51%	478			0%	478	0%	478			5%	478	0%	478		
Chester	53%	210	46%	215	59%	27	1%	215	0%	215	0%	28	5%	215	0%	304	0%	28
Clarendon	44%	260	30%	322	50%	10	1%	352	0%	322	0%	17	4%	322	1%	336	0%	16
Colleton	45%	251	44%	266	50%	4	2%	266	0%	266	0%	4	3%	266	1%	291	0%	4
Darlington	44%	228	40%	252	27%	11	0%	259	0%	252	0%	12	1%	252	1%	313	0%	12
Dorchester	66%	929	49%	1,237			0%	1,251	0%	1,237			1%	1,237	1%	1,394		
Fairfield	56%	165	57%	179	59%	22	1%	182	1%	179	4%	24	2%	179	0%	179	0%	23
Florence	48%	944	37%	987	46%	57	3%	998	2%	987	4%	57	4%	987	1%	1,091	0%	57
Georgetown	55%	336	41%	382	80%	15	2%	384	1%	382	0%	17	5%	382	1%	408	0%	17
Greenville	48%	3,591	44%	4,070	60%	497	7%	4,083	5%	4,070	1%	512	7%	4,070	3%	4,209	2%	512
Allendale-Hampton-Jasper	60%	140	58%	149	80%	5	0%	150	0%	149	0%	6	3%	149	1%	174	0%	6
Horry	54%	1,396	50%	1,549	70%	20	2%	1,556	2%	1,549	5%	22	8%	1,549	0%	1,615	0%	22
Lancaster	50%	404	47%	421	57%	56	1%	421	0%	421	0%	56	4%	421	0%	504	0%	56
Laurens	41%	494	42%	558	46%	41	1%	559	2%	558	0%	41	4%	558	2%	559	0%	41
Newberry and Saluda	59%	338	58%	387	60%	10	1%	411	1%	387	0%	10	3%	387	1%	404	0%	10
Orangeburg-Bamberg-Calhoun	47%	730	34%	922	57%	47	1%	936	1%	922	0%	71	3%	922	0%	971	4%	71
Pickens	47%	748	35%	994	24%	50	2%	1,114	1%	994	0%	53	5%	994	0%	1,074	0%	53
LRADAC	41%	3,530	33%	3,939	55%	139	9%	3,949	7%	3,939	6%	150	4%	3,939	2%	3,989	1%	150
Spartanburg	51%	1,139	48%	1,340			3%	1,342	1%	1,340			5%	1,340	1%	1,348		
Sumter	50%	524	47%	568	40%	30	2%	573	2%	568	0%	30	4%	568	1%	633	0%	30
Union	46%	175	32%	269			0%	269	0%	269			4%	269	1%	298		
Williamsburg	45%	222	40%	247	38%	21	0%	247	0%	247	0%	23	6%	247	0%	277	0%	23
York	45%	1,748	44%	1,852	63%	708	5%	1,855	3%	1,852	4%	769	6%	1,852	3%	1,945	1%	767
Cornerstone - GEMA	55%	642	56%	689	57%	42	3%	690	1%	689	0%	45	7%	689	1%	698	0%	45
Kershaw-Chesterfield-Lee	48%	956	40%	1,052	30%	40	1%	1,108	0%	1,052	0%	40	6%	1,052	1%	1,112	0%	40
Marion-Dillon-Marlboro	38%	479	26%	568	30%	10	1%	576	0%	568	0%	19	2%	568	1%	715	0%	18
Total	50%	26,731	44%	30,181	60%	2,246	4%	30,528	3%	30,181	2%	2,435	5%	30,181	1%	31,929	1%	2,429

Employment comparisons limited to clients 18 and older during episode
Arrest comparisons limited to clients 12 and older during episode

