# South Carolina Commission on Alcohol and Drug Abuse State Plan Update FY87-88

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South Carolina Commission on Alcohol and
Drug Abuse
3700 Forest Drive
Columbia, South Carolina 29204

South Carolina Commission on Alcohol and Drug Abuse

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# INTRODUCTION

This plan is an update to the FY87-89 South Carolina State Plan on Alcohol and Drug Abuse published in July 1986. Its purpose is to provide guidance and information to state and local officials who are involved in providing alcohol and drug abuse services. This plan emphasizes an analysis of the funding needs of the county commissions on alcohol and drug abuse and describes statewide funding needs.

Section 44-49-10(c) of the South Carolina Code of Laws and Act 1068 of 1974 designates SCCADA as the single state agency responsible for planning, coordinating and evaluating all programs and services directed toward the prevention and control of the state's alcohol and drug problem.

For additional information regarding SCCADA's activities, the reader may want to refer to the agency's Annual Report for FY85-86 which is available for review at the State Library. In addition, individual county plans prepared by the county commissions on alcohol and drug abuse can be reviewed for more detailed data and information. A listing of these agencies is in the appendix.

# SCCADA STATE PLAN SCHEDULE

| | |
|---|---|
| June 86 | County Commission Directors' Retreat-FY88 Appropriations Request priorities discussed |
| July 86 | FY88 Plan update scheduled approved by Division Director |
| August 86 | SCCADA budget request for FY88 submitted to Budget and Control Board |
| August 86 | Substance Abuse Agencies Management Information System (SAAMIS) FY86 data published |
| September 86 | SAAMIS data analyzed for alcohol and drug abuse trends |
| September 86 | SCCADA presents FY88 Appropriations Request to Budget and Control Board |
| October 86 | SCCADA makes presentation to the Joint Legislative Study Committee on the Problems of Alcohol and Drug Abuse |
| November 86 | County plan guidelines distributed to county commissions |
| December 86 | FY87 State Plan distributed for review and comment |
| February 87 | FY88 county plans submitted to SCCADA |
| March 87 | County plan unmet needs and future directions compiled and analyzed |
| May 87 | Final draft of plan is completed incorporating data and describing needs for FY88 funding |
| June 87 | FY88 State Appropriations Act passed |
| July 87 | State Plan finalized |

## Historical Perspective

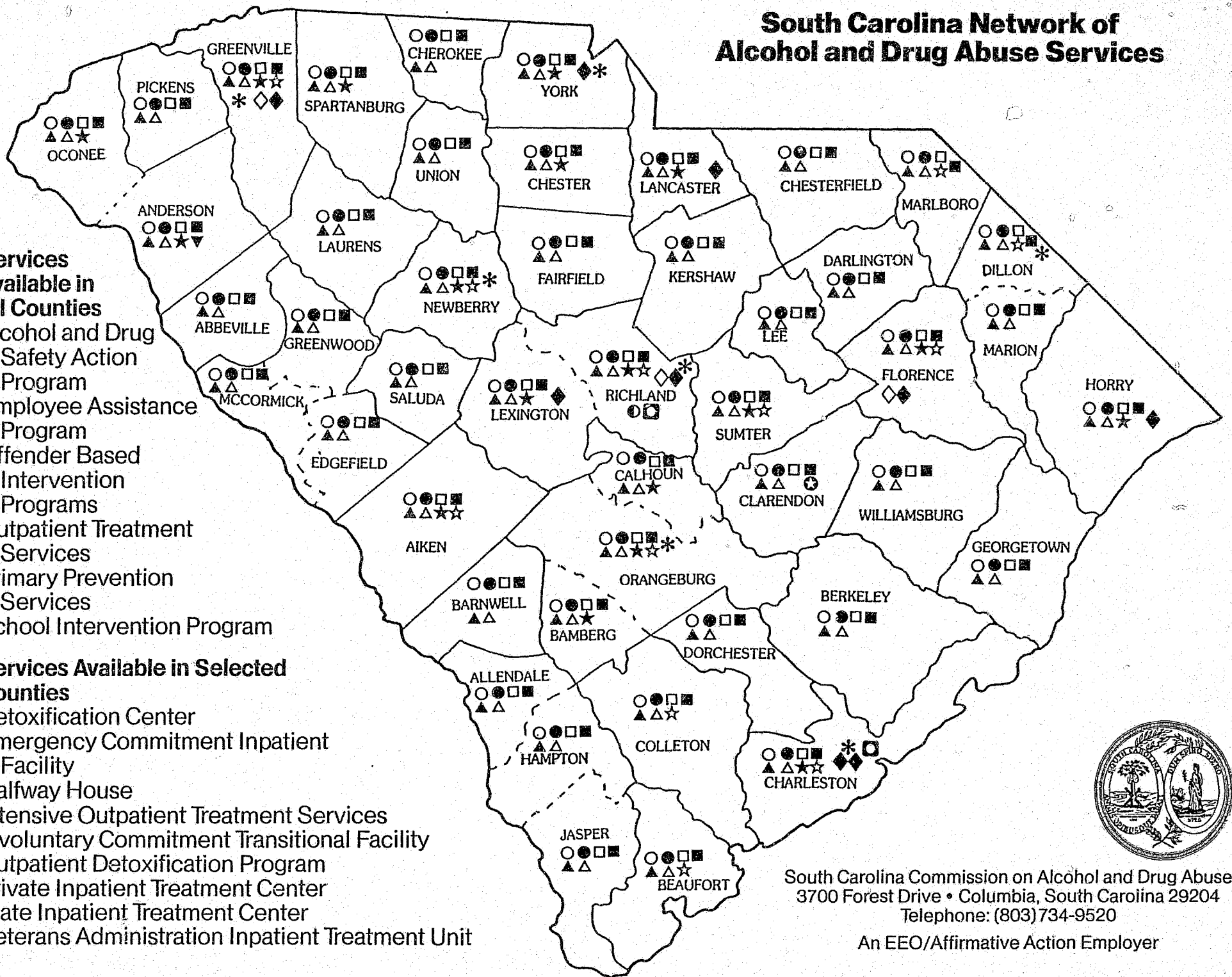
During the past two decades, there has been unprecedented growth in the alcohol and drug abuse treatment system in South Carolina. In 1957, Act 309 authorized the creation of the South Carolina Alcoholic Center. This marked the beginning of a comprehensive, statewide network specifically designed to deal with the problems of alcohol and drug abuse. The state's first inpatient treatment facility opened in Florence in 1962. In 1966, the South Carolina Alcoholic Center became the South Carolina Commission on Alcoholism.

The Joint Legislative Committee on Narcotics and Controlled Substances was created by the 1970 General Assembly to study the state drug abuse problem. In 1971, the South Carolina Office of the Commissioner of Narcotics and Controlled Substances was created by Act 445 and became the state's drug abuse authority. The office's primary responsibility was education and coordination of drug abuse programming.

By this time, many counties and other local entities offered alcohol and drug abuse services. However, the establishment of a comprehensive network for service provision came from two actions. One was the passage of Act 301, the "Minibottle Law," which established local alcohol and drug abuse authorities in all counties and gave them a foundation source of income derived from minibottle sales distributed on a per capita basis. Equally important was Act 1068 of 1974, which merged the Commission on Alcoholism with the Office of the Commissioner of Narcotics and Controlled Substances into one single state agency, SCCADA. This provided a state level focus for substance abuse planning, coordination, funding and programming.

The transformation into a single state authority for alcohol and drug abuse provided an opportunity for further expansion and implementation of what is now know as the architectural concept of alcohol and drug abuse programming. This concept is still in use today by the 301 System and is described in Chapter II.

# South Carolina Network of Alcohol and Drug Abuse Services




**Services Available in All Counties**

- ○ Alcohol and Drug Safety Action Program
- ● Employee Assistance Program
- □ Offender Based Intervention Programs
- ■ Outpatient Treatment Services
- ▲ Primary Prevention Services
- △ School Intervention Program

**Services Available in Selected Counties**

- ✻ Detoxification Center
- ▼ Emergency Commitment Inpatient Facility
- ☆ Halfway House
- ★ Intensive Outpatient Treatment Services
- ◐ Involuntary Commitment Transitional Facility
- ✪ Outpatient Detoxification Program
- ◆ Private Inpatient Treatment Center
- ◇ State Inpatient Treatment Center
- ◘ Veterans Administration Inpatient Treatment Unit

South Carolina Commission on Alcohol and Drug Abuse
3700 Forest Drive • Columbia, South Carolina 29204
Telephone: (803)734-9520

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## Description of the State

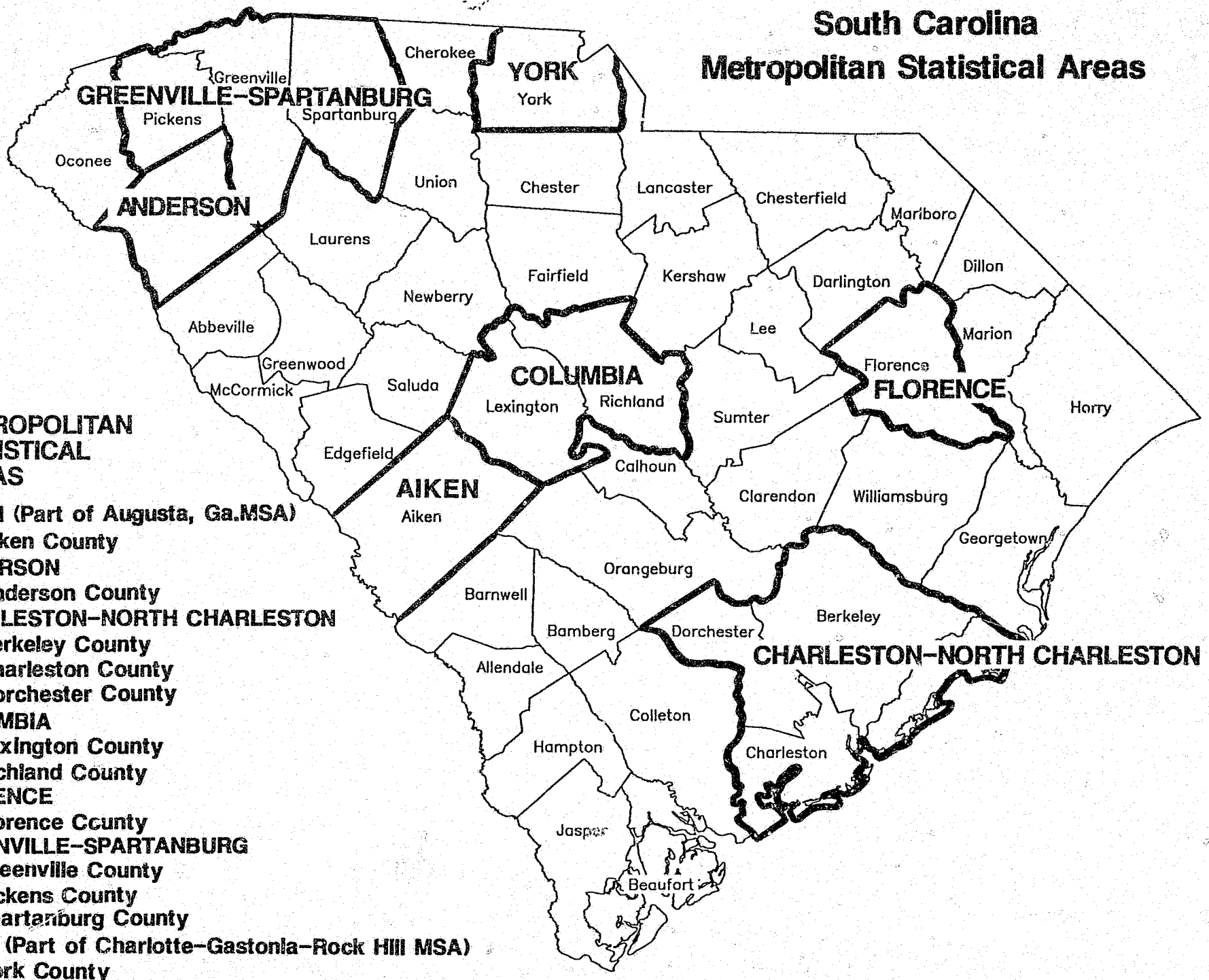
The population of South Carolina, according to the most recent estimate (1985), is 3,367,000, a 7 percent increase since 1980. There are seven standard metropolitan statistical areas (SMSAs) in South Carolina. In 1984, these SMSAs contained 53 percent of the state's population.

Females comprised approximately 51.2 percent of the population in 1985. The disparity in the proportion of males and females is greatest among the elderly, as females represent 61 percent of this population.

The non-white population in South Carolina was estimated at 31.6 percent in 1985. Blacks account for well over 97 percent of this population group. There is a wide variation of racial mix of counties. For example, blacks make up 64 percent of the population of Allendale County, while only 8 percent of the Pickens County population.

Most South Carolinians are poor. South Carolina ranked 45th nationally in per capita income in 1984, with an average of $10,075. In 1979, almost one-half million people in the state lived below poverty level, 61 percent of which were black.

# South Carolina
# Metropolitan Statistical Areas




## METROPOLITAN STATISTICAL AREAS

**AIKEN (Part of Augusta, Ga.MSA)**
- Aiken County

**ANDERSON**
- Anderson County

**CHARLESTON–NORTH CHARLESTON**
- Berkeley County
- Charleston County
- Dorchester County

**COLUMBIA**
- Lexington County
- Richland County

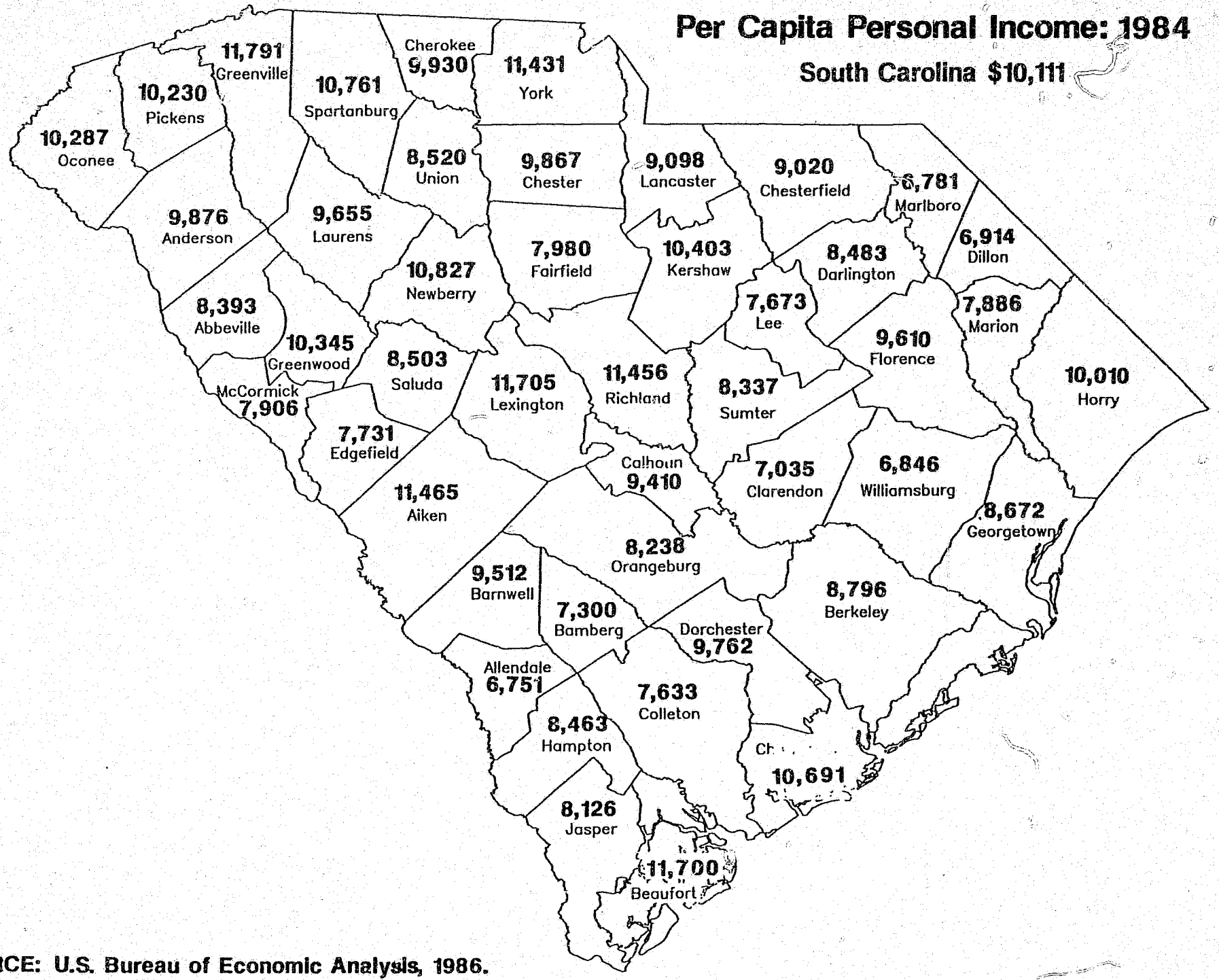
**FLORENCE**
- Florence County

**GREENVILLE–SPARTANBURG**
- Greenville County
- Pickens County
- Spartanburg County

**YORK (Part of Charlotte–Gastonia–Rock Hill MSA)**
- York County

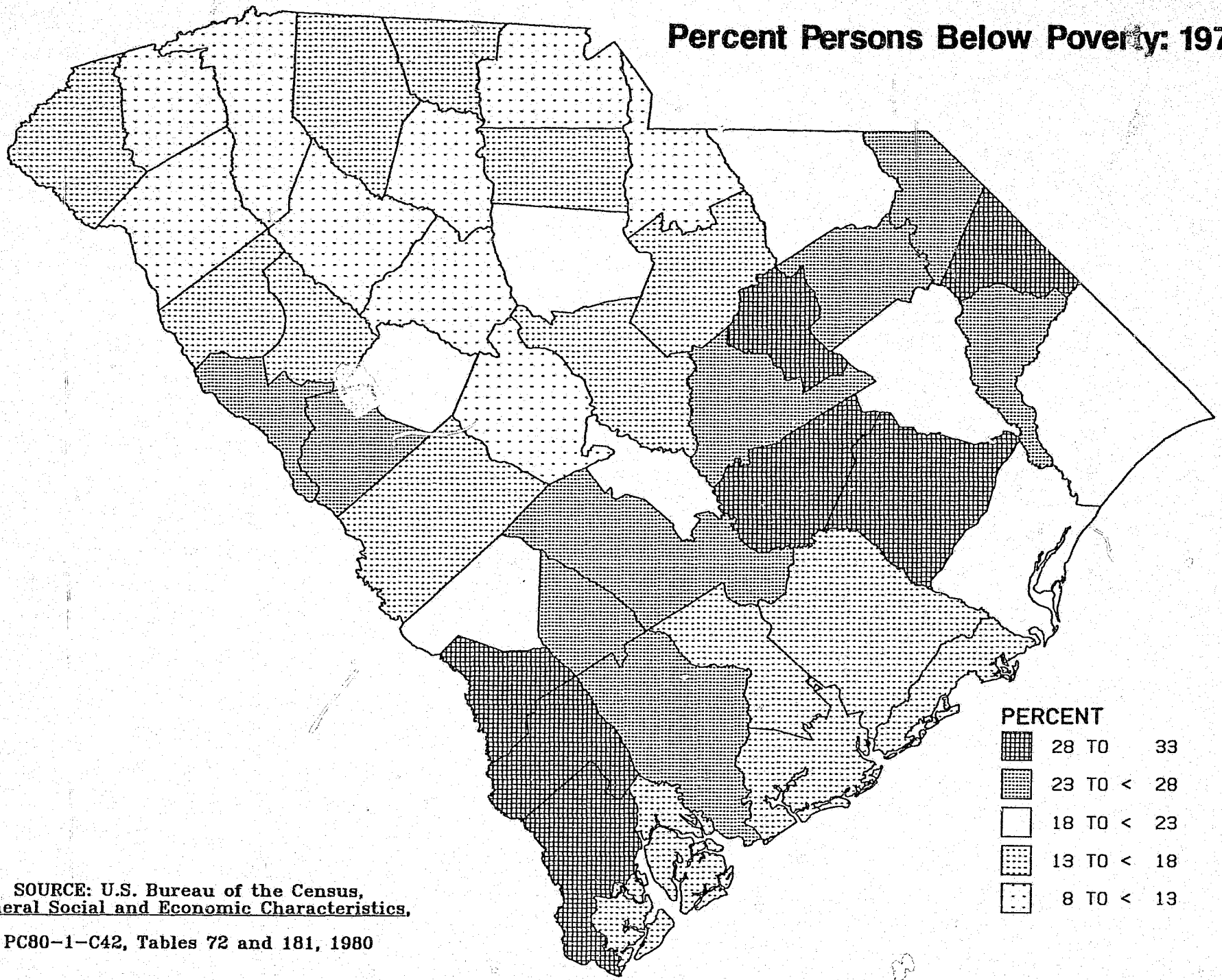
# Per Capita Personal Income: 1984

## South Carolina $10,111




SOURCE: U.S. Bureau of Economic Analysis, 1986.

# Percent Persons Below Poverty: 1979




SOURCE: U.S. Bureau of the Census,
General Social and Economic Characteristics,
PC80-1-C42, Tables 72 and 181, 1980

# CHAPTER I
# THE PROBLEM OF ALCOHOL AND DRUG ABUSE

## A. Introduction

The misuse and abuse of alcohol and drugs affects every community in South Carolina and creates a tremendous burden on our society's resources each year. Not only is the health of South Carolinians impaired, but alcohol and drug abuse impacts the social and economic fabric of the environment. The magnitude of the problem is reflected in the most current forecast indicating that nearly 390,000 people will suffer from alcohol and drug abuse in state during 1987.

The National Institute of Alcohol Abuse and Alcoholism reports that one in ten Americans are problem drinkers, with another 26 percent at risk of potential alcohol abuse.

A number of diseases such as cirrhosis of the liver, cardiopulmonary diseases and cancer are associated with substance abuse. In 1985, cirrhosis of the liver accounted for 324 deaths in South Carolina, and there were 109 deaths from other diseases directly related to alcohol or drug abuse. Alcohol and drug abuse also contributed to numerous other health problems, including fetal alcohol syndrome and motor vehicle and other accidents. Of the 944 fatal automobile accidents occurring in the state during 1986, 41.4 percent involved drinking drivers. A study, combining coroners' reports with the South Carolina Department of Highways and Public Transportation accident reports, indicates that more than one-half of the fatal accidents are related to substance abuse.

Many involuntarily committed persons suffering from alcohol and drug abuse are handled under the emergency provisions of the state's commitment law and are committed to facilities of the South Carolina Department of Mental Health. In 1985, 7,384 persons were admitted to state psychiatric facilities. Of this number, 1,134 (15.4 percent) were subsequently given a primary alcohol and/or drug diagnosis. When secondary diagnoses are included, 2,031 (27.5 percent) of admissions were for alcohol and/or drug addiction. Presently South Carolina is implementing the new involuntary commitment law which addresses the substance abuse problems frequently affecting these persons. A later section of this report describes this program.

A final measure of substance abuse as a health problem in South Carolina is the number of individuals seeking substance abuse services in the state's public and private sector agencies and facilities. During calendar year 86, there were 34,731 residents admitted to county commission treatment programs in South Carolina.

## B. Trends and Issues

South Carolina's alcohol and drug treatment programs are influenced by a number of related trends and issues. The following have been selected for discussion and review in this plan.

### 1. Consumption Trends

Trends in consumption of alcoholic beverages in South Carolina and the United States (rising through the 1960s and mid-1970s, peaking in

the late 1970s and early 1980s, and plateauing or declining since) parallel several other consumption patterns.

One such parallel is the pattern of national and Southern region public opinion survey results reporting the percentage of the adult population who are drinkers (persons having more than one or two drinks per year). At the national level, the approximate proportion of drinkers in the adult population remained relatively stable at 64 percent from 1960 through the early 1970s, rising rapidly to 71 percent by the late 1970s, and declining since to 66 percent by the mid-1980s. Data for the Southern region reveal a similar pattern for the years 1966 to 1985. During the mid 1960's approximately 38 percent of the Southern region adults were reported as drinkers. This percentage rose to approximately 57 percent by the late 1970s and has decreased to approximately 54 percent by the mid-1980s. Forty-seven percent of South Carolinians are drinkers (SCCADA Survey, 1986).

As supporting evidence, the National Institute on Drug Abuse reports that the proportion of persons within the United States population who had a drink in the last month declined significantly between 1979 and 1985. In the youth group (age 12 to 17), the percentage of drinkers declined from 37 percent to 32 percent. The proportion of young adult (age 18 to 25) drinkers declined from 76 percent to 72 percent and the proportion of older adult (26 and older) drinkers remained stable at 61 percent.

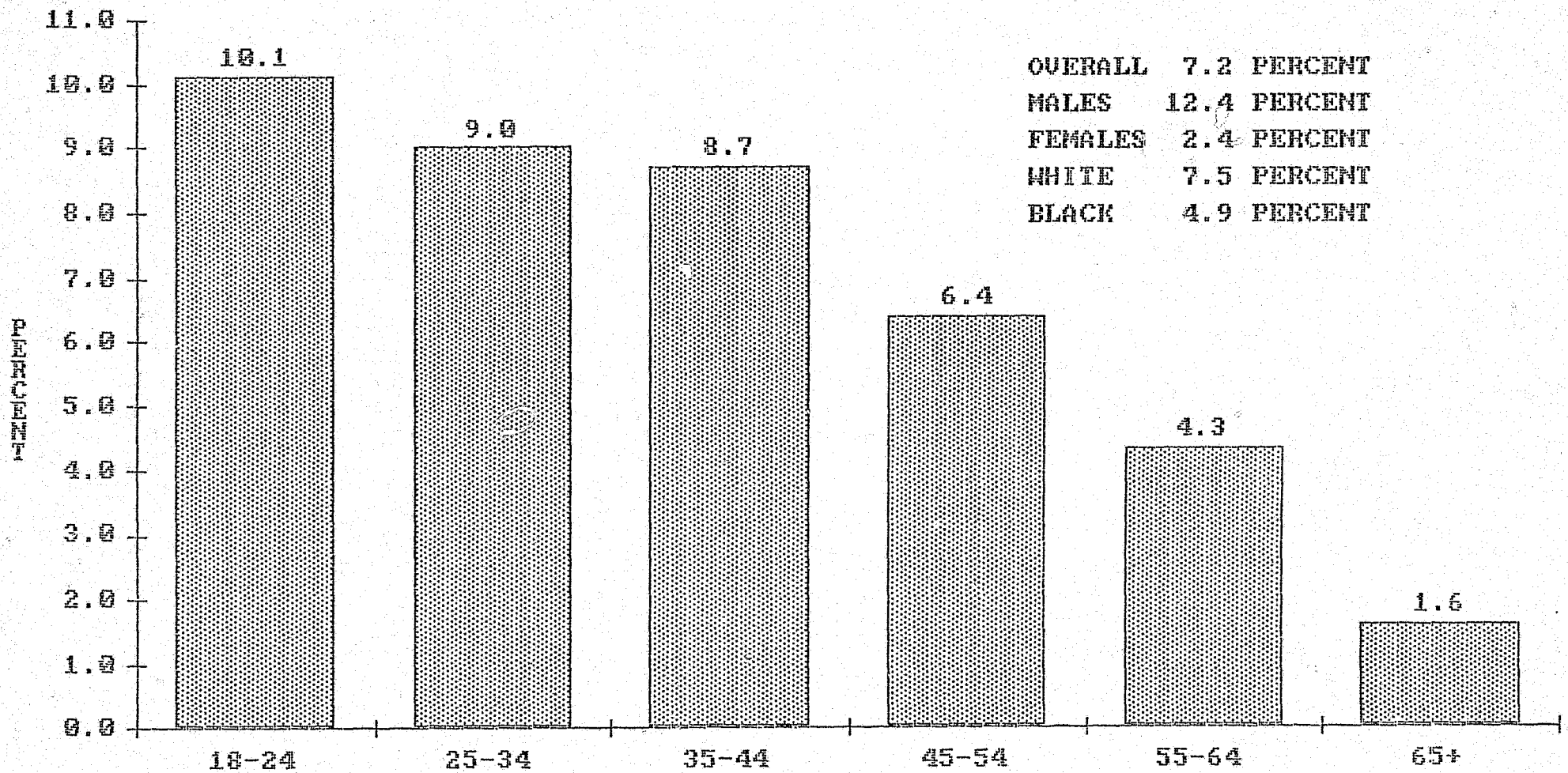
The proportion of the high school senior population who are drinkers (one or more drinks in the previous month) has stabilized or slightly declined since the late 1970s (Johnson, 1986). The proportion of high school seniors who are thus defined as drinkers rose from approximately 68 percent in 1975 to approximately 72 percent in 1979, and declined slightly to 65 percent by 1985. The proportion of Southern region high school seniors who are thus defined as drinkers increased from approximately 63 percent in 1975 to approximately 66 percent in 1979 and declined to 58 percent in 1986. Fifty percent of seniors in South Carolina report drinking alcohol in the last month (SCCADA Survey, 1985-1986).

Not only did fewer people drink during the last five years, but also those who did drink were drinking less. On this issue, a national poll (Yankelovich, Skelly, and White, 1985) reports that 52 percent of drinkers 18 and older have reduced their alcoholic beverage consumption of the "past few years." Thirty-nine percent of drinkers report drinking about the same quantity, and only 9 percent of drinkers reported drinking more in 1985 than several years prior. Another poll (Gallop, 1985) reported that 14 percent of adult drinkers planned to cut down on drinking in the upcoming year and two percent planned to quit drinking entirely.

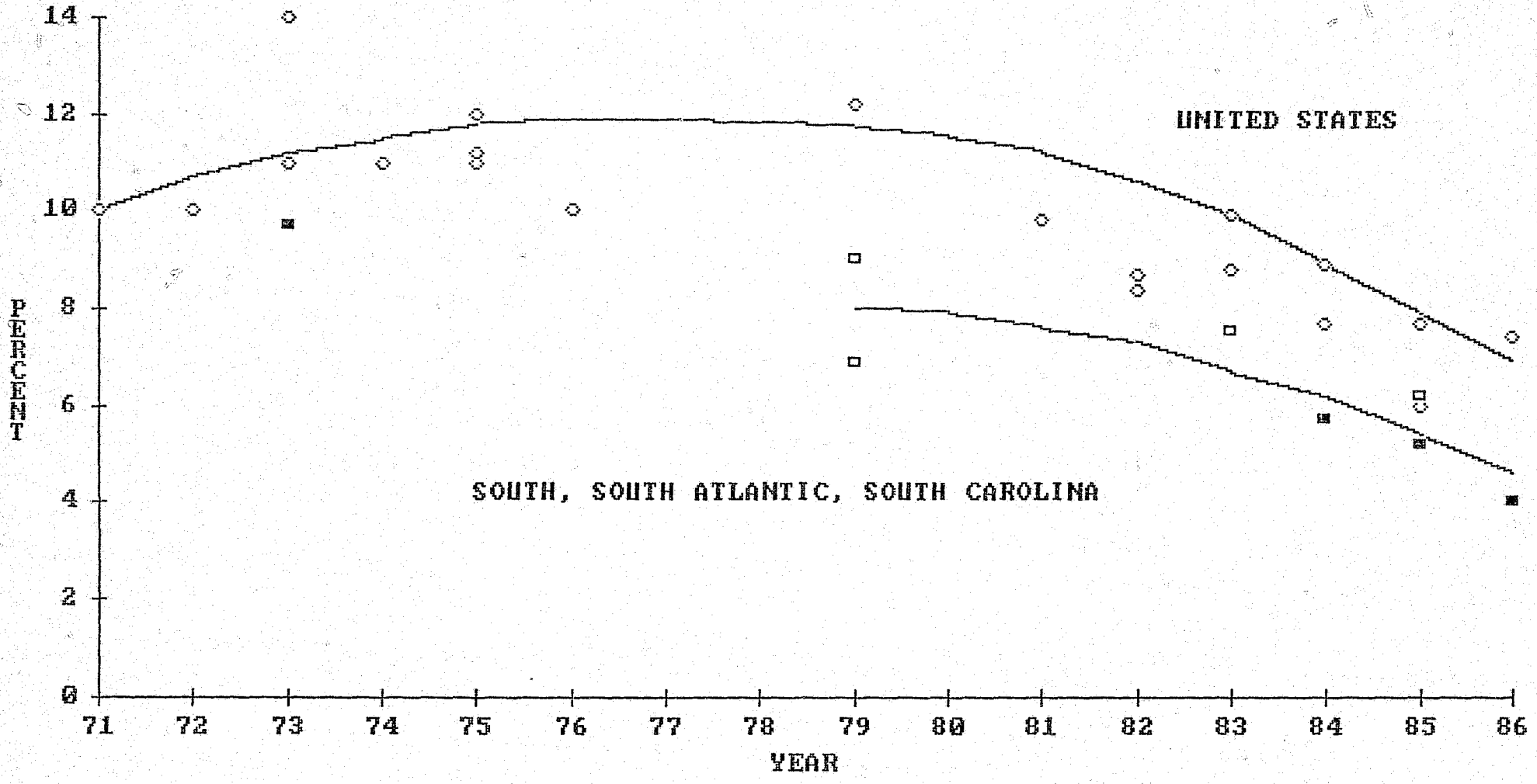
Further indications of increasing conservativeness in drinking behavior in recent years can be observed in the increasing popularity of lower proof distilled spirits, light beer, and lower alcohol wine and wine coolers. While not significant in market share, the presence of low alcohol and no alcohol beer suggests increasing moderation in drinking habits.

The proportion of the adult population who are classified as "heavy" and "problem" drinkers may be decreasing (Clark and Midenik, 1979, Center for Disease Control, 1986). In 1971, approximately 10 percent of the United States population 18 and older were classified as

# *BINGE DRINKERS IN THE LAST MONTH FIVE OR MORE DRINKS PER OCCASION BY AGE, SOUTH CAROLINA, 1996*



# *PERCENT OF THE ADULT POPULATION WHO ARE HEAVIER DRINKERS MORE THAN 60 DRINKS PER MONTH*



"heavier" drinkers (60 or more drinks per month or 1.0 ounce or more ethanol per day, annual prevalence). This proportion increased to approximately 12 percent by 1979. Monthly prevalence of heavy drinking at the national level has decreased from about 8.7 percent in 1981 to 7.4 percent in 1986. The monthly prevalence of heavy drinking among adult South Carolinians has decreased from 5.7 percent in 1984 to 4 percent in 1986. The proportion of high school seniors who are heavy drinkers (drink on 20 or more occasions in the previous 30 days) has declined since the late 1970's (Johnson, O'Malley and Beckman, 1986). At the national level, the proportion of high school seniors who were defined as heavier drinkers rose from approximately 5.7 percent in 1975 to approximately 6.9 percent in 1979, declining to 4.8 percent by 1986. For the Southern region, the proportion of heavier drinkers among high school seniors increased from 5.1 percent in 1975 to 5.7 percent in 1979, declining to approximately 4.9 percent by 1986.

The percentage of the adult population who are "binge" drinkers (consume five or more drinks on one or more occasions in the previous month) has been decreasing in recent years. On the national level about 22.7 percent of the adult population were classified as binge drinkers in 1981, as compared to 16.9 percent in 1986 (Center for Disease Control, 1986). In South Carolina, the prevalence of binge drinking has decreased from 11.0 percent in 1984 to 7.2 percent in 1986.

In summary, since the mid and late 1970s, proportionately fewer adults are drinking, those who do drink are drinking less and drinking lower alcohol content beverages, and the incidence and prevalence of heavy and problem drinkers may also be on the decline.

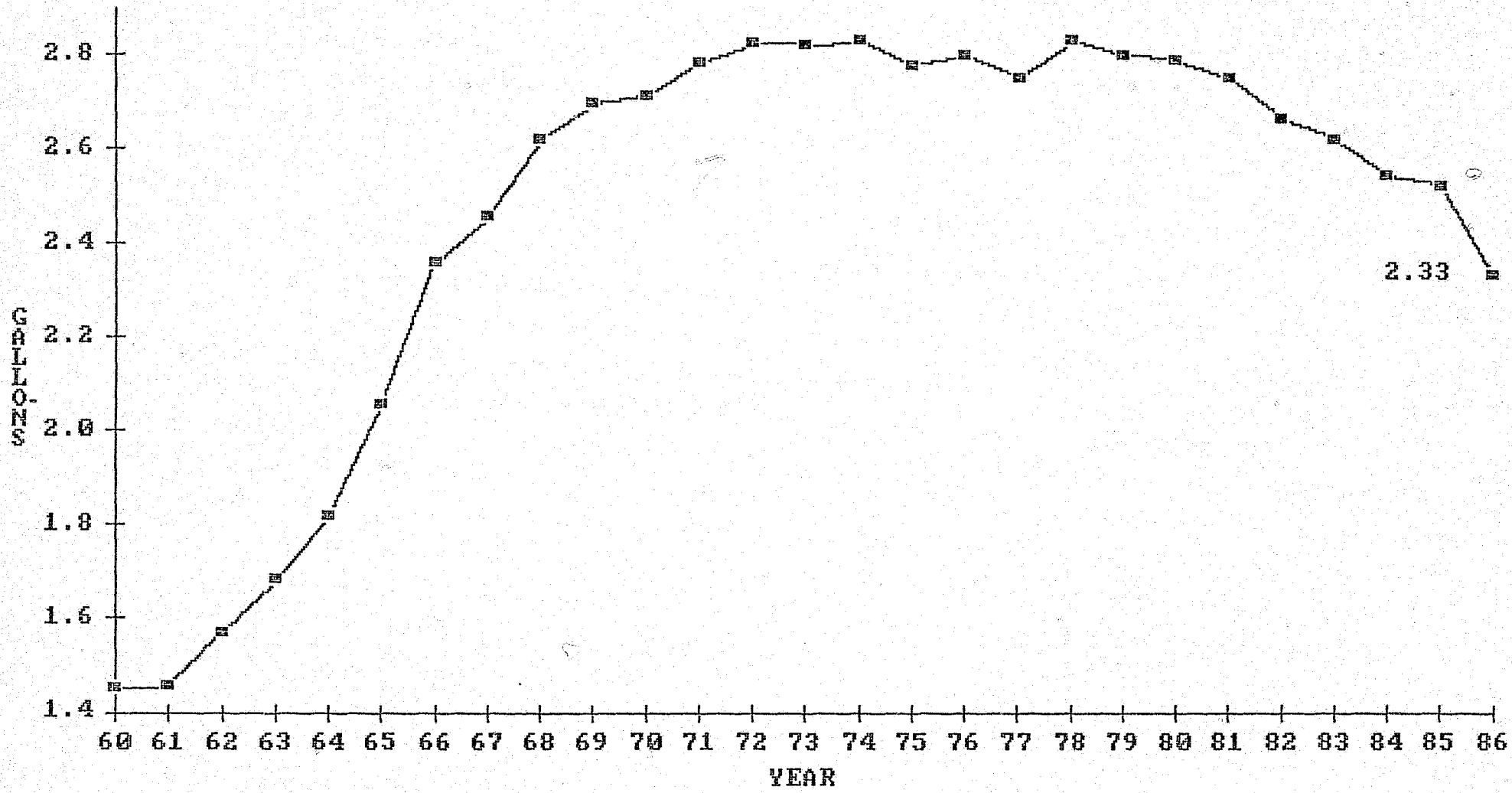
Annual consumption of distilled spirits in South Carolina increased from 1.5 gallons per adult (18 and older) in 1960 to a peak of 2.8 gallons in 1974. Since the late 1970s, consumption of distilled spirits in South Carolina has declined to 2.3 gallons per capita or about four drinks a week. Consumption of distilled spirits in South Carolina was 72 percent of the national average in 1960, approximately equal to the national average in the mid and late 1970s and 6 percent above the national average in 1985.

Annual consumption of beer in South Carolina increased from 9.4 gallons per capita in 1960 to 30.5 gallons in 1981. In 1986, consumption of beer in South Carolina has increased slightly to 31.5 gallons per capita or about six 12-ounce beers a week. Consumption of beer per capita in South Carolina was 40 percent of the national average in 1960 and has risen to 94 percent of the national average in 1985.

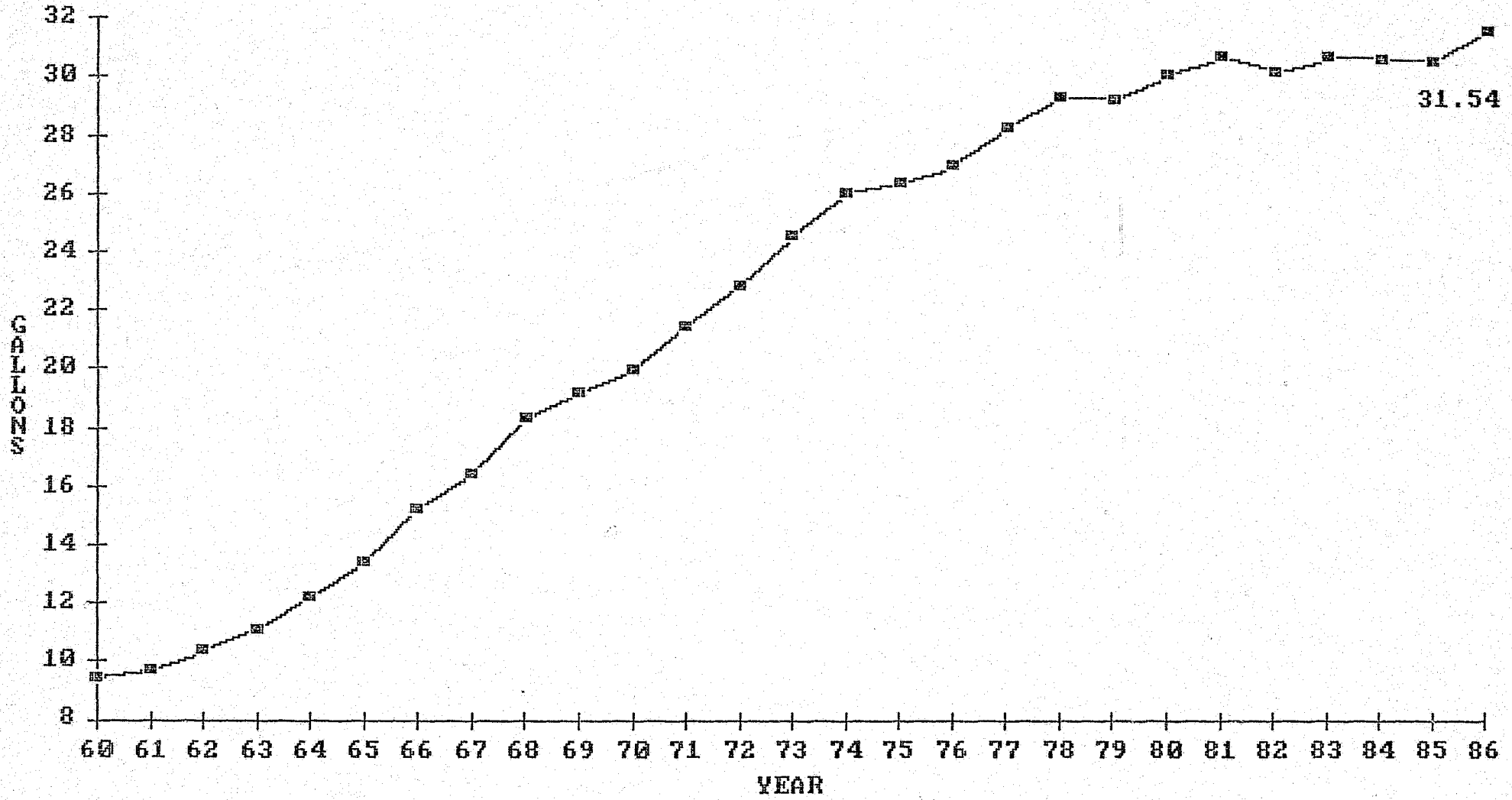
Annual consumption of wine in South Carolina increased from 0.5 gallons per capita in 1960 to 2.3 gallons (approximately one glass per week) in 1986. The consumption of wine per capita in South Carolina was 36 percent of the national average in 1960 and has risen to 65 percent of the national average in 1985.