RUN DATE=09/05/2019

DAODAS PATIENT OUTCOMES FOR ALL DISCHARGED EPISODES OCCURRING IN SFY 2019
BY COUNTY

Agency	Past 30 Day Alcohol Use						Past 30 Day Substance Use					
	Admission		Discharge		Outcome		Admission		Discharge		Outcome	
	% With Any Use at Admission	Total Admissions	% With Any Use at Discharge	Total Discharges	% With Any Use at Outcome	Total Outcomes	% With Any Use at Admission	Total Admissions	% With Any Use at Discharge	Total Discharges	% With Any Use at Outcome	Total Outcomes
Aiken Center	41%	785	5%	792	39%	146	32%	785	1%	792	2%	146
Anderson Oconee	37%	1,229	3%	1,308	0%	2	38%	1,229	2%	1,308	0%	2
Barnwell	39%	171	5%	185	0%	9	40%	171	2%	185	11%	9
Beaufort	46%	808	4%	861	5%	116	33%	808	4%	861	2%	116
Berkeley	38%	849	1%	890	0%	78	39%	849	1%	890	1%	78
Charleston	48%	2,447	15%	2,574	27%	77	56%	2,447	18%	2,574	30%	77
Cherokee	23%	478	0%	478			47%	478	1%	478		
Chester	49%	215	7%	304	18%	28	37%	215	0%	304	4%	28
Clarendon	33%	322	1%	336	0%	16	35%	322	2%	336	0%	16
Colleton	31%	266	2%	291	0%	4	46%	266	2%	291	0%	4
Darlington	26%	252	2%	313	0%	12	29%	252	3%	313	0%	12
Dorchester	31%	1,237	2%	1,394			29%	1,237	2%	1,394		
Fairfield	39%	179	0%	179	35%	23	20%	179	0%	179	0%	23
Florence	39%	987	3%	1,091	9%	57	46%	987	5%	1,091	9%	57
Georgetown	31%	382	6%	408	12%	17	43%	382	3%	408	0%	17
Greenville	39%	4,070	21%	4,209	19%	512	44%	4,070	18%	4,209	17%	512
Allendale-Hampton-Jasper	48%	149	32%	174	17%	6	34%	149	5%	174	0%	6
Horry	32%	1,549	1%	1,615	0%	22	39%	1,549	0%	1,615	0%	22
Lancaster	32%	421	4%	504	9%	56	27%	421	2%	504	2%	56
Laurens	25%	558	3%	559	2%	41	47%	558	6%	559	12%	41
Newberry and Saluda	37%	387	5%	404	20%	10	32%	387	1%	404	10%	10
Orangeburg-Bamberg-Calhoun	43%	922	3%	971	3%	71	46%	922	4%	971	1%	71
Pickens	16%	994	2%	1,074	6%	53	36%	994	5%	1,074	0%	53
LRADAC	44%	3,939	14%	3,989	20%	150	51%	3,939	16%	3,989	17%	150
Spartanburg	40%	1,340	2%	1,348			43%	1,340	3%	1,348		
Sumter	47%	568	7%	633	10%	30	43%	568	7%	633	17%	30
Union	24%	269	8%	298			29%	269	0%	298		
Williamsburg	51%	247	4%	277	4%	23	44%	247	3%	277	13%	23
York	41%	1,852	12%	1,945	4%	767	56%	1,852	15%	1,945	8%	767
Cornerstone - GEMA	36%	689	3%	698	0%	45	41%	689	1%	698	2%	45
Kershaw-Chesterfield-Lee	28%	1,052	9%	1,112	8%	40	35%	1,052	3%	1,112	5%	40
Marion-Dillon-Marlboro	25%	568	2%	715	0%	18	39%	568	2%	715	6%	18
Total	38%	30,181	8%	31,929	12%	2,429	43%	30,181	8%	31,929	10%	2,429

Alcohol and other substance use comparisons limited to clients 12 and older during episode

Use measures restricted to patients with qualifying Alcohol or other substance use disorder diagnosis during episode