Overall, alcohol consumption in South Carolina (as measured by the total amount of ethanol consumed from distilled spirits, beer and wine) increased from 1.2 gallons per capita in 1960 to a peak of 2.7 gallons per capita in 1980. Since the early 1980s, the consumption of ethanol from all sources has declined slightly to 2.6 gallons per capita in 1985. The consumption of ethanol from all sources in South Carolina was 53 percent of the national average in 1960 and has risen to 94 percent of the national average in 1985.

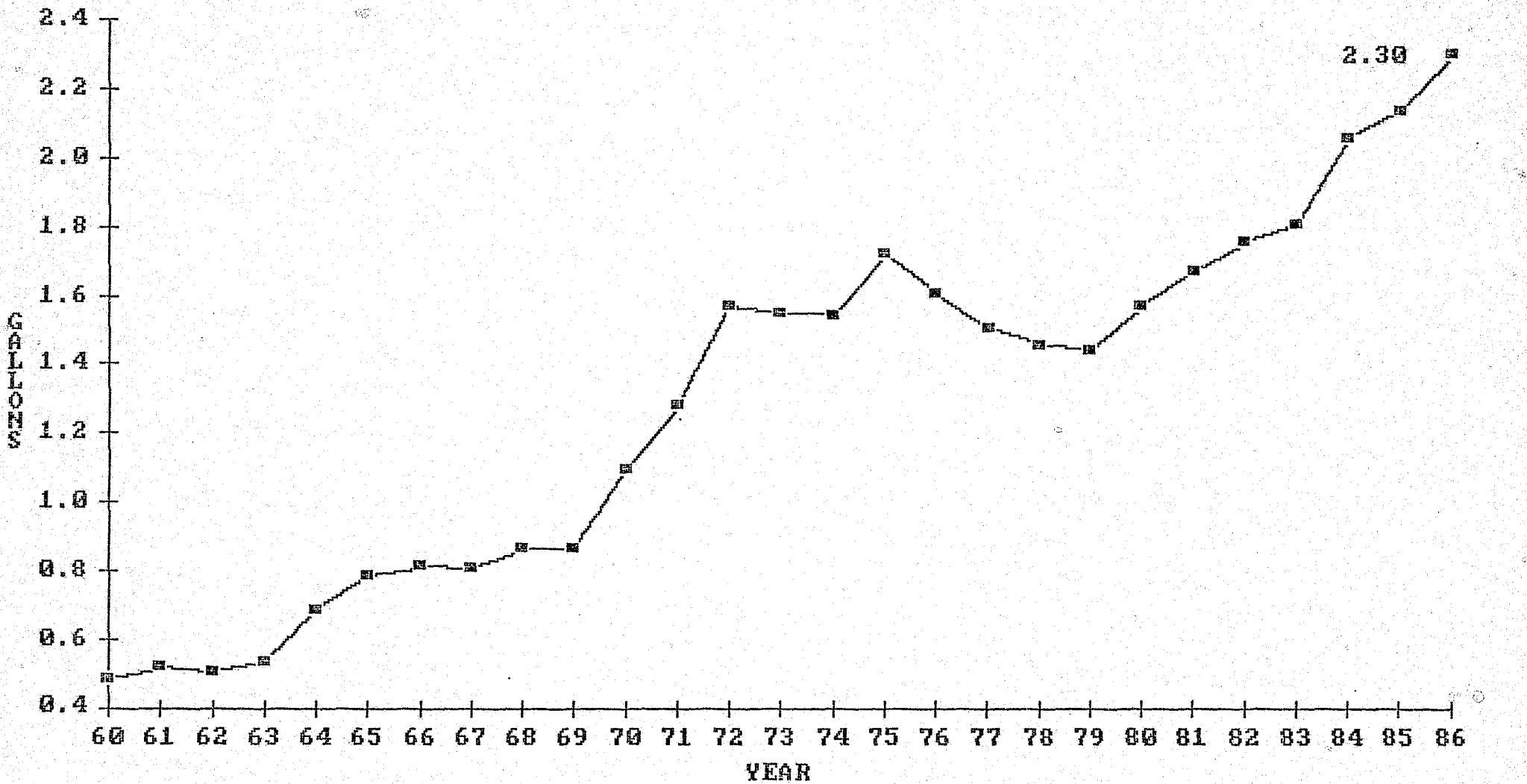
# *DISTILLED SPIRITS CONSUMPTION PER CAPITA IN SOUTH CAROLINA*



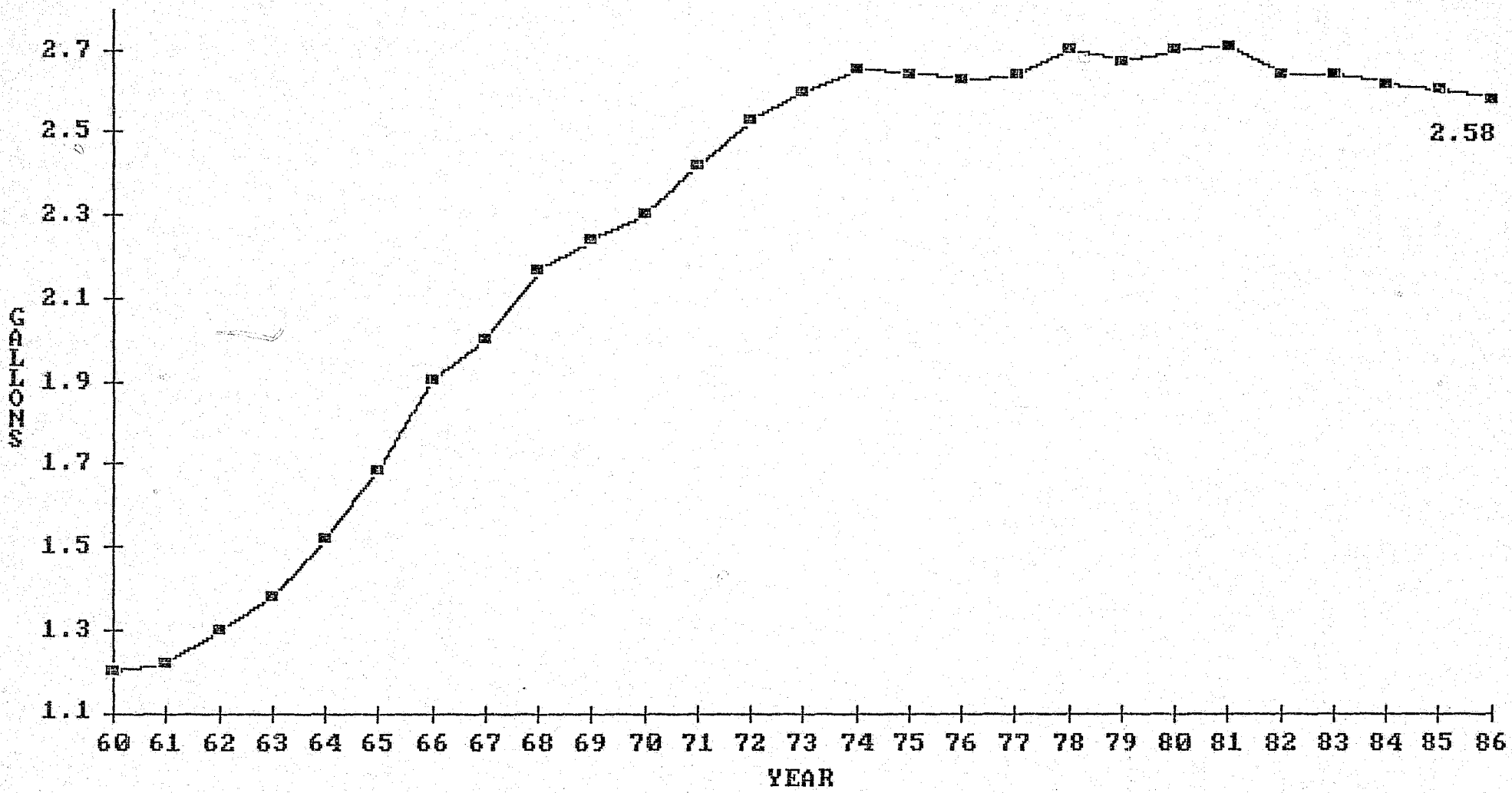
# *BEER CONSUMPTION PER CAPITA IN SOUTH CAROLINA*



# *WINE CONSUMPTION PER CAPITA IN SOUTH CAROLINA*



# *TOTAL ETHANOL CONSUMPTION PER CAPITA IN SOUTH CAROLINA*



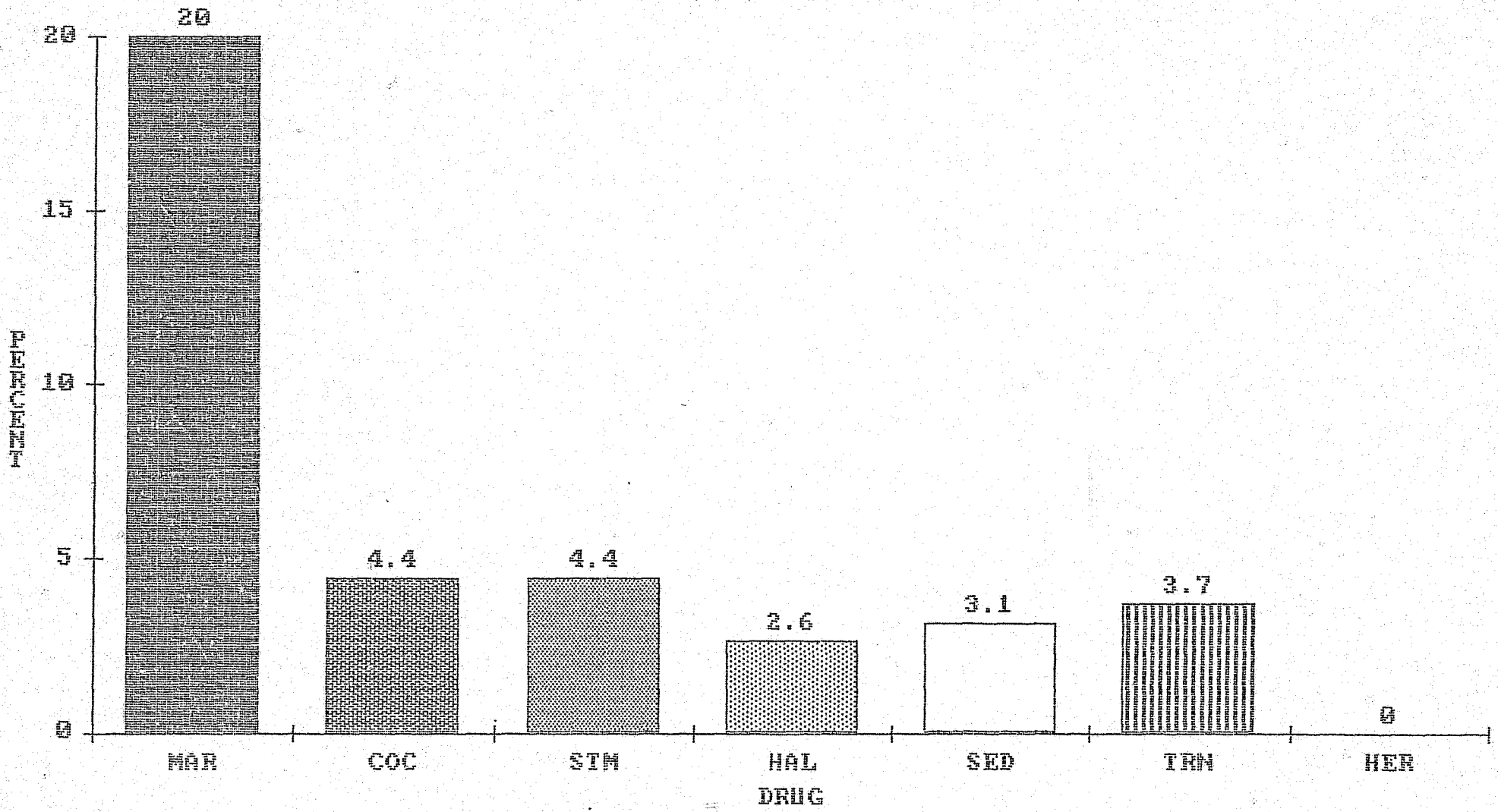
Data on the use of drugs in South Carolina is seriously lacking. One reason for the difficulty in obtaining this data is that it often involves an illegal activity. Available arrest data show that drug-related arrests have increased from 9 percent of all substance-related arrests in 1978 to 15.2 percent in 1986. Drug arrests made up 6.3 percent of all arrests recorded by SLED in 1986. Care should be taken, however, in the use of arrest data as an indicator of drug usage. Changes may indicate shifts in enforcement efforts rather than in actual drug usage. For example, drug arrest data show that the proportion of drug-related arrests have increased in recent years and the percent of youth arrests has declined. While there is data to indicate that drug usage among youth may be declining nationwide, arrest data may or may not support this. It may simply demonstrate that law enforcement agencies are concentrating efforts on the older drug dealers as opposed to younger users.

Another reason drug arrest data cannot be representative of the problem is that drug abuse often occurs through the use of legally prescribed medications. An analysis of data from one private alcohol and drug treatment center in South Carolina shows that the percentage of persons with a primary diagnosis of drug abuse has remained stable in recent years (16 percent) while the percentage of persons with a combined alcohol/drug addiction has increased from 17 to 22 percent. Most often, this involves the combination of alcohol with prescribed tranquilizers. Morris Village, a facility of the South Carolina Department of Mental Health, also reports increases in the proportion of clients abusing drugs. In 1978, 29 percent of Morris Village clients were diagnosed as having a drug problem. By 1982, the percentage of residents with a primary drug diagnosis increased to 37 percent; however, by FY83-84, the percentage dipped to 30 percent. As for clients reporting a cross-addiction to alcohol and drugs (all diagnoses), the increase was from less than 1 percent in 1978 to 11.5 percent in 1982 at Morris Village.

Drug use in certain categories may be on the decline. The National Household Surveys conducted by the National Institute on Drug Abuse show a decrease in the percentage of school-age (12-17 years old) youth who used marijuana in the last month (from a peak of 17 percent in 1979 to 12 percent in 1985). In addition, the percentage of the school age population reporting hallucinogen use in the last month has declined from a peak of 2.2 percent in 1979 to 1.1 percent in 1985. Cocaine use appears to be increasing. In South Carolina, the Substance Abuse Management Information System (SAAMIS), operated by SCCADA, reported an increase in cocaine-related intakes from 91 in 1980 to 1,464 in 1986. The largest increase in this population was in the age group over 26 which increased from 29 clients in 1980 to 403 in 1984. Cocaine arrests in the state also increased from 242 in 1980 to 2,006 in 1986, again, with a large increase in the over 26 population from 96 in 1980 to 630 persons in 1984.

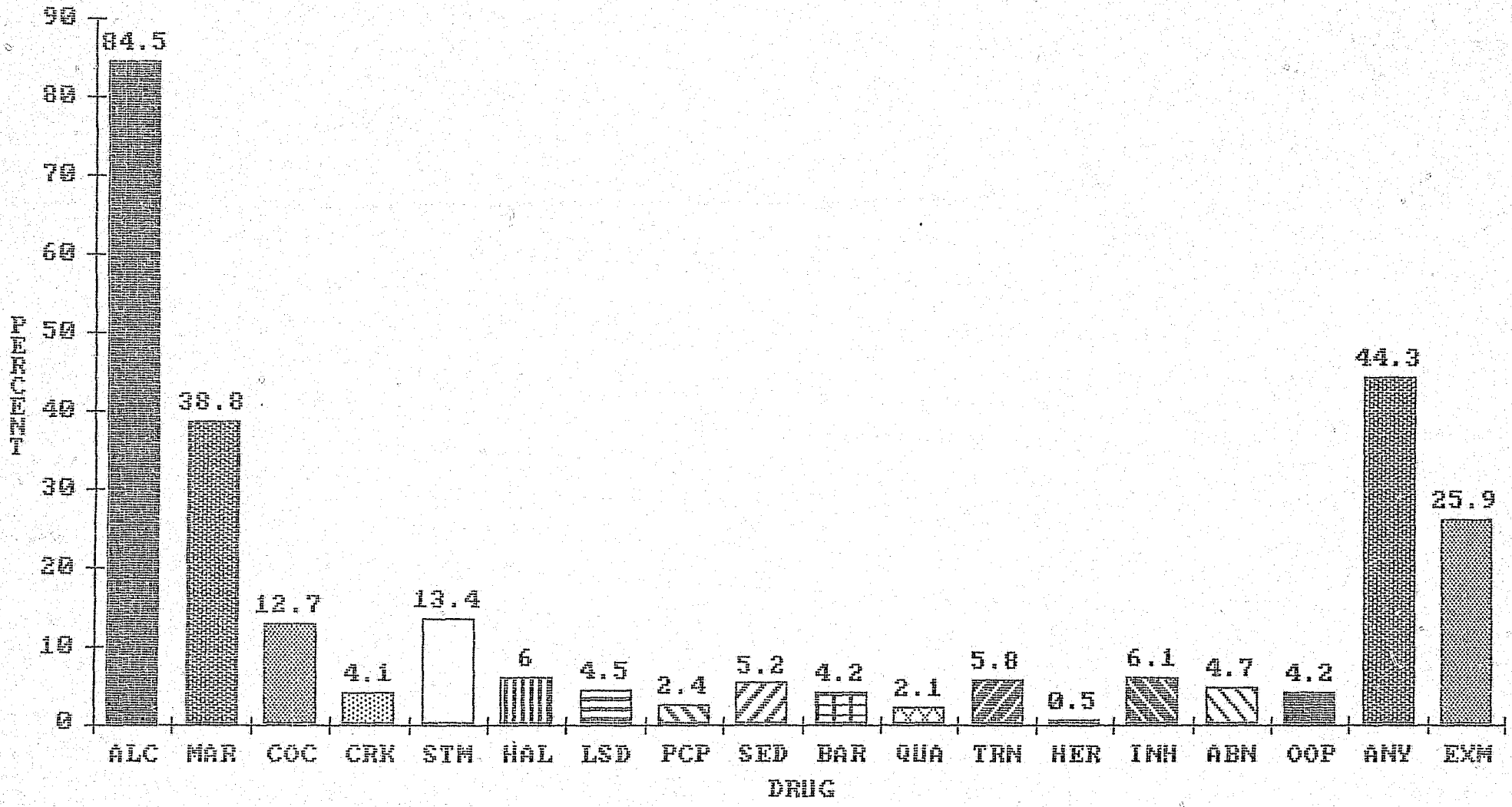
Drug use patterns among high school seniors have been assessed by NIDA since 1975. At the national level, the percentage of high school seniors who used marijuana in the past month reached a peak of 37.1 percent in 1978 and declined to 23.4 percent in 1986. Monthly marijuana use among high school seniors in the Southern region occurs at lower prevalences than for the nation as a whole, although the pattern over time is similar to the national data. Monthly cocaine use among seniors

# YOUTH (12-17) USING EACH DRUG LAST YEAR UNITED STATES 1985




SOURCE: NIDA HOUSEHOLD SURVEY 1985
DFN 3/1/87

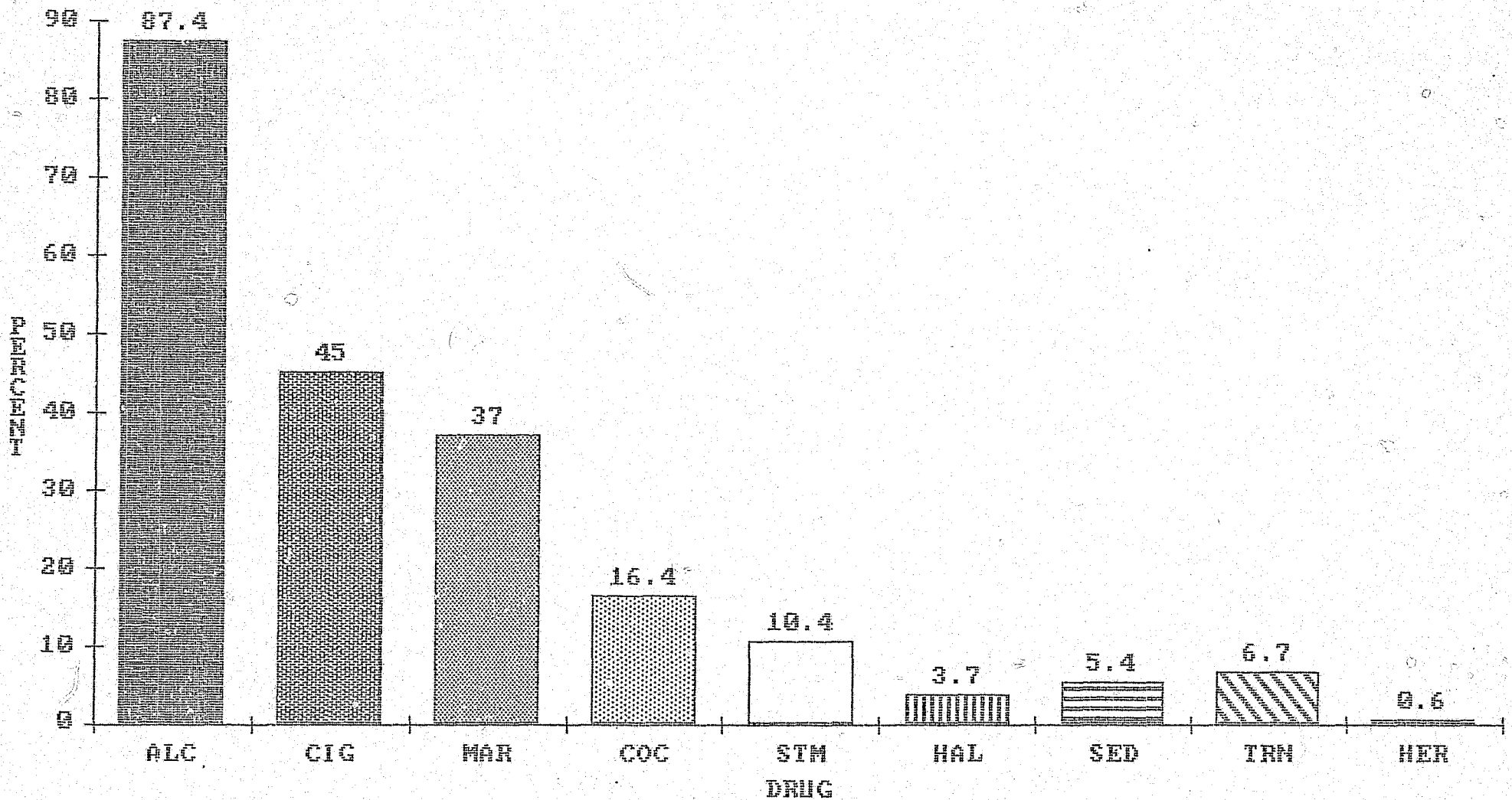
# HIGH SCHOOL SENIORS USING EACH DRUG LAST YEAR UNITED STATES 1986




SOURCE: NATIONAL INSTITUTE ON DRUG ABUSE/UNIVERSITY OF MICHIGAN ANNUAL HIGH SCHOOL SENIOR SURVEY

DFN 3/1/87

# YOUNG ADULTS (18–25) USING EACH DRUG LAST YEAR UNITED STATES 1986

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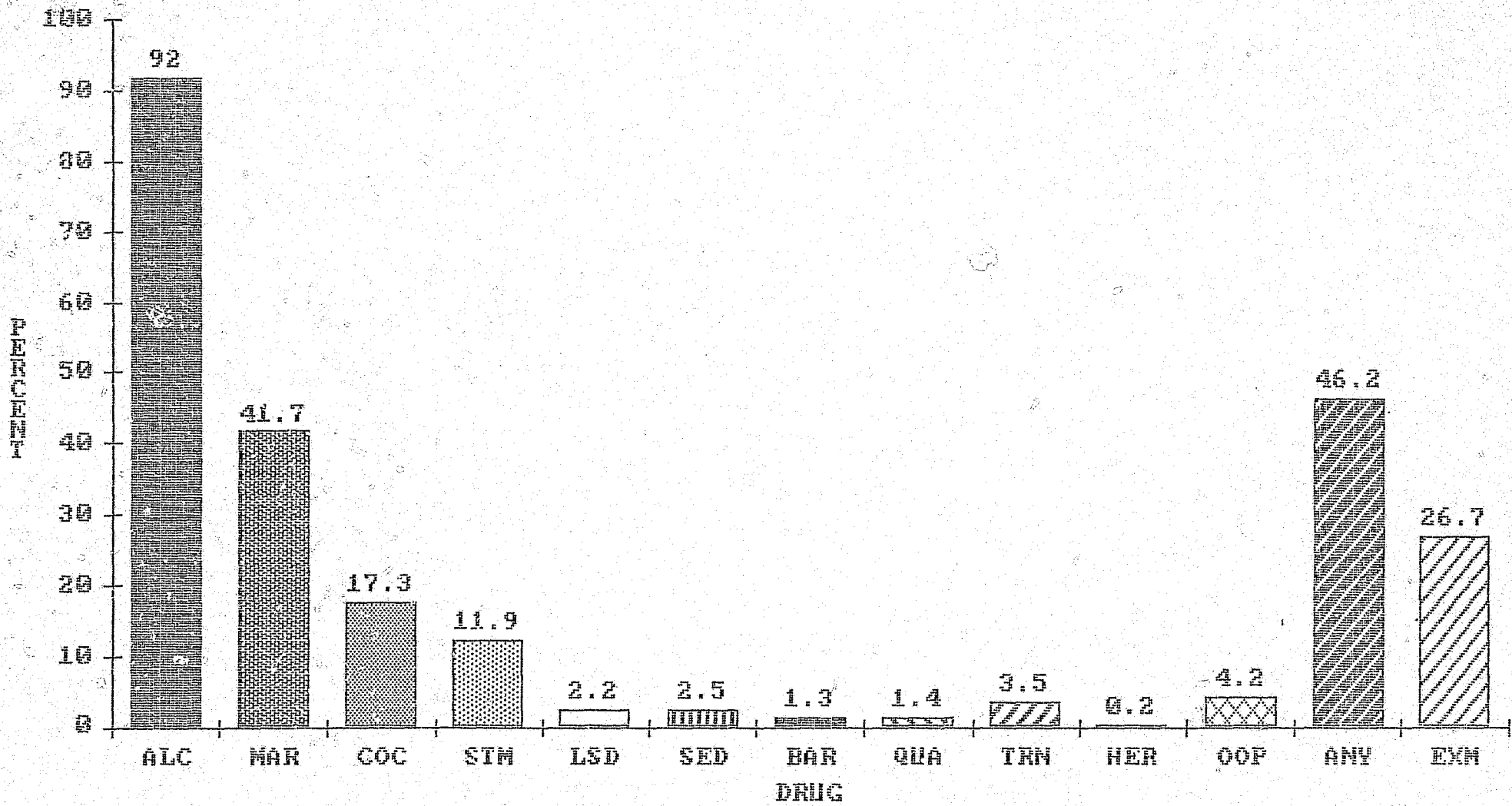
# COLLEGE STUDENTS USING EACH DRUG LAST YEAR UNITED STATES 1985




SOURCE: NATIONAL INSTITUTE ON DRUG ABUSE/UNIVERSITY OF MICHIGAN ANNUAL HIGH SCHOOL SENIOR SURVEY FOLLOW-UP STUDY

DFN 3/1/87

at the national level went from 1.9 percent in 1975 to 6.7 percent in 1985, declining slightly to 6.2 percent in 1986. The data for the Southern region show a similar pattern, though at a reduced prevalence.

Monthly stimulant use among high school seniors at the national and Southern region levels has been declining from peak values in 1981-82.

Monthly use of sedatives, barbiturates and hallucinogens among high school seniors has been declining since the 1970s at both the national and Southern region levels.

## 2. Arrests

While accurate information is not available on the total number of crimes committed as a result of alcohol and drug abuse, the number of alcohol and drug related arrests in South Carolina is one indicator of the problems caused by substance abuse in this state. However, caution must be used in interpreting this data because it represents only the number of reported arrests, not the actual number of occurrences of an offense, and the data cannot be used to establish the true extent or pattern of substance abuse because arrests are influenced by many factors unrelated to the incidence and prevalence of alcohol and drug abuse. But, the number of arrests for some offenses (such as DUI) can have direct impact on the 301 System by increasing or decreasing the number of clients in various program components.

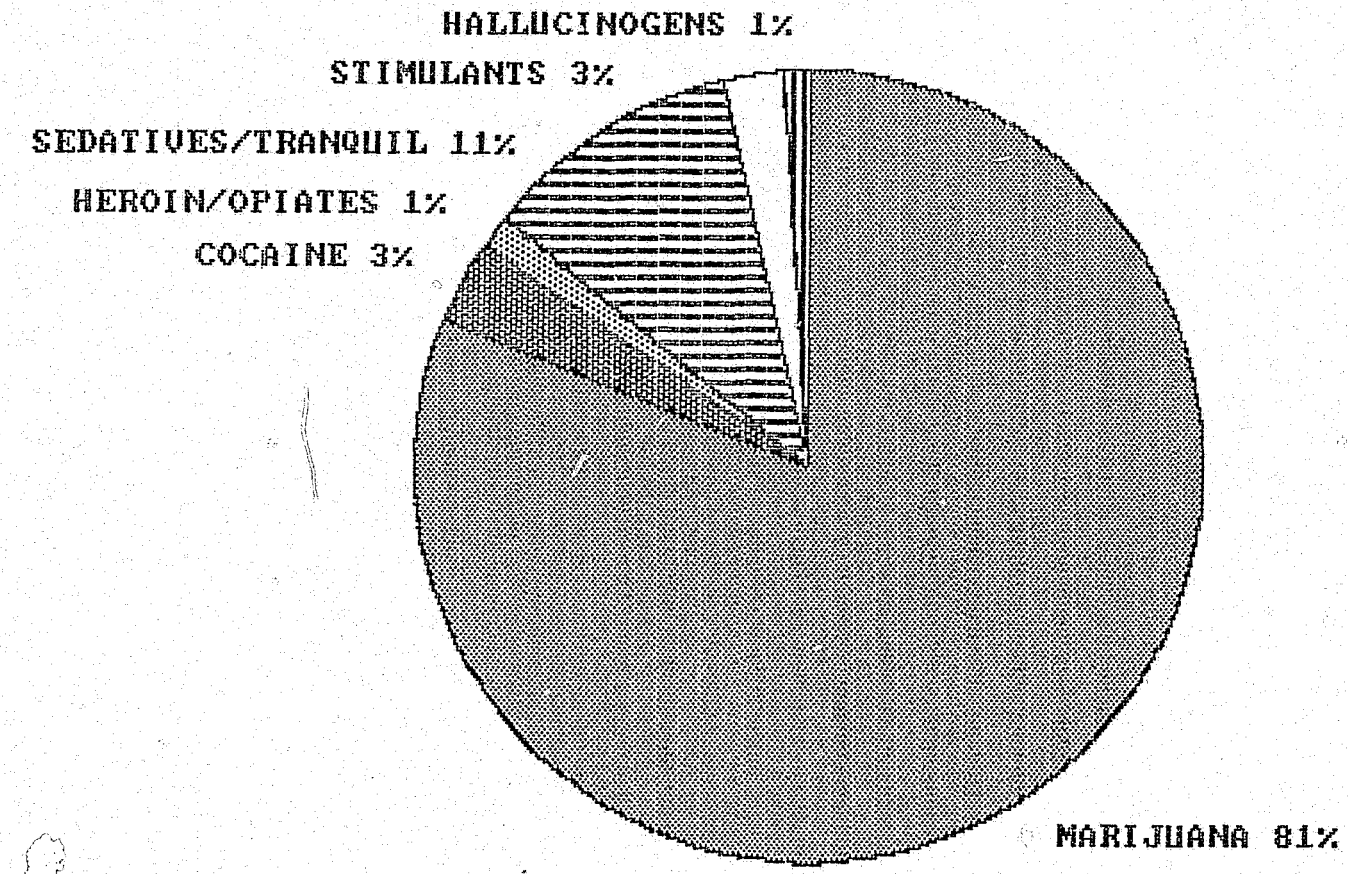
Nevertheless, an analysis of uniform crime report data indicates trends in substance-related arrests which reflect to some extent patterns of substance abuse in South Carolina. The number of substance-related arrests have been increasing each year since 1981 although, because of an increase in arrests for other offenses, substance-related arrests accounted for a lower proportion of all arrests in 1986 than any of the previous four years (41.51 percent).

Arrests for public drunkenness continue to decline while arrests for DUI increased in 1986. Arrests for liquor law violations remained high in 1986, indicating a continuum of the phenomenon noted in the 1984 data, when arrests were twice as high as in the previous years. The increase in these arrests during 1984 were suggested to be the result of new legislation which increased the minimum purchase age and made it illegal to possess open containers of beer and wine in automobiles and other motor vehicles. If, indeed, these two pieces of legislation are responsible, the 1986 data indicate that individuals in the state have not yet adjusted to these legislative changes. Arrests for drug law violations, again, accounted for 6 percent of all arrests, but remained high at 11,020 arrests in 1986, due primarily to the increases in arrests for cocaine violations. Arrests for cocaine violations have been increasing dramatically each year since 1981. Marijuana arrests decreased in 1986 to 8,249, following a five year high of 9,071 arrests in 1985. Arrests for heroin and other narcotic violations remain low and arrests for other dangerous drugs remained well below the six year peak in 1981.

Substance-related arrest data suggest that, while there are changes in the number of arrests for specific alcohol or drug related violations between years, the overall picture remains unchanged. Substance-related arrests continue to account for over 40 percent of all arrests each year and this figure does not reflect the level of alcohol and drug involvement in other criminal activities. The arrest data indicate that drinking and driving continue to be a problem in South Carolina and suggest that cocaine and marijuana are the current drugs of choice among drug abusers in this state.

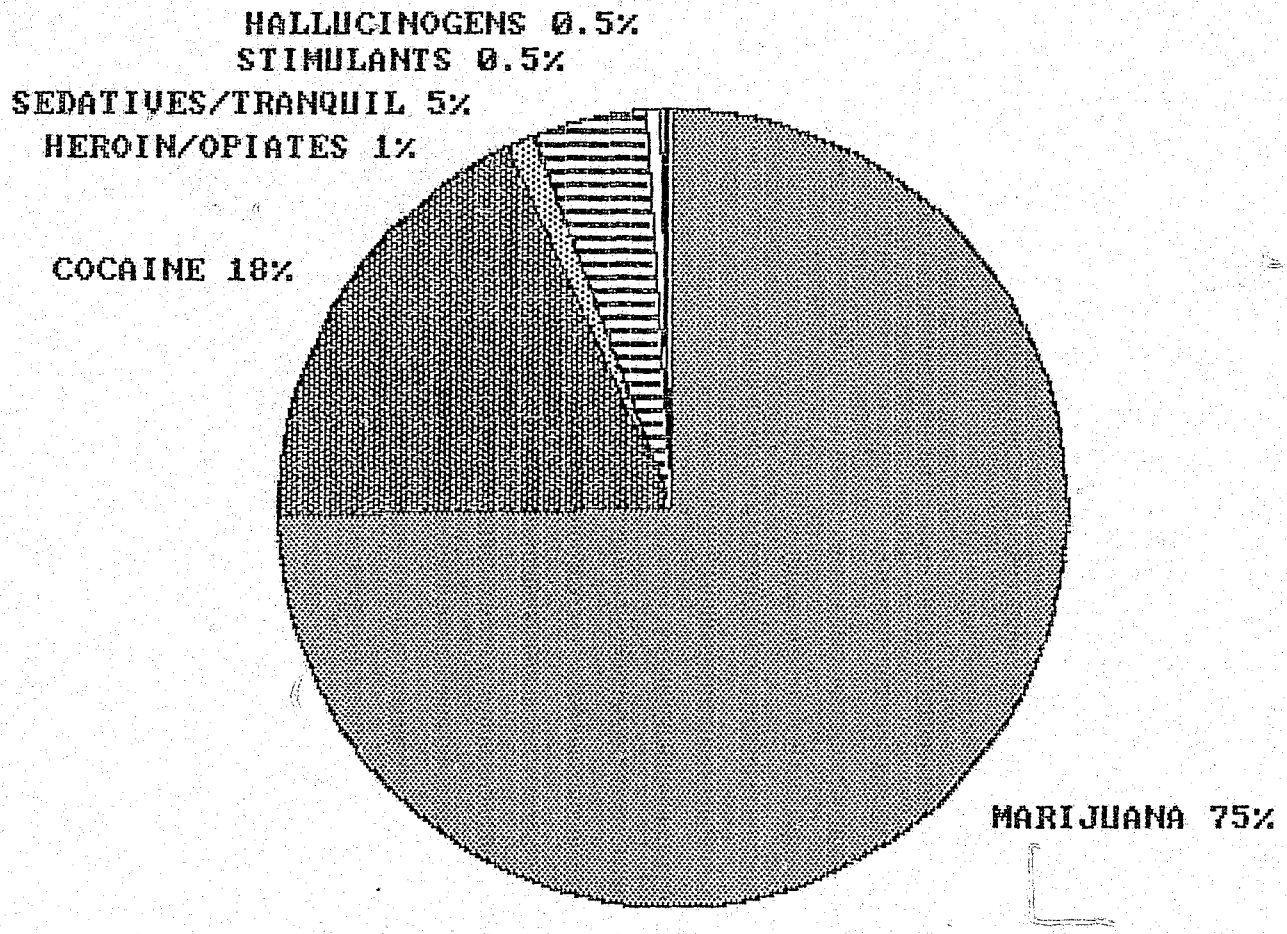
Of the 69,308 substance-related arrests in South Carolina during 1985, 4 percent were of individuals under age 18. Youth and adult proportions have changed notably only for arrests for drug law violations. The proportion of youths arrested have been declining since 1981.

# *DRUG ARRESTS IN SOUTH CAROLINA BY DRUG CY 1980*




SOURCE: SCCADA ANALYSIS OF SLED DATA

# *DRUG ARRESTS IN SOUTH CAROLINA BY DRUG CY 1986*




SOURCE: SCCADA ANALYSIS OF SLED DATA

SUMMARY OF ALL SUBSTANCE-RELATED
ARRESTS IN SOUTH CAROLINA: 1982-1986

| Arrest Category and Percent of All Arrests | YEAR 1982 | 1983 | 1984 | 1985 | 1986 |
|---|---|---|---|---|---|
| Alcohol-Related Arrests | 54,438 | 57,566 | 58,452 | 58,128 | 61,480 |
| Percent | 37.10 | 40.19 | 39.10 | 35.94 | 35.20 |
| Public Drunkenness | 29,116 | 28,835 | 27,224 | 25,158 | 25,890 |
| Percent | 19.84 | 20.13 | 18.20 | 15.55 | 14.82 |
| DUI | 20,726 | 23,981 | 21,650 | 21,922 | 23,047 |
| Percent | 14.13 | 16.74 | 14.48 | 13.55 | 13.20 |
| Liquor Law Violations | 4,596 | 4,750 | 9,578 | 11,048 | 12,543 |
| Percent | 3.13 | 3.32 | 6.40 | 6.83 | 7.18 |
| Drug-Related Arrests | 10,022 | 9,023 | 10,092 | 11,180 | 11,020 |
| Percent | 6.83 | 6.30 | 6.75 | 6.91 | 6.31 |
| Heroin and Other Narcotics | 211 | 119 | 144 | 135 | 146 |
| Percent | .14 | .08 | .10 | .08 | .08 |
| Cocaine | 346 | 614 | 1,028 | 1,398 | 2,006 |
| Percent | .24 | .43 | .69 | .86 | 1.15 |
| Marijuana | 8,530 | 7,571 | 8,308 | 9,071 | 8,249 |
| Percent | 5.81 | 5.29 | 5.55 | 5.61 | 4.72 |
| Other Dangerous Drugs | 935 | 719 | 612 | 576 | 619 |
| Percent | .64 | .50 | .41 | .36 | .35 |
| All Substance-Related Arrests | 64,460 | 66,589 | 68,544 | 69,308 | 72,500 |
| Percent | 43.93 | 46.48 | 45.83 | 42.85 | 41.51 |
| All Arrests[1] | 146,717 | 143,252 | 149,567 | 161,748 | 174,650 |
| Percent | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 |

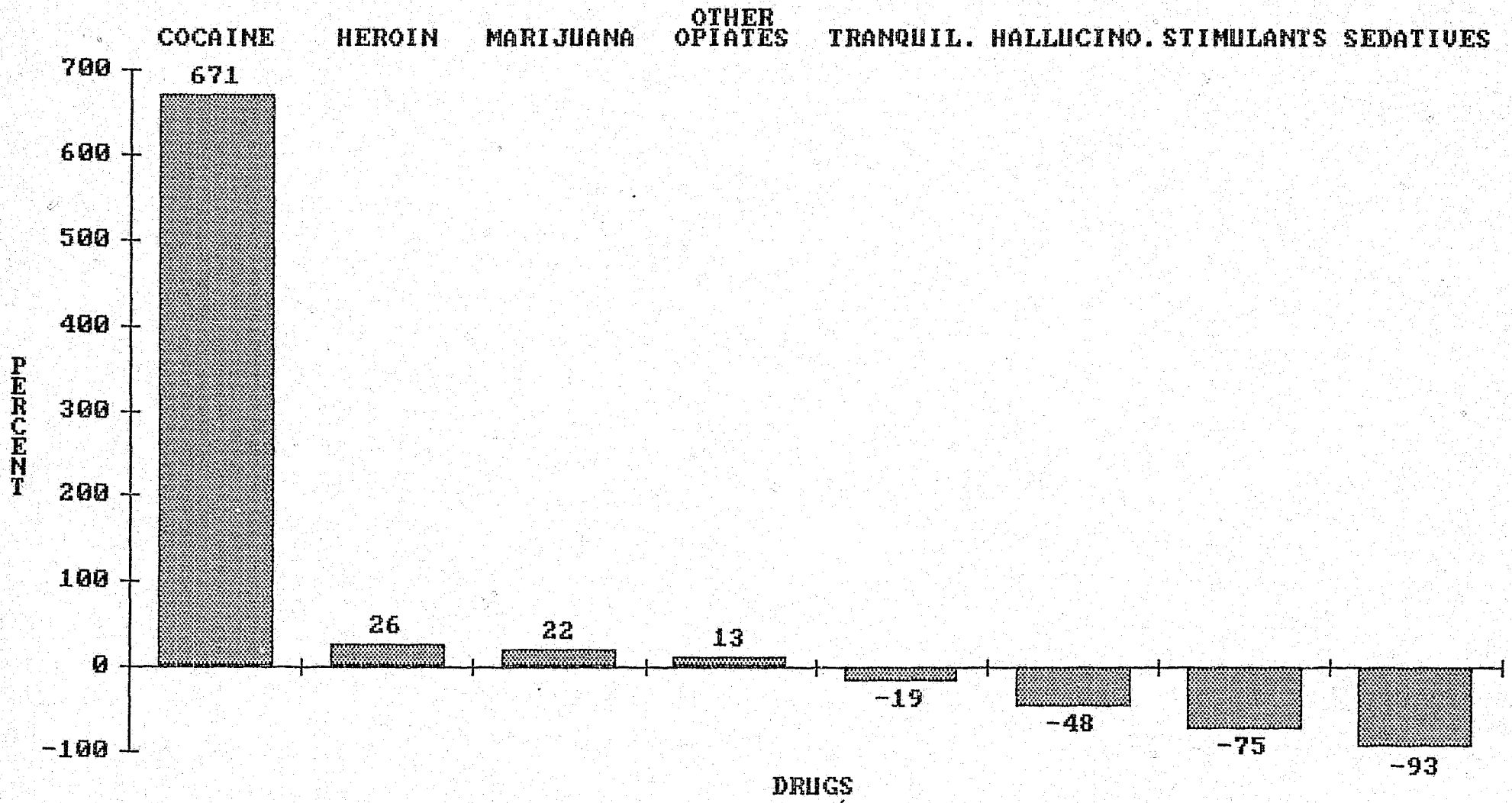
[1]Total arrests reported by SLED in all crime categories

SUBSTANCE-RELATED ARRESTS OF YOUTHS AND ADULTS, 1981-1985

| Arrest Category | 1981 # | 1981 % | 1982 # | 1982 % | 1983 # | 1983 % | 1984 # | 1984 % | 1985 # | 1985 % |
|---|---|---|---|---|---|---|---|---|---|---|
| Drug Law Violations | | | | | | | | | | |
| Youth[1] | 1,021 | 10 | 777 | 8 | 554 | 6 | 678 | 7 | 726 | 6 |
| Adult | 9,114 | 90 | 9,245 | 92 | 8,469 | 94 | 9,414 | 93 | 10,454 | 94 |
| Liquor Law Violations | | | | | | | | | | |
| Youth | 462 | 10 | 537 | 12 | 472 | 10 | 1,175 | 12 | 1,376 | 12 |
| Adult | 4,050 | 90 | 4,059 | 88 | 4,278 | 90 | 8,403 | 88 | 9,672 | 88 |
| DUI | | | | | | | | | | |
| Youth | 378 | 2 | 379 | 2 | 356 | 1 | 285 | 1 | 322 | 1 |
| Adult | 18,711 | 98 | 20,347 | 98 | 23,625 | 99 | 21,365 | 99 | 21,600 | 99 |
| Public Drunkenness | | | | | | | | | | |
| Youth | 679 | 2 | 698 | 2 | 543 | 2 | 487 | 2 | 454 | 2 |
| Adult | 28,233 | 98 | 28,418 | 98 | 28,292 | 98 | 26,737 | 98 | 24,704 | 98 |
| All Substance-Related | | | | | | | | | | |
| Youth | 2,540 | 4 | 2,391 | 4 | 1,925 | 3 | 2,625 | 4 | 2,878 | 4 |
| Adult | 60,108 | 96 | 62,069 | 96 | 64,664 | 97 | 65,919 | 96 | 66,430 | 96 |

[1]Youths are defined as individuals under age 18.

# *PERCENT CHANGE IN ARREST RATES BY DRUG SOUTH CAROLINA, 1980–1986*




SOURCE: SCCADA ANALYSIS OF SLED DATA

## 3. Economic Costs

There are many serious consequences related to the use of alcohol and other drugs. Most apparent are the social and economic costs such as broken families, lost productivity in the work place, crime, ruined careers, medical expenses, deaths and injuries. However, little is known about the true economic cost of substance abuse -- the actual dollar value.

In South Carolina, the largest single cost area associated with alcohol abuse is lost production due to alcohol-related causes (Self, et al., 1982). This occurs when the capacity to produce goods and services is reduced or lost, resulting from such things as excessive absenteeism, reduction in work efficiency, frequent and disruptive job changes and other consequences related to poor job performance. The most recent (1981) South Carolina estimate indicated that as many as 69,000 of the state's 1,000,298 employees were experiencing job impairment due to drinking problems. The yearly value of this lost production was estimated at $225,000,000.

A second major area of alcohol and drug related costs is health care. The costs involved consist of the utilization of scarce resources to provide health care as the result of alcohol and drug abuse. In the absence of alcohol-related health problems, these resources could be diverted to other socially useful purposes, even providing health care for other diseases or for other types of socially beneficial activities.

It has been determined that alcohol abuse results in disproportionately heavier use of hospitals. The cost of health care services to alcoholics in 1980 was estimated at $196,000,000. It should be noted that this figure does not include health care by state and county programs that provide treatment services to alcohol abusers. The total estimated expenditure for alcohol and drug specific services in South Carolina was $22,000,237 during FY83.

Most of the economic costs of alcohol-related traffic accidents result from lost production due to early death in fatal accidents. The costs of such deaths are especially high because of the large proportion of young people who are killed. In South Carolina, there have been 354 deaths, 5,926 injuries and 7,759 property damage accidents resulting from alcohol or drug use in 1985. Although the total cost of these traffic accidents in South Carolina is not known for 1985, in 1980, alcohol and drug related traffic accidents cost between $137,000,000 and $146,000,000.

The principal costs of alcohol-related fires include lost production due to early death and injury, medical expenses and property damage. There were an estimated 79 alcohol-related fire deaths in South Carolina in 1980. It is estimated that the cost of lost production from early death due to alcohol-related fires is approximately $10.5 million annually. The estimated property damage cost due to alcohol-related fires is approximately $4,000,000 annually. Combining the cost of lost production and property damage results in an estimated cost of alcohol-related fires of approximately $14.5 million.

Major lost production costs also occur through alcohol-related drownings and boating accidents, falls and other accidents. Using age-specific cost figures, it is estimated that these alcohol-related accidents cost South Carolinians over $30,000,000 annually. Another category of cost that can be linked to alcohol abuse results from

various governmental expenditures designed to assist citizens in need of economic support. Some proportion of these expenditures go to alcohol abusers or their families and would not be necessary in the absence of abusive use of alcohol.

The major categories of such costs include unemployment compensation; workman's compensation; public assistance, including Aid to Families with Dependent Children, Supplemental Security Income and other kinds of public assistance such as food stamps and emergency assistance. Expenditures attributable to alcohol abuse amount to approximately $27,000,200 for unemployment compensation, $5,400,000 for workmen's compensation and $142,000,000 to various public assistance programs. Administrative costs alone amount to approximately $11.5 million annually. While cost attributable to alcohol and drug abuse in South Carolina are alarming, the economic cost nationally of alcohol alone was estimated at $116.6 billion in 1983. The estimated cost of drug abuse nationally was at least $59.7 billion.

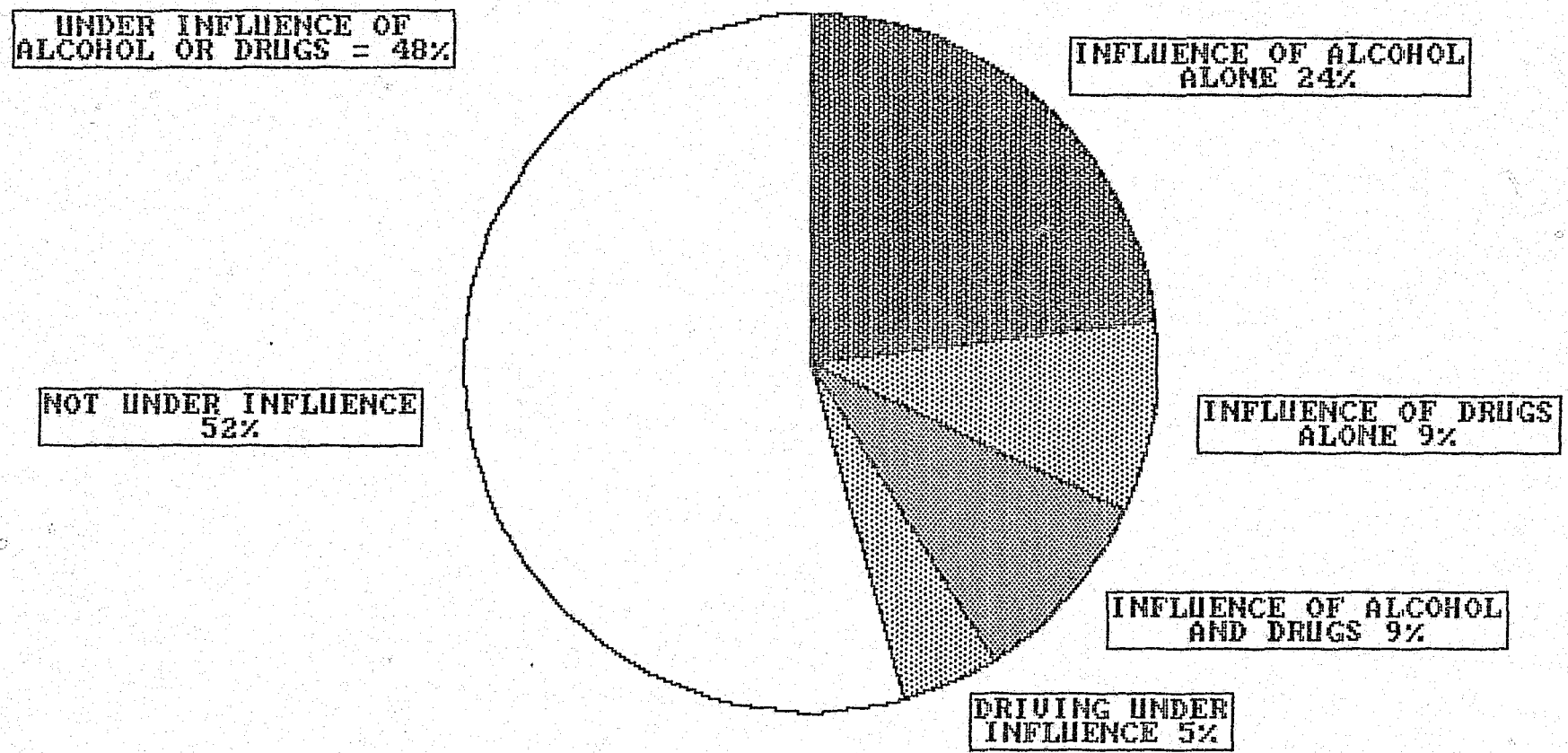
4. Crime

A number of studies have demonstrated that alcohol-related crime results in tremendous social and economic burdens to society. Alcohol-related crime includes a wide range of illegal behavior, from public drunkenness to homicide. Together, alcohol-related crime has significant impact on the public, ranging from the harm done to victims and their families to the economic costs of arresting, prosecuting and incarcerating the offender.

Attempting to determine the extent of alcohol involvement in crime and its impact on the criminal justice system presents a number of problems. Some types of illegal behavior, such as public drunkenness, always involve alcohol; but with other offenses, such as homicide, although alcohol is frequently thought to be involved, by no means is it always involved. However, data are not always collected on alcohol involvement in various types of illegal behavior. When it is collected, its accuracy is uncertain and the manner or extent of alcohol involvement often unspecified. For these reasons, for many crimes only a rough estimate can be made of the extent and manner of alcohol involvement and the cost imposed by that behavior.

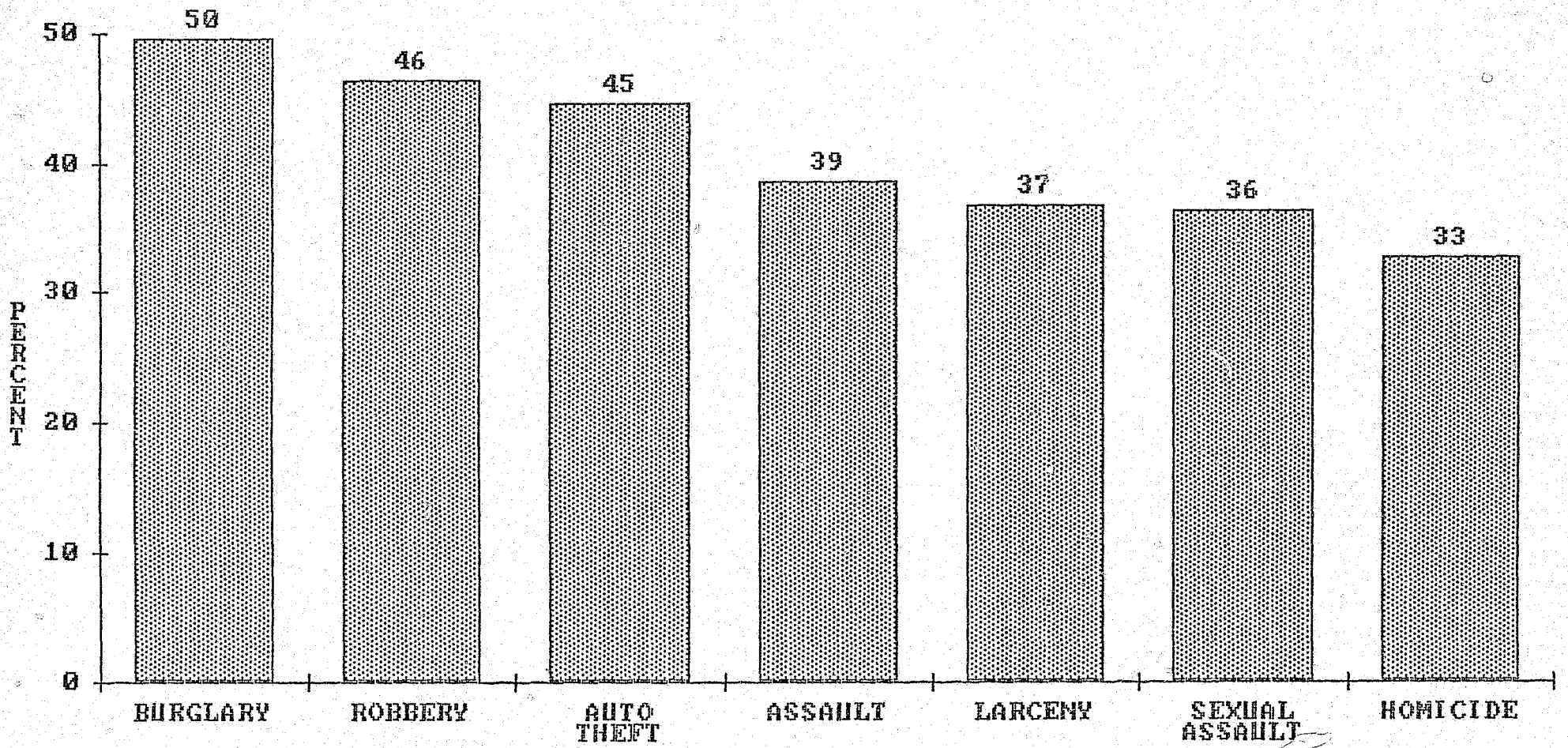
Another problem which makes it difficult to define the impact alcohol has on a criminal justice system is the difficulty of establishing a causal of relationship between alcohol use and illegal behavior. In the case of public drunkenness, alcohol clearly functions as the agent leading directly to the violations; in the case of homicide, even when alcohol is known to have been involved, the manner and extent to which it was a factor is often unclear. Alcohol may be involved through the perpetrator's having been drinking, the victim's having been drinking, or because the setting was one in which alcohol was sold for being consumed. In many cases, it is likely that the violation would not have occurred in the absence of alcohol, but the precise role of the alcohol may be very difficult to determine. Such determinations are difficult to arrive at because there does not presently exist an agreement on a theory that successfully explains the relationship between drinking and illegal behavior, and incorporates empirical data that have been collected concerning this relationship. Numerous explanations for this relationship have been offered. One hypothesis is that alcohol

# *INMATES WHOSE CURRENT OFFENSE WAS COMMITTED UNDER THE INFLUENCE OF ALCOHOL OR OTHER DRUGS SOUTH CAROLINA DEPARTMENT OF CORRECTIONS, FY 1986*




SOURCE: SC DEPARTMENT OF CORRECTIONS

# *PERCENT OF CRIMES COMMITTED UNDER INFLUENCE OF ALCOHOL OR OTHER DRUGS, UNITED STATES, 1979*




SOURCE: FBI REPORT ON CRIME & JUSTICE, SURVEY OF STATE PRISON INMATES

functions as a disinhibitor, which reduces the effectiveness of an individual's behavior control mechanism. It has also been argued that alcohol use produces chemical reactions affecting the brain and resulting in more aggressive behavior. Other theories argue that alcohol lessens a person's capacity to function effectively in a complex situation, resulting in violent behavior, or that alcohol has the effect of intensifying existing moods, including anger and frustration, that in certain circumstances could result in a greater likelihood of aggression and violence. In summary, the extent to which the alcohol-crime relationship is a casual one remains to be determined for many kinds of illegal behavior.

The exact relationship between drugs and crime is not fully understood. However, several recent studies (Grupper, et al., NIJ Reports, 1984) have examined the nature and extent of the linkages between drugs and crime. Some of the findings of these studies are:

1. Different levels of abuse of such drugs as heroin are directly related to criminal activity at an individual level, and individuals who abuse such drugs in different degrees of severity will tend to have corresponding patterns of severity in criminal behavior.

2. Even among high-risk individuals with status patterns of both drug use and criminality, an increase or reduction in the level of drug abuse will be associated with a corresponding increase or reduction in criminality.

3. Street level heroin users tend to engage in a variety of criminal acts and other behavior to support their drug habit and personal survival needs, with corresponding costs to their victims, their families and society in general.

These findings do have implications for state policy aimed at prevention and control of drug abuse and drug-related crime. Narcotic addicts/users as a group engage in a great deal of crime; however, amounts and types of crimes committed vary considerably among the individuals. For the majority of narcotic users, current patterns of criminality are strongly influenced by their current drug usage status. Based on the findings of these studies, it has been suggested that treatment and education programs be targeted toward reducing drug usage by the most frequent and intensive users to gain more significant reductions in drug-related criminality than undirected efforts and those aimed toward lesser users.

### 5. Problem Estimation

There are many different methods being explored today to determine the alcohol and drug problem population. Almost every state uses a different methodology. The SCCADA uses a modification of the Marden procedure to determine problem drinkers in South Carolina.

The Marden method for estimating the number of problem drinkers is based upon national survey results conducted by Cahalan and colleagues in the mid and late 1960s (Cahalan, et al., 1969; Cahalan, 1970; Cahalan and Room, 1974). Cahalan rated respondents as to the severity of 11 problems associated with drinking.

A cut-off score was utilized in the Cahalan surveys to classify a respondent as a problem drinker. The proportions of the respondents (by sex and various age groups) so classified as problem drinkers formed the Marden Problem Drinker Matrix.

SCCADA has modified the Marden procedure to include estimates of the proportion of the adolescent population who are problem drinkers. These estimates were obtained from South Carolina school surveys conducted in 1979 and 1980. The resulting age and sex proportions of the South Carolina population who are problem drinkers are presented in

Several concerns have been expressed concerning the Marden method. Chief among these is the observation that 1960s survey data may no longer be valid.

Several alternative methods for estimating the number of problem drinkers (by age group and sex) are presented below and on the following charts.

A detailed nationwide household survey (1,772 adults) conducted in 1979 provides the most recently available data which attempt to define problem drinkers for various age groups and by sex. This NIAAA-funded survey has been analyzed in different ways by Clark and Midanik (1982), Clark (1982) and Hallwood, et al. (1984).

One method identifies the proportion of the national population by age group and sex who are problem drinkers in terms of heavy consumption, defined as more than 60 drinks per month. Another method defines problem drinking in terms of loss of control or alcohol dependence symptoms (e.g., binge drinking, morning drinking, fear that one was an alcoholic). A third alternative method classifies a person as a problem drinker if he or she experienced any of several negative social consequences as a result of drinking during the past 12 months. These include serious marital, family, legal and occupational consequences of drinking to excess. As final example, Clark (1982) reviewed the national survey on the issue on frequency of drunkenness.

These data suggest that the greatest estimated number of problem drinkers would be obtained from the heavy consumption definition, the Marden method, and the loss of control/dependence measure.

A small estimated number of problem drinkers will accrue from the use of social consequences definition, with the smallest estimation provided by the frequency of drunkenness definition.

SCCADA estimates the drug-abusing population to be approximately 25 percent of the alcohol-abusing population. This estimate was added to the problem drinker estimate for each definition. Overall, the heavy consumption method identifies approximately 15 percent of the South Carolina population as problem drinkers or drug abusers. The Marden defines approximately 14 percent of the population as at risk, and the loss of control dependence method estimates 12 percent. The social consequences methods identifies 6 percent of the population, and the frequency of drunkenness measure estimates 5 percent of the population to be alcohol or drug abusers. The following charts show the percentage and number of the at-risk population served by the 301 System for the years FY80 through FY85 under the various estimates of the problem drinker/drug abuser population. These estimates range from 6 percent under the Marden method to 17 percent according to the frequency of drunkenness estimate.

SCCADA is currently reviewing these and other methods of estimating the at-risk population.

SCCADA CLIENT ADMISSIONS (FIRST AND RE-ENTRY): FY80-85

| | Primary Alcohol | Primary Drug | Total Substance | Total Including Non Substance |
|---|---|---|---|---|
| FY80 | 18,309 | 4,841 | 23,150 | 25,853 |
| FY81 | 16,823 | 4,648 | 21,471 | 25,510 |
| FY82 | 16,444 | 3,953 | 20,397 | 25,924 |
| FY83 | 18,349 | 3,453 | 21,802 | 27,232 |
| FY84 | 17,868 | 3,674 | 21,542 | 27,537 |
| FY85 | 19,123 | 4,347 | 23,470 | 30,266 |

SCCADA PRIMARY ALCOHOL AND DRUG ADMISSIONS AS PERCENT OF POPULATION AT RISK VIA FIVE METHODS

| | 1980 | 1981 | 1982 | 1983 | 1984 | 1985 |
|---|---|---|---|---|---|---|
| Marden | 6.37 | 5.78 | 5.42 | 5.72 | 5.59 | 5.92 |
| Social Consequences | 15.50 | 14.07 | 13.21 | 13.97 | 13.66 | 14.38 |
| Loss of Control-Dependence | 7.83 | 7.11 | 6.68 | 7.07 | 6.92 | 7.28 |
| Heavy | 6.37 | 5.75 | 5.37 | 5.66 | 5.51 | 5.79 |
| Drunk | 18.15 | 16.60 | 15.68 | 16.68 | 16.42 | 17.24 |

## Special Populations

### Women

There are a number of issues related to services for women with alcohol and drug problems. In FY85, females receiving services in the alcohol and drug system were approximately 24 percent, which is significantly lower than their percentage within the population. It is possible that, to some extent, women are less involved with alcohol and illicit drugs. It is also possible that Southern social attitudes toward females may affect arrest rates as well as the existence of closet alcoholics and/or the reluctance of the family to identify the female as an abuser. It is true also that a great many more women than men make frequent use of prescribed psychoactive drugs.

Accurate information is not available for the number of women with drug abuse problems in the state. Based on data from the South Carolina Hospital Discharge Survey, approximately two women are discharged with a primary diagnosis of drug abuse for every three women with a primary alcohol diagnosis. To estimate the prevalence of alcohol abuse among women, the Marden probability matrix was employed utilizing the state 1985 population projection for South Carolina. The tabulations indicated that there are approximately 101,090 women experiencing problems with alcohol abuse in South Carolina. An analysis of MIS data shows that 4.6 women receive services from 301 System Agencies for an alcohol problem for each woman entering as a result of a drug problem. Based on these ratios, we might expect between 12,000 and 32,000 women to be experiencing problems with drug abuse in South Carolina.

Compared to men, women are more likely to abstain from drinking alcoholic beverages. However, some research suggests that women who develop substance abuse problems do so later in life than men and that the addiction process progresses more rapidly in women (Beckman 1976). There is evidence that drinking among females is increasing, which may indicate a future increase of drinking problems among women (Wilmore 1979; and Wilsnack 1978). There may be indications of this phenomenon occurring in the 301 System detox centers where the number of females increased from 16.2 percent in FY80 to 20 percent in FY84, before declining to 18.2 percent in FY85.

Sociological changes, such as women entering the work force, more women becoming divorced or separated and an increase in women serving as heads of household are expected to have an impact on the number of women developing substance abuse problems. Research suggests that working women have significantly higher rates of alcohol problems than housewives (Johnson 1978), however "role confusion" may be a greater risk factor. It is harder, however, to identify and treat the female problem drinker in the occupational setting. Typically, the female substance abuser tries harder than her male co-worker to hide her problem. Additionally, supervisors, especially males, may be unwilling to identify women as substance abusers. Divorced and separated women are known to have a higher incidence of problem drinking than single and married women. Between 1970 and 1980 the number of divorces in South Carolina increased by 133 percent. At the same time, the number of female heads of household almost doubled. Women alcoholics are divorced or separated more frequently than men alcoholics and more often serve as single heads of household.

Several physiological differences between men and women may intensify the effects of alcohol on women, potentially increasing their risk

of developing alcohol problems. These include the generally smaller body frames and lower weight of women, hormone changes due to the menstrual cycle, lower water volume in women's bodies, and, possibly, the use of oral contraceptives. Special problems faced by women in obtaining treatment services include limited research into the specific treatment needs of women, few facilities that target the treatment needs of women, lack of child care, lack of support from family members and friends, and the potentially loss of income.
The threat of losing custody of their children may also prevent women from entering treatment (USDHEW 1978).

Women are more likely than men to develop a cross addiction to alcohol and prescription drugs. Sixty-one percent of psychotropic drugs, 71 percent of antidepressants and 80 percent of barbituates are prescribed for women. Psychoactive drugs are prescribed for women twice as often as for men. An analysis of South Carolina hospital data for 1980 shows that females made up 72 percent of persons discharged with a diagnosis of poisoning by psychoactive drugs. Physicians often prescribe tranquilizers and antidepressants for women to relieve symptoms of boredom, tension, pressure and loneliness, many times being unaware of or hesitant to approach the woman's underlying alcohol problem. Private physicians sometimes treat alcohol problems with tranquilizers, thereby increasing the risk of cross addiction and ultimately creating more difficulties during treatment (Aldoory 1978 and Sandmaier 1980). One private treatment center in South Carolina reports that 26 percent of its current client population has a cross-addiction to alcohol and drugs. While data is not available as to the sex of cross-addiction patients at the center, this proportion (cross-addiction compared to alcohol diagnosis) has increased steadily in recent years.

Another special concern is the impact of a woman's use of alcohol and drugs on the fetus during pregnancy. The use of these substances is associated with an increase risk of physical and mental abnormalities in offspring. The pregnant woman who drinks is at risk of having a child with fetal alcohol syndrome (FAS) or fetal alcohol effects (FAE). Infants with fetal alcohol syndrome have small head and body size, facial disfiguration, mental retardation, and other mental and physical abnormalities. Fetal alcohol effects are less severe but include low birth weight, increased risk of miscarriage, behavior problems in infancy and childhood, and impaired physical development. The incidence of fetal alcohol syndrome in the U.S. is one in every 1,500 - 2,000 births. The incidence of fetal alcohol effects is one in every 100 births. However, research has indicated that there is an increased risk of lesser fetal alcohol effects with regular use of even relatively small amounts of alcohol (Little 1979). No safe level of alcohol consumption has been established for pregnant women and evidence is increasing that the use of certain drugs during pregnancy may have adverse effects on the fetus.

Often, women's drinking problems are less obvious than men's since there is a tendency to "protect" women from the social stigma associated with substance abuse problems. Because of this, women are less subject to outside intervention. Medical professionals often eliminate more appropriate treatment mechanisms by disguising female alcoholism under other diagnoses (USDHEW 1978) and police are reluctant to arrest women for alcohol-related offenses (Schuckit and Morrissey 1976). Women represented only 12 percent of ADSAP clients in FY85 20 percent of OBI

clients. There is a high representation of women in 301 System occupational programs (53 percent). However, 88 percent of these female clients enter occupational programs for non-substance problems.

While women in general are underrepresented in the 301 System as compared to the statewide population, black women had the lowest representation of any subgroup. Black women make up 16 percent of the state's population, yet they accounted for only 5 percent of 301 System clients in FY84. Hospital discharge data indicate that 9 percent of persons with an alcohol or drug abuse diagnoses were black females.

PROJECTED SOUTH CAROLINA PROBLEM ALCOHOL USERS FY87

| | Male | Female | Total |
|---|---|---|---|
| 0- 9 | 0 | 0 | 0 |
| 10-19 | 30,162 | 21,248 | 51,410 |
| 20-29 | 81,349 | 38,285 | 119,634 |
| 30-39 | 45,536 | 22,467 | 68,003 |
| 40-49 | 33,520 | 13,646 | 47,166 |
| 50-59 | 17,983 | 3,032 | 21,015 |
| 60-69 | 14,061 | 1,793 | 15,854 |
| 70+ | 1,253 | 619 | 1,872 |
| TOTALS | 223,864 | 101,090 | 324,954 |

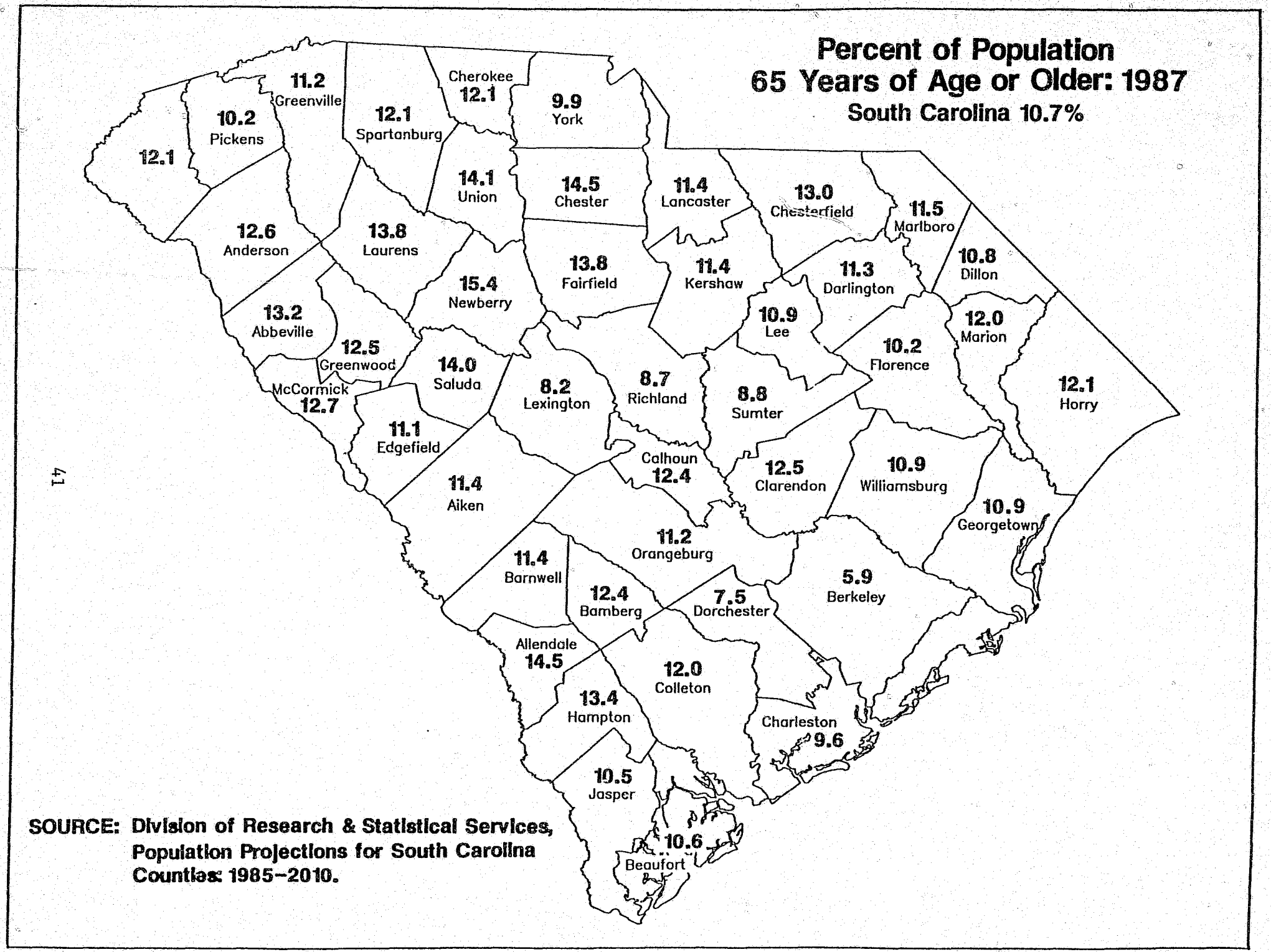
Elderly

Alcohol is the substance most often abused by the elderly, followed by prescribed drugs and over-the-counter medications (Porsch 1981). An analysis indicates that more than 90 percent of 301 System clients over the age of 65 report a primary problem of alcohol abuse. It is estimated that there are more than 17,726 problem drinkers in South Carolina over the age of 60. Older women are less likely to have an alcohol problem, with men making up 86 percent of the elderly projected problem drinking population.

A significant increase in life expectancy along with a decline in the birth and death rates in the 1960s and 1970s has resulted in older persons making up a larger proportion of the state's population. In South Carolina the 65 and older population increased more than 50 percent between 1970 and 1980. The elderly showed the greatest percent of change in any age group, increasing from 7 percent to over 10 percent of the state's resident population. Clients over age 65 made up only 1.75 percent of SCCADA clients in FY85. While the over 65 age group has shown marked increases as a proportion of the population in the state, the actual number of elderly clients served by 301 System agencies increased only 1 percent between FY81 and FY85.

The comparison of clients served by 301 System agencies with the expected problem drinking population suggests that males over age 70 had the highest percentage representation of alcohol clients (Exhibit 23). A closer analysis, however, shows that approximately half of these clients (as well as half of the clients in the 60 to 69 year old bracket) received services through detoxification programs.

Although the proportion of problem drinkers decreases with age, there remains a significant number of elderly who are problem drinkers.




**SOURCE: Division of Research & Statistical Services, Population Projections for South Carolina Counties: 1985–2010.**

Higher rates of substance abuse have been found among unmarried elderly persons including widowers as well as older individuals who have difficulty with police and those living in disadvantaged areas.

One of the problems in dealing with the elderly is that many of the psychological, behavioral and physical problems associated with substance abuse also occur frequently in elderly persons who do not have substance abuse problems. Brain damage, heart disease and gastrointestinal disorders are more frequent among the elderly. Psychological and behavioral factors which are common in the elderly such as depression, mood disorders, and changes in employment, economic and marital status are also associated with the diagnosis of alcoholism. When the elderly person is experiencing a problem caused by alcohol or drug abuse, these signals are often misinterpreted as problems simply caused by aging, with the underlying substance abuse problem going undiagnosed.

In addition to older people's substance abuse problems being masked by health complications, this population is less likely to enter through the traditional intervention programs. The older client is less likely to have job-related problems because he or she is less likely to work. The elderly are less likely to come to the attention of police. Because they are more likely to be widowed, elderly persons are less likely to be brought in for treatment as a result of marital conflict.

The elderly take more medication than any other age group; therefore, they are at a high-risk of developing problems which occur as a result of the interaction of alcohol with various drugs (Glassoch 1979). One study has shown that although the elderly rarely take medication more often than prescribed, more than half use some combination of prescription and over-the-counter medications and/or alcohol (Guttman 1977). Alcohol reacts negatively with many prescriptions, including many of those prescribed for older patients such as antidepressants, sedatives, tranquilizers and over-the-counter drugs (Seixas 1979). The use of alcohol in conjunction with other drugs can reduce the effectiveness of medications or change the effect of drugs, sometimes leading to coma or death. Women of all ages consume more tranquilizers and psychoactive drugs than men. Therefore, adverse interactions of alcohol and drugs are more likely to occur among elderly females.

Adverse health consequences of drinking are not limited to those elderly persons who are heavy drinkers. Alcohol tolerance is low for those elderly individuals with a number of medical problems including diabetes, heart disease, liver disease and central nervous system degeneration (Schuckit 1980). Older persons taking medication may have negative reactions to even small amounts of alcohol when combined with other drugs.

Although the diagnosis of substance abuse problems is often difficult among the elderly, there is general consensus that the treatment prognosis is good for older substance abusers, especially for those whose problems are of recent onset. These clients are also more likely to complete treatment than younger persons (Zimberg 1974).

The elderly often have special medical, psychological, social, financial and transportation needs. Often substance abuse programs fail to address the treatment and prevention needs of the elderly. The elderly have not been widely identified in the past as a target population for prevention programs (Weener 1978).

Youth

Younger children are often victims of alcohol. Many national research studies show that there is a definite connection between alcohol and family violence. The violence takes several forms. In abusive/neglect families, heavy drinking is a factor. Studies have shown that a number of alcoholic parents receiving treatment are often child abusers. Parents with alcohol problems have a high potential for exhibiting neglect for their children, especially through erratic and inconsistent parenting (Cork 1969, Fox 1972). Often the scenario shows the youngsters being rejected, not only by the alcoholic parent, but also by the non-alcoholic spouse. However the nature of the children's experience, strategies of coping and ways of understanding and reacting to the alcoholic parent will probably vary according to their age at the onset of the parent's drinking problems (Wilson and Orford, 1978). Parental neglect and/or inconsistent parenting can leave psychological scars on children. The ability to get along well with others is likely to be missing in these children, while suffering from feelings of guilt, fear and loneliness beneath the surface. Many of these children have a low self-esteem, feel they don't belong (Cork 1969, Fox 1972), are generally disoriented and may exhibit problems with sex role identification (Fox 1968). Indeed, the impact of child neglect and family dysfunction resulting from alcoholism and alcohol abuse has been and will continue to be great unless more emphasis is placed on this problem.

By the adolescent years, substance abuse is becoming a direct problem for the youth of South Carolina. According to the recent estimate, over 70,000 adolescents are currently experiencing problems with alcohol and drug abuse in South Carolina. Accurate data are not available on drug abuse for this population; however, the number of adolescents entering the 301 System with a primary diagnosis of drug abuse in FY85 was substantially greater than the number entering under a diagnosis of alcohol abuse. Likewise, the number of adolescents discharged from short-term hospitals with a primary diagnosis of drug abuse in 1980 was more than twice that with a primary diagnosis of alcohol abuse.

A 1980 survey of middle and high school students reported that 58 percent had used alcohol in the past (Porter and Townsend 1980). Most students who had used alcohol started between the ages of 14 and 16 years, and 21 percent reported drinking weekly. Twenty-eight percent reporting have used marijuana. The use of other drugs is listed in Exhibit 25.

A national survey conducted in 1983 by the University of Michigan Institute of Social Research found that 63 percent of high school seniors reported illicit drug use at some time in their lives. However, a substantial portion of them had only used marijuana (37 percent of all illicit users). The study also indicated that four in very 10 seniors surveyed reported using an illicit drug other than marijuana at some time. Another recent survey (NIDA, 1985) focusing on high school senior drug use over the period 1975-1984 found that in 1984 67 percent of the seniors had used alcohol in the past month; 4.8 percent used alcohol daily; and 93 percent had used alcohol at some point in their lives. Fifty-five percent of these seniors had at some point used marijuana, significantly higher than the marijuana usage portrayed in the 1980 South Carolina study.

As an analysis of data collected from high school seniors in the southern region of the United States (1984/85) shows that 85.6 percent reported using alcohol, 31 percent had used marijuana and 28.9 percent had used other stimulants or cocaine in previous years.

Children of Alcoholics

Children of alcoholics represent a classical example of a group toward which prevention and intervention programs should be focused. However, the identification of these children and their problem will likely require many more resources than are presently available; if we are to reduce this profound human and economic suffering caused by alcoholism and alcohol-related problems.

It has become apparent in recent years that more attention must be paid to those children whose parents are alcoholics or problem drinkers. Scientific research suggests that the sons and daughters of approximately 11 percent of the adult population in this country are prime candidates to develop alcohol-related problems. COA's are at 3-4 times a higher risk than the general population of becoming alcoholics. Additionally, they may experience a wide range of personal problems, including poor communication skills, repressed anger, inability to trust others, juvenile delinquency, learning difficulties, and physical and sexual abuse.

According to a recent estimate (NIAAA, 1984), there are between 12 and 25 million children of alcoholics in the United States, (one out of every eight Americans) with only about 5 percent of these receiving any help at all; many of these children are ignored or are treated inappropriately. A recent SCCADA study revealed that there was as many as 250,000 children under age 20 in South Carolina with one or more parents who were problem drinkers in 1984. This amounted to about 23 percent of all children under age 20 in the state, and about 170,000 of these children are living at home.

The SCCADA study revealed that among SCCADA clients with substance abuse problems, the percentage who had parents with drinking problems was much higher, about 38 percent. About 42 percent of the female clients reported having a parent with a drinking problem; consistent with other studies. The percentage of clients with problem-drinking parents increased with increasing problem severity; among clients rated as casual or experimental in their substance use, 20 percent reported parental drinking problems. Among "lifestyle-involved" clients, the rate was 37 percent; among "dependent" clients, 45 percent; and among 101 dysfunctional clients, 58 percent reported drinking problems for one or both parents.

It is evident that where there is an alcohol or drug abusing parent prevention or early intervention strategies need to aim at the offspring.

## 301 SYSTEM CLIENT CHARACTERISTICS FOR ADOLESCENTS (UNDER AGE 18)

| | FY85 | FY84 | FY83 | FY82 | FY81 | FY80 |
|---|---|---|---|---|---|---|
| **All Diagnoses** | | | | | | |
| Number of Adolescents As A | 4,460 | 3,720 | 3,631 | 2,715 | 2,717 | 2,758 |
| Percent of All Clients | 15 | 14 | 13 | 11 | 11 | 11 |
| **Alcohol Diagnoses** | | | | | | |
| Number of Adolescents As A | 889 | 747 | 1,069 | 480 | 438 | 453 |
| Percent of All Alcohol Clients | 5 | 4 | 6 | 3 | 3 | 2 |
| **Drug Diagnoses** | | | | | | |
| Number of Adolescents As A | 1,179 | 1,001 | 865 | 805 | 1,099 | 1,273 |
| Percent of All Drug Clients | 27 | 27 | 25 | 24 | 26 | 26 |
| Total Adolescent Substance Abuse Clients | 2,068 | 1,748 | 1,934 | 1,285 | 1,537 | 1,726 |
| **Non-Substance Diagnosis** | | | | | | |
| Number Adolescents As A | 2,392 | 1,972 | 1,697 | 1,430 | 1,180 | 1,043 |
| Percent of All Non-Substance Diagnoses | 35 | 33 | 31 | 26 | 29 | 39 |
| **ScIP Clients** | | | | | | |
| Number Clients Under Age 18 | 3,307 | 2,505 | 2,449 | 1,794 | 1,563 | 1,503 |
| Number of Adolescent Clients Excluding ScIP | 1,153 | 1,220 | 1,182 | 921 | 1,154 | 1,266 |

## DRUG USAGE IN SOUTH CAROLINA HIGH SCHOOL POPULATION (1980)

| Drug | Percentage Ever Used |
|---|---|
| Marijuana | 28.0 |
| Cocaine | 6.0 |
| Opiates | 2.5 |
| Depressants | 8.0 |
| Inhalants | 6.5 |
| Hallucinogens | 4.0 |
| PCP | 5.0 |

Blacks

There is an increasing recognition that the nation's alcohol problems affect every segment of our society. The black community represents the largest ethnic minority in the United States, and alcohol use and abuse is perceived to be one of the most significant health, social and mental health problem within that population.

Within the state of South Carolina, the black community represents approximately 31.6 percent of the total population. However, the 301 System clientele is approximately 27 percent black.

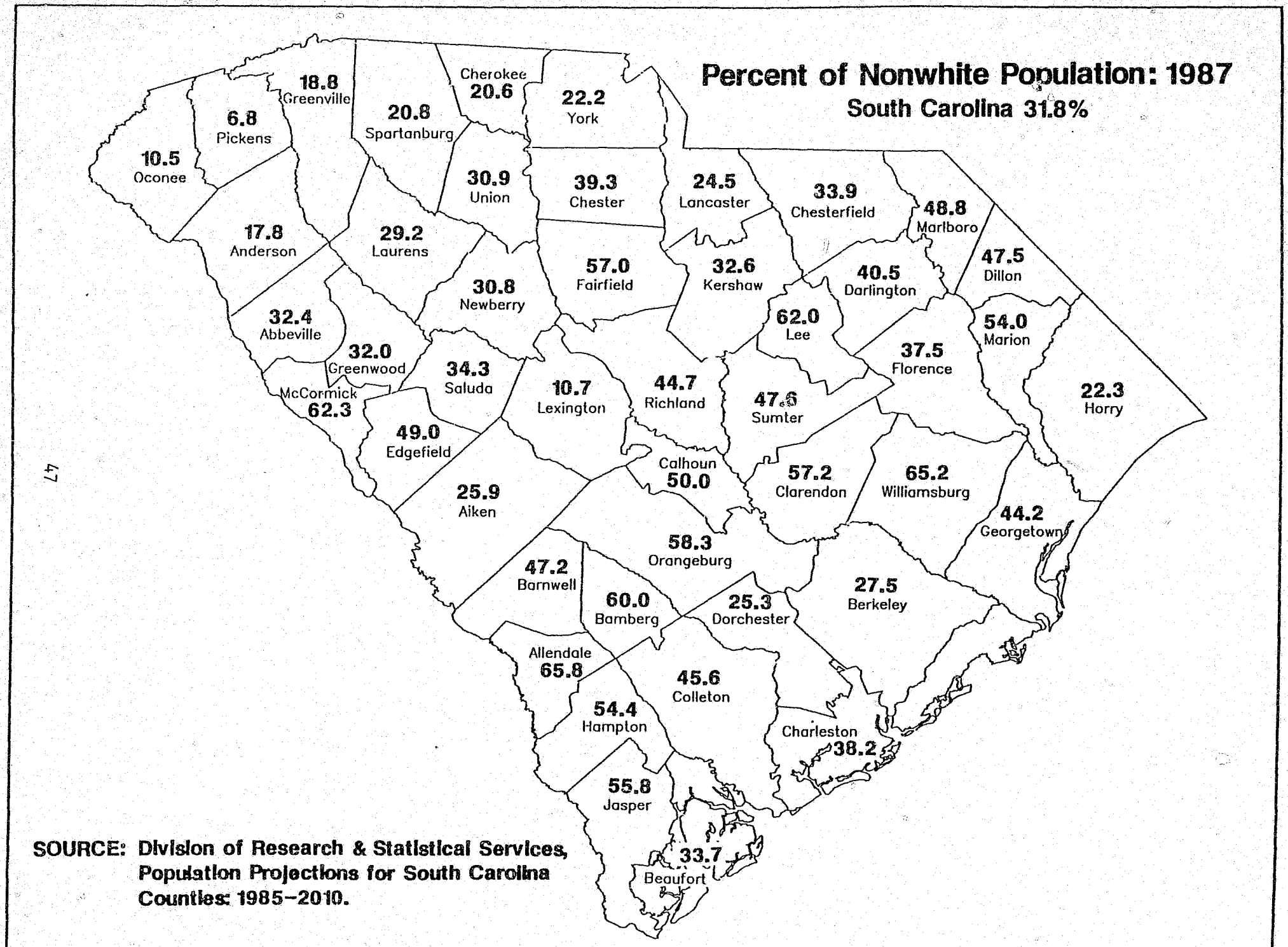
While there is a dearth of data on the ways alcohol and drugs affect South Carolinians, national statistics indicate that blacks surpass their counterparts in rates of occurrence of alcoholism (Cahalan, 1970; Caution, 1979; Davis, 1973; Haberman, 1970 and a host of others). Psychological illness resulting from alcohol abuse is also greater (Harper, 1978). These factors are compounded with the indication that alcohol-related illnesses have become chronic before medical attention is sought, which places the health of black Americans at great risk. For example, Harper (1978; 1976a; 1976b) found that blacks have a higher rate of admissions to hospitals (52 percent) than whites (11 percent) due to alcoholism, and those blacks admitted to hospitals tend to be younger then whites. Black adolescents who drink report a greater number of health problems, with a correlation between pregnancy and drinking for young black females, which has significant implications for fetal alcohol syndrome (Harper, 1976b).

Several hypotheses have been posed to explain black drinking patterns (Harper, 1976a, 1976b, 1978 and 1981; Stern and Pitman, 1972). Most of the theories constructed to explain alcoholism such as anxiety reduction and the need to escape from oppressive an undesirable environment. An important fact is that among blacks who drink the risk of becoming a problem drinker was extremely high.

The quantity and frequency of alcohol consumption for blacks and white men are comparable when social class is controlled. Surveys in the 1960s indicated that 38 percent of black men were abstainers as compared to 31 percent of white men, and 19 percent of black men were heavier drinkers. However, in some instances, alcohol use and abuse among blacks manifests itself in ways that are distinct from those experienced by whites. (It should be noted that the following statistics and conclusions were based on a poor urban black sample population.)

A survey on drinking practices (Cahalan and Cisin, 1968) observed that black women differed from white women in their higher proportions of both abstainers and heavier drinkers. Fifty-one percent of black women were abstainers, compared with 39 percent of white women; 11 percent of black women were heavy drinkers in contrast with 4 percent of white women. Cahalan and Cisin conclude that the heavier level of abstinence for black women might stem from the lack of money to buy alcoholic beverages, their religious beliefs or a different style of living. Also, the higher rate of heavier drinkers could be a result of greater alienation linked with economic deprivation or the more frequent assumption of the role of head of household.

A national survey of cirrhosis mortality rates for several US metropolitan areas indicated the overall cirrhosis rate to be 44 percent higher for blacks than whites in the same area. The area surveyed (New York; Washington, DC; Detroit; Chicago; Los Angeles-Long Beach;




SOURCE: Division of Research & Statistical Services, Population Projections for South Carolina Counties: 1985–2010.

Philadelphia and Baltimore) account for half of the reported cirrhosis deaths among US blacks, even though these areas contain only about 30 percent of the black population in the United States. The same study shows reported cirrhosis mortality for young blacks to be 10 times that of equivalent rates for white youths 25 to 34 years of age. In South Carolina, blacks accounted for 56.9 percent of the cirrhosis mortalities in this age group in 1984.

There is also evidence that blacks suffer a greater incidence of heart disease, hypertension and psychological disorders as a result of alcohol abuse than do whites. A 1979 National Institute on Alcohol Abuse and Alcoholism (NIAAA) report noted that studies in two mid-Western hospitals showed that more blacks than whites (52 percent versus 11 percent) reported hospital admissions for medical complications associated with alcoholism and that more blacks than whites had cases of delirium tremons (54 percent versus 26 percent) and alcoholic hallucinosis (47 percent versus 16 percent). Studies of hospitals and clinical data in urban areas show that more blacks than whites seem to be admitted for "alcohol psychosis" and that blacks tend to be admitted at an earlier age. In South Carolina, blacks accounted for 38.5 percent of "alcohol psychosis" mortalities and approximately 45 percent of all alcohol-related deaths. One possible explanation for this increase in occurrence of alcohol-related health problems among blacks is that they tend to have less knowledge of the effects of alcoholism and that fewer blacks have entered treatment.

Another aspect of black alcohol use and abuse is the role alcohol appears to play in certain crimes that occur in the black community. Results of a study on the rate of homicide in the city of Atlanta in 1974 show that 65 percent of black males as compared to 58 percent of white males, and 48 percent of black females as compared to 3 percent of white females had been under the influence of alcohol at the time of death. In contrast, studies show that blacks are less likely than whites to commit crimes while under the influence of alcohol. A national survey of prisoners (a 1974 census of prisoners conducted by the United States Department of Justice, Law Enforcement Assistance Administration) shows 50 percent of whites compared to 37 percent of blacks had been drinking when they committed a crime. In the same sample, 58 percent of whites as compared to 50 percent of blacks who were in prison for homicide were under the influence of alcohol.

## SPECIAL POPULATION DATA

### CLIENTS ADMITTED TO COUNTY COMMISSION PROGRAMS

| Fiscal Year | 80-81 | 81-82 | 82-83 | 83-84 | 84-85 | 85-86 |
|---|---|---|---|---|---|---|
| Blacks | 6,720 | 6,685 | 7,093 | 7,103 | 8,206 | 9,034 |
| Females | 5,424 | 5,694 | 6,117 | 6,378 | 7,170 | 7,767 |
| Under 18 | 2,717 | 2,715 | 3,631 | 3,720 | 4,460 | 5,090 |
| 65 and Over | 516 | 520 | 547 | 526 | 531 | 505 |

CLIENTS ADMITTED AS % OF ALL ADMISSIONS

| Fiscal Year | 80-81 | 85-86 |
|---|---|---|
| Blacks | 26.3 | 28.1 |
| Females | 21.3 | 24.2 |
| Under 18 | 10.7 | 15.8 |
| 65 and Over | 2.0 | 1.6 |

Public Inebriates

Municipal and county jails in South Carolina are responsible for housing large number of persons who have alcohol and/or drug problems. Although there is no statewide information system on the exact nature and extent of drug problems among persons detained in jail, it can be safely assumed that more than half of the persons detained in these facilities are alcohol intoxicated at the time of their incarceration. A large number of these persons have been arrested for public drunkenness.

In 1982, a report title "Criminal Justice Handling of Public Drunkenness in South Carolina" was prepared by Dr. John Memory for the Governor's Office, Division of Public Safety Programs. The findings and recommendations of this comprehensive report were endorsed by its 11 member advisory committee and the Governor's Committee on Criminal Justice, Crime and Delinquency.

In summary, this statewide study concluded that criminal justice agencies are not suited to handle public drunks. Consequently, it suggested that many of the problems facing the police, jails and the courts in handling of public drunks can best be reduced through the provision of assistance to those agencies by health, service agencies such as emergency medical services, commissions on alcohol and drug abuse, mental health centers and hospitals. The report also concluded that some social service agencies and housing agencies might be of greater assistance in this area.

With regard to the "revolving door" public drunk, the report suggests the provision of a home with a supportive atmosphere. Further, it is noted that there is now little precedent for any requirement that government provide shelter for the homeless and public drunk. The report also states that the experience of cities across the U.S. has been that acceptable housing can be provided less expensively by charitable organizations such as the Salvation Army, than be government agencies.

The report recommended that county commissions on alcohol and drug abuse:

1. Maintain close liaison with jails.
2. Provide alcohol screening services for jails.
3. Aid these types of clients in obtaining monetary entitlements for meeting their needs.
4. When appropriate, initiate proceedings to have committees appointed to manage estates of public drunks.

5. Provide follow-up treatment services for persons convicted of public drunkenness.
6. Give emphasis on detox services for arrested persons in life-threatening situations.
7. Establish short-term sobering up programs in detox centers.

During January 1984, a survey of county commissions on alcohol and drug abuse was conducted to collect information regarding the services being provided to local detention facilities by county commissions on alcohol and drug abuse. Most county commissions on alcohol and drug abuse are providing at least an on-call service to the local jails.

Jail suicide has been a problem for the local detention facilities in South Carolina. Consequently, a great deal of emphasis has been placed on the training of jailers regarding the identification and handling potentially suicidal inmates.

The South Carolina Code of Laws, Section 24-9-35, requires that city and county jail personnel report inmate deaths to the South Carolina Department of Corrections Jail and Prison Inspection Division. There were a total of 15 deaths in local jails reported to jail inspection officials from January 1986 through January 1987. Local detention facilities also reported 69 attempted suicides by inmates for the same 13 month period.

The South Carolina Criminal Justice Academy has conducted a number of regional training sessions regarding jail suicide. In addition, in 1983, the South Carolina Jail Commission developed a number of recommendations to improved jail practices regarding the handling of potential suicide situations.

The South Carolina State's Standards for Local Detention Facilities require that local jails meet certain minimum standards regarding the handling of intoxicated persons. These standards are enforced by the State Department of Corrections and pertain to screening, medical assessment, referral to medical care, and the training of jailers regarding the handling of intoxicated persons.

## CHAPTER II
## SOUTH CAROLINA'S RESPONSE TO ALCOHOL AND DRUG ABUSE

### A. The South Carolina Commission on Alcohol and Drug Abuse

The SCCADA, in viewing alcohol and drug abuse as perhaps the most significant health problem, utilizes the public health model of prevention along a multi-faceted dimension: 1) the agent (alcohol and drugs); 2) the host (the individual); and 3) the environment (society). This model and concept is reflective of the philosophy behind the agency's alcohol and drug abuse programming and that of the South Carolina Alcohol and Drug Abuse system.

This philosophy which operates under a three-factored approach -- the host, agent and environment -- coupled with the concept of primary, secondary and tertiary prevention, provides the conceptual foundation for the SCCADA's prevention efforts. Primary prevention involves avoiding the clinical manifestations of health problems. Secondary prevention focuses upon early detection and remedial action. Tertiary prevention addresses the cure of the disabling effects of the problem and the prevention of its reoccurrence. This category of prevention has most frequently been associated with the process of treatment, while primary and secondary prevention have involved information, education, alternative and intervention approaches to the problems of drug abuse. Primary prevention and treatment are not polarized, but constitute aspects of a continuum.

Alcohol and drug use and abuse program relating to this continuum, while divided into three major components -- primary, secondary and tertiary prevention -- should not be seen as separate entities; rather, they are a continuous progression of strategies that meet identifiable needs ranging from birth to death. There are no clear divisions between primary, secondary or tertiary programming. These various approaches are designed to identify critical points in an individual's, group's or society's life where an investment of limited resources will have a higher likelihood of changing lifestyle in a positive direction. The development of programs and strategies along this continuum has widely varying personal, social, political and economic considerations.

It is known that agent factors such as the kinds, the amounts, the effects and the availability of chemicals contribute significantly to substance abuse problems. Therefore, SCCADA supports informing the public about the effects of alcohol and other drugs and the hazards of using them uncritically.

The SCCADA also attempts to promote policies and practices which influence alcohol and drug availability, price, distribution, arrangement and consumption practices. Such goals are best pursued through an array of public education efforts as well as by advocating appropriate legislation. Groups such as physicians, legislators, pharmaceutical companies, distilleries and breweries can act in an effective and expanded manner by doing their part to reduce substance abuse when mobilized to address prevention. We all have a shared goal in minimizing the occurrence and severity of disability and reducing the incidence of premature death related to the abuse of alcohol and other drugs. Herein, organizations and systems are seen as benefiting society and its human beings by reducing illegal, irresponsible and inappropriate use of alcohol and other drugs.

Host factors in alcohol and drug abuse involve an individual's motivation for using alcohol and other drugs. Individuals are frequently motivated to engage in alcohol and drug abuse by perceived need to eliminate distress and to find pleasure through chemicals. By engaging in the critical use of drugs, individuals replace the constructive, pleasurable and meaningful benefits which are naturally derived from healthy development and effective living. The South Carolina Commission on Alcohol and Drug Abuse attempts to promote healthy development and effective living skills by providing learning and skill-developing experiences such as effective education, values clarification, peer counseling, alternative recreational activities, communication training and decision-making training for appropriate groups of individuals. Consequently, the SCCADA supports policies and programs which promote healthy development and effective living skills gained through effective education and alternative recreational activities.

In particular, the SCCADA supports those activities which: 1) strengthen identification with viable role models; 2) strengthen identification with and responsibility for "planning processes;" 3) develop problem-solving abilities; 4) develop intrapersonal skills; 5) develop interpersonal skills; 6) strengthen systems skills; and 7) develop judgmental skills. Such primary prevention activities provide opportunity and support for the development of personal living skills and responsible decision making. By strengthening individuals, families and groups with resources necessary to constructively confront complex, stressful life conditions, people are enabled to live personally satisfying and enriching lives. Through this, there is the reduction of demand for chemicals. Proactive prevention is accomplished in part by having a society of healthy individuals.

Environmental factors in alcohol and drug abuse also need to be addressed. It is known that the social, cultural, political, geographical, religious, ethnic, educational, legal, economic and family milieu has an influence on the degree of consequences of alcohol and drug abuse in this pluralistic society. Therefore, the SCCADA supports those prevention efforts which enhance each community's capability to mobilize organizational and legislative efforts to change those systems that impact negatively on the environment relative to substance abuse. One example of this phenomena of the Parent Power Movement and its potential to shape our communities toward a drug-free culture.

The aim here is to minimize those environmental norms and factors that contribute to the problems of alcohol and drug abuse. The SCCADA advocates those actions, policies and procedures which are designed to shape our culture and our systems with their norms and policies in a way which is supportive of healthier lifestyles. These efforts take for granted that strengthening the individual is insufficient and that responsible citizens and agencies should not neglect the environment, but rather to build on a social and cultural base.

The SCCADA does not endorse any one of the above approaches to the exclusion of the others. Balance and a combination of approaches is the key within the unique demands of each situation. More than likely, the situation will help determine what combination of approaches is best.

In summary, the SCCADA places its highest priority on the prevention of alcohol and drug abuse by influencing the availability of alcohol and drug or agent factors and by influencing the reduction of demand for them through the modification of environmental factors and

strengthening of host resistance. To this endeavor, SCCADA commits all its fiscal and human resources wherever possible.

The alcohol and drug abuse system in South Carolina is based on an architectural concept. The concept began to evolve in 1967 when the Commission on Alcoholism was removed from direct treatment responsibilities. The system's basic premise is that no single agency can deal with all of the alcohol and drug abuse needs in the state and that local agencies should have considerable influence on substance abuse programming. The SCCADA acts as the architect of the system and coordinates available resources to develop solid programs. At the state level, SCCADA coordinates and serves as a catalyst for both state and private resources to meet the service needs created by the abuse of alcohol and drugs. The community level components of other state agencies are stimulated vertically through their organizational structures to do the same. The community level alcohol and drug abuse agencies, referred to as 301 System agencies (see Appendix), are administratively independent of SCCADA, but are closely tied through joint planning and service contracts for service. In addition to providing direct services, these local agencies perform the coordinating functions with other agencies at the local level that SCCADA performs at the state level. The South Carolina network of alcohol and drug abuse services is shown on the following page.

As the designated Single State Authority for Alcohol and Drug Abuse, SCCADA is responsible for:

1. Coordinating a statewide service-delivery system as authorized by Act 301 of 1973 which provides for the designation of single county authorities and the development of county alcohol and drug abuse plans.
2. Planning, coordinating, and evaluating programs and services directed toward the prevention and control of the state's alcohol and drug abuse problems.
3. Developing and administering the State Alcohol and Drug Abuse Plan.
4. Increasing the public's knowledge and understanding of the nature of the problems of alcohol and drug abuse and their solutions.

The SCCADA is responsible for advising the General Assembly, the Executive Branch of the State, other state agencies and local 301 System agencies in identifying and making recommendations for meeting needs in alcohol and drug abuse service delivery. The agency's policy-making and governing board is the Commission which consists of 11 members appointed by the Governor.

## B. County Commissions on Alcohol and Drug Abuse

The SCCADA contracts annually with local alcohol and drug abuse agencies through a Comprehensive Consolidated Contract to provide for the delivery of services. These include detoxification and residential services (inpatient programs), community-based treatment (outpatient counseling), intervention programs and prevention programs.

In addition to contracted funding from SCCADA, local agencies receive on a per capita basis 25 percent of minibottle tax revenues for alcohol and drug abuse programming upon approval of the County Alcohol and Drug Abuse Plan. Local agencies also receive funding through the State Block Grant program.

Detoxification

There are six detoxification centers operated by county commissions, all of which are licensed by the Department of Health and Environmental Control, with a statewide bed capacity of 95. One new facility located in Marion County has become operational during the last year. Five of the current state detoxification facilities are in free-standing, sub-acute centers where nursing care is offered under the supervision of physicians who authorize limited amounts of medication to minimize life-threatening withdrawal. One of the state's detoxification centers, located in Newberry County, operates on what is known as a "social setting" model. In this type of facility, no medications are used in the withdrawal process although patients are kept under close observation by skilled, non-medical staff with contracted emergency room backup care available. Detoxification services are also provided within general hospitals and private treatment centers throughout the state.

Residential Facilities

There are 12 halfway houses and one family residential center operated by the county commissions, all of which are licensed by the Department of Health and Environmental Control. The halfway houses are designed as transitional centers for persons prior to their returning to families or independent living within the community, while the family residential center (located in Charleston) features a stronger treatment component involving both family members and patient in a six-week program. In addition to providing a structured residential environment, these facilities provide individual, group and family counseling services. The following 301 System residential facilities are currently in operation in South Carolina.

| County of Location | Bed Capacity |
|---|---|
| Colleton | 4 |
| Richland | 20 |
| Greenville | 20 |
| Aiken | 15 |
| Orangeburg | 16 |
| Newberry | 10 |
| Florence | 10 |
| Beaufort | 8 |
| Sumter | 8 |
| Marlboro | 13 |
| Marion | 7 |
| Charleston | 12 |
| | 143 |

Community-Based Treatment (CBT)

The community-based treatment services offered through county commissions consist of individual, group, pre-treatment, spouse and family, and aftercare counseling. These services are provided on an outpatient basis throughout the state. Persons may enter CBT directly through self-referral or referral from a physician, Alcoholics Anonymous, or a number of other sources. In addition, CBT clients may enter indirectly through an intervention mechanism.

Under the umbrella of CBT are specialized services: family counseling, treatment of adolescents and women, and intensive outpatient treatment.

Family Counseling

The SCCADA promotes treatment of the family whenever possible. Training in family dynamics and family counseling is stressed in the agency's training calendar and treatment consultation to local programs. The number of family counseling hours delivered by county alcohol and drug agencies almost doubled between 1984 and 1985, reaching a total of 28,311 hours. However, these represent only 8 percent of all treatment hours provided. If the system's performance is to be consistent with the understanding that addiction is a family disease, there is room for continued growth in family counseling as a treatment of choice.

Treatment of Adolescents

In its 1985 report to the Governor, the Children's Coordinating Cabinet made sweeping recommendations for expanding the availability of treatment for children and adolescents. Accordingly, SCCADA has begun the coordination of treatment services designed especially to impact adolescent alcohol and drug abuse. Also, SCCADA has developed an interagency training model.

Treatment of Women

During the FY86-87 the State Commission funded a number of projects designed to target women. These projects included: 1) a live theatrical performance titled "On a Pedestal" which serves as an educational tool; 2) the development of an educational curriculum and group leader manual which focuses on addictions as a women's issue; 3) a media campaign targeting women and 4) a number of women's projects at county commissions on alcohol and drug abuse emphasizing educational programs for women and the networking of community services.

Intensive Outpatient Treatment

Intensive outpatient treatment fills the gap between traditional 28-day inpatient programs and less intensive outpatient treatment. The program enables patients to participate in a program which typically runs four hours daily, four days a week, from four to six weeks. Such programs incorporate the elements of good inpatient treatment (e.g., group counseling, individual counseling, family involvement, AA participation, alcohol and drug education) but enable the patient to remain on the job and live at home. Additionally, they can be offered at substantially lower costs.

Intervention

In South Carolina the intervention system is designed to provide for a comprehensive program which results in the systematic identification, assessment, referral and follow-up of individuals with alcohol and drug problems through existing social institutions.

Alcohol and Drug Safety Action Program

The Alcohol and Drug Safety Action Program (ADSAP) is designed to reduce the number of alcohol-related vehicle accidents and fatalities in South Carolina and to identify clients having problems with alcohol and

drugs at an early stage in problem development. ADSAP services are available to all South Carolina residents. As a result of the DUI Offender Relicensing Act, persons are required to successfully complete this program prior to the reissuance of the driver's license.

School Intervention Program

The School Intervention Program (ScIP) is designed to identify troubled students in the school system and to intervene before substance abuse problems mature. The ScIP is now operational in schools in all 46 counties, and it is required by law that every county have access to this program.

In addition to ScIP, several prevention/intervention programs have been developed on college campuses to educate the students on substance abuse issues and to identify and treat students already experiencing substance abuse problems. Prevention programs have been operational at the University of South Carolina, Newberry College, The Citadel, the Medical University of South Carolina, Coker College and Winthrop College. Early intervention programs are underway at the USC campus in Aiken, Aiken Technical Center, Clemson University, and Central Wesleyan College.

Offender Based Intervention

Offender Based Intervention Programs are designed to provide services to clients who are referred to county alcohol and drug abuse agencies as a result of an alcohol/drug arrest or a related arrest, excluding DUI. There are different OBI programs offered which operate in various local commissions.

Primary Prevention

Recognizing the importance of primary prevention, SCCADA contracts for and supports alcohol and drug abuse prevention activities in 301 System agencies and other local organizations, while assisting in the development and implementation of community-based prevention programming.

Employee Assistance Programs

Employee Assistance Programs provide consultation, technical assistance, and support to private businesses and industries, federal civil service agencies, and state and local governmental agencies and the military communities of the state in establishing and implementing policies aimed at the prevention and control of alcohol and drug abuse.

A listing of other prevention initiatives in South Carolina is provided in the Appendix.

## C. Description of Other Agencies and Organizations

Service continuity for all services is provided by the existing referral patterns between county 301 agencies, state agencies, Alcoholics Anonymous, Vocational Rehabilitation, private treatment centers, physicians, clergymen, and other related professionals. A description of other resources which provide services and coordinate efforts aimed at alcohol and drug abusers follows.

South Carolina Department of Mental Health

Community-based alcohol and drug treatment services are provided by 17 community mental health centers and clinics, and on a centralized basis, primarily by the Earle E. Morris, Jr. Alcohol and Drug Treatment Center (Morris Village).

In FY85, 1,236 clients were admitted to the 17 regional Community Mental Health Centers for alcohol or drug-related disorders. Approximately 77 percent of the substance abuse clients at Community Mental Health Centers reported a primary problem of alcohol disorders. Females represented 26 percent of the substance abuse population, making up a higher percentage of drug abuse clients (32 percent) than alcohol clients (23 percent). The percentage of female alcohol clients closely approximates that of the expected problem population and indicates that Community Mental Health Centers continue to have a better representation of females than other state-operated substance abuse programs.

Morris Village is a 186 bed residential treatment facility for chemically dependent persons. Morris Village also operates a halfway house for discharged persons who are in need of a transitional environment prior to release.

Morris Village provided services to 1,231 persons in FY85, a slight increase (less than 1 percent) over the FY84 level. Males made up over 80 percent of the client population, a 2 percent increase over FY84. The adolescent and young adult population accounted for 67 percent of the clients. The number of black clients increased by 3 percent in FY85 from FY84, as did the number of clients with a primary alcohol diagnosed problem.

The ratio of female to male clients at Morris Village is below the statewide population percentage as well as the projected problem drinking population for females. Women generally are admitted to Morris Village in a later stage of the addictive process and are more likely to require multiple admissions in order to effect a significant life change.

The Office of Program Development and Training Management at Morris Village is involved in the training of the professional and paraprofessionals.

The SCCADA and the Department of Mental Health signed a memorandum of agreement in June of 1986 to specify the specific roles and responsibilities of the two agencies in identification and treatment of citizens of the state who are seriously and chronically addicted to alcohol or other drugs.

## DEMOGRAPHIC CHARACTERISTICS OF COMMUNITY MENTAL HEALTH CENTER CLIENTS WITH ALCOHOL AND DRUG DISORDERS FY85

| | All Ages | 0-17 | 18-24 | 25-44 | 45-54 | 55+ | Unknown |
|---|---|---|---|---|---|---|---|
| **Alcohol Clients** | | | | | | | |
| Male | 738 (77%) | 11 | 99 | 390 | 109 | 111 | 18 |
| Female | 216 (23%) | 8 | 23 | 118 | 31 | 36 | 0 |
| TOTAL | 954 (100%) | 19 (2%) | 122 (13%) | 508 (53%) | 140 (15%) | 147 (15%) | 18 (2%) |
| **Drug Abuse Clients** | | | | | | | |
| Male | 180 (64%) | 22 | 59 | 75 | 15 | 3 | 6 |
| Female | 102 (36%) | 13 | 31 | 47 | 2 | 5 | 4 |
| TOTAL | 282 (100%) | 35 (12%) | 90 (32%) | 122 (43%) | 17 (6%) | 8 (3%) | 10 (4%) |

Breakdown by Age and Sex as Percentage of Substance Abuse Clients

| | |
|---|---|
| **All Substance Abuse Clients** | |
| Male | 918 (74%) |
| Female | 318 (26%) |
| TOTAL | 1,236 (100%) |

## MORRIS VILLAGE RESIDENT DATA FY84-85

TOTAL ADMISSIONS - 1,520

| Sex | Percentage | Race | Percentage |
|---|---|---|---|
| Male | .81 | White | .71 |
| Female | .19 | Non-white | .29 |

| Age | Percentage | All Diagnoses | Percentage |
|---|---|---|---|
| 13-17 | .06 | Alcohol Only | .32 |
| 18-24 | .22 | Drug Only | .17 |
| 25-34 | .40 | Alcohol and Drug | .30 |
| 35-44 | .20 | Unknown | .20 |
| 45-55 | .08 | Other | .01 |
| 55-64 | .03 | | |
| 65+ | .01 | | |

| Primary Diagnosis | Percentage |
|---|---|
| Alcohol | .58 |
| Drug | .21 |
| Unknown | .20 |

South Carolina Department of Vocational Rehabilitation

The South Carolina Department of Vocational Rehabilitation operates two residential facilities which provide substance abuse treatment services. Palmetto Center is a 48 bed facility in Florence which offers a therapeutic regime ranging from 28 to 56 days. Its occupancy rate in FY86 was 75 percent.

Holmesview Center is a 40-bed facility near Greenville and its occupancy rate in FY86 was 88 percent. The 28- or 56-day treatment program utilizes the group therapy approach in a therapeutic atmosphere. Group counseling is also available for former residents and their family members.

CLIENT CHARACTERISTICS FOR VOCATIONAL REHABILITATION RESIDENTIAL CENTERS

| | FY83 | FY84 |
|---|---|---|
| Number of Clients | 889 | 846 |
| Resident Days | 24,643 | 24,371 |
| Sex | | |
| Male | 84% | 84% |
| Female | 16% | 16% |
| Race | | |
| Black | 23% | 21% |
| White | 77% | 79% |
| Age | | |
| 0-17 | 2% | 1% |
| 18-20 | 3% | 6% |
| 21-44 | 71% | 74% |
| 45-64 | 24% | 17% |
| 65+ | 0% | 0% |

South Carolina Department of Health and Environmental Control (DHEC)

The Office of Health Education at the Department of Health and Environmental Control provides health education to schools and community groups on drug and alcohol abuse. This office provides maternity education materials which deal with fetal alcohol syndrome. DHEC health educators periodically offer educational programs for DHEC staff and the public in cooperation with SCCADA. The Office of Health Education is especially interested in working with SCCADA to reduce adolescent mortality and morbidity resulting from substance abuse.

The Department of Health and Environmental Control is responsible for reviewing proposals for facilities constructed for the treatment of alcohol and drug abusers prior to issuance of a Certificate of Need (CON). SCCADA reviews these Certificate of Need proposals and provides comments to DHEC prior to issuance of the Certificates of Need. In

addition, DHEC has recently been assigned the responsibility of licensing all institutions opened for the care or treatment of alcoholics and drug abusers. The appendix includes a listing of alcohol and drug abuse treatment centers in the state.

The State Health and Human Services Finance Commission

The State Health and Human Services Finance Commission was created in 1983 to insure that health and human service programs are operated in coordinated and efficient manner. The State Health Planning and Development Agency is staffed by the Commission and its plan addresses alcohol and drug abuse issues affecting the state.

South Carolina Department of Corrections

The Department of Corrections provides human services care to a population of approximately 10,000 inmates. Inmates entering the Department are processed through reception and evaluation centers and the information obtained is used to identify initial assignment and program recommendations.

A significant number of inmates entering the Department during fiscal year 1984 indicated that they had problems with substance abuse and were recommended for treatment services on a voluntary basis. The inmates' requests for substance abuse treatment are met through the social workers at most of the statewide institutions. The Department has also offered for over 16 years a statewide system of Alcoholic Anonymous (AA) groups administered by community volunteer sponsors. In addition, over the past several years, the Department has endeavored to establish Narcotics Anonymous groups statewide.

The Department has a memorandum of understanding with the South Carolina Department of Mental Health's Morris Village for providing substance abuse treatment to selected inmates during their last 60 days prior to parole or release.

As of August 26, 1987 there were 81 inmates serving sentences in the Department for Felony DUI and 462 inmates serving sentences for DUI.

During FY86, 47.8 percent (3,700) of all inmates admitted to the Department of Corrections indicated that they were under the influence of alcohol or drugs or both during the commission of their crime. Eleven percent (882) were admitted for drug offenses and 39 percent indicated that they feel they have a substance abuse problem.

A proposed alcohol and drug treatment facility for inmates is discussed in detail in Chapter V.

South Carolina Department of Parole and Community Corrections

The Department of Parole and Community Corrections supervises offenders on probation, parole, and other community-based programs. The Department is not a service delivery agency, consequently, supervisory agents refer offenders to other agencies for service delivery. Agency policy requires that all DUI offenders be referred for services.

NUMBER OF CASES UNDER SUPERVISION
BY DEPARTMENT OF PAROLE AND COMMUNITY CORRECTIONS
FOR DUI RELATED OFFENSES

| Offense | AS OF June 1983 | June 1984 | June 1985 |
|---|---|---|---|
| Felony DUI | 1 | 1 | 11 |
| DUI 2nd | 641 | 622 | 941 |
| DUI 3rd | 353 | 345 | 398 |
| DUI 4th (or more) | 109 | 108 | 83 |
| DUS 2nd | 26 | 25 | 52 |
| DUS 3rd | 34 | 33 | 67 |
| TOTAL | 1,164 | 1,134 | 1,552 |

The agency utilizes a statewide case classification and management system which includes procedures for the assessment of offender needs. Based upon this classification system and the assessment of the Probation/Parole Agent, offenders with identified needs can be referred to the appropriate local treatment agency.

The agency has six regional offices. Each regional office employs a Regional Rehabilitation Coordinator who is responsible for providing technical assistance to county probation and parole agents regarding rehabilitative services for their clients. In addition, these persons are responsible for developing and monitoring agreements and contracts with local provider agencies, and serving as the liaison with public and private human services agencies.

In 1983 a contract was signed between the SCCADA and the Department of Parole and Community Corrections for halfway house services. Probationers, parolees and other inmates released by the Parole Board can be placed in one of the 301 commissions halfway houses subject to the approval of both agencies.

Since January 1, 1987, 300 urine tests have been ordered by Probation/Parole Agents and about 60 percent were positive (not tested for alcohol).

Medical University of South Carolina

The Medical University's Department of Psychiatry and Behavioral Sciences located in Charleston places significant emphasis on medical professional education in substance abuse and the associated medical/social problems. The department provides a setting in which student health-care professionals may acquire basic science knowledge and expert clinical skills related to substance abuse service, teaching and research, and the capacity to work toward a lessening of the severity and incidence of drug and alcohol-related medical and psycho-social complications in South Carolina. Training in substance abuse areas is facilitated by ongoing clinical and basic science research in the Department. Beginning in FY85, SCCADA, in cooperation with the University Family Practice Department, developed a family practice project focusing on alcohol and drug abuse for family practitioners.

University of South Carolina School of Medicine

The University of South Carolina School of Medicine in Columbia has offered a Career Teacher in Substance Abuse program since 1980. This program addresses physician education in alcohol and drug abuse. The Career Teacher program, originally funded through a grant from the National Institute on Drug Abuse, is currently jointly supported by the SCCADA, the Department of Mental Health, the USC School of Medicine and the Medical University of South Carolina.

Medical students are trained in the detection and diagnosis of alcohol and drug abuse. This training deals with attitudes about substance abuse, the art of confrontation, case management and the use of existing community referral sources. The relationship between family practice programs and existing clinical and educational resources is stressed.

South Carolina Department of Education

Alcohol and Drug Education Week is a joint effort between the South Carolina Department of Education and the SCCADA. By state law, every school is required to devote one week to alcohol and drug education. Local alcohol and drug abuse program staff provide resources to the school systems and deliver presentations at student assemblies and in the classroom.

The substance abuse unit of the South Carolina Department of Education provides on-site in-service training for teachers and other personnel in public school districts across the state. SCCADA works in conjunction with the Department of Education on the School Intervention Program. The Department also encourages national defusion network alcohol and drug abuse programs for local school students.

During FY85 SCCADA and the Department of Education entered into a formal cooperation agreement. The main objectives of this agreement are: 1) to further improve methods for preventing alcohol and drug use and abuse among students; 2) to further improve methods of identification, intervention and treatment of alcohol and drug abuse among students; 3) to assist county alcohol and drug abuse authorities and school districts in implementing relevant state laws, requirements and programs.

Department of Youth Services

According to the MIS system at the Department of Youth Services, among all juveniles handled by that agency during FY86-87:

- about 25 percent indicated at intake that they used alcohol and/or drugs;
- about 29 percent placed on probation indicated that they used alcohol and/or drugs;
- about 47 percent admitted to correctional facilities indicated that they used alcohol and/or drugs.

Also during FY86-87, county commissions admitted 1,360 juveniles for services, an increase of 261 juveniles from the previous year, and an increase of 506 juveniles from FY84-85.

Through funds provided by SCCADA, the Lexington/Richland Alcohol and Drug Abuse Council provides addiction counselors to the Department of Youth Services (DYS) on DYS campuses. The SCCADA/DYS Task Force developed a curriculum on alcohol and drug abuse which has been imple-

mented as part of the regular criteria within the educational system at the correctional school.

Law Enforcement Agencies

Approximately half of the 301 System clients enter the system as a result of arrest. Local commissions collaborate with local law enforcement officers on substance abuse issues by conducting joint community education and prevention programs and evaluating and treating offenders referred by law enforcement agencies.

The State Law Enforcement Division (SLED) is a state agency responsible for criminal investigations, law enforcement coordination and for uniform crime reporting on a statewide basis. Through its uniform crime report, SLED provides the commissions with valuable statewide as well as local criminal justice data which is used for planning purposes and program evaluation.

The Court System

SCCADA and county commissions provide information to judges on the utilization of treatment services as a condition of sentence. Many commissions provide the court with case consultation, evaluation and treatment services for referred offenders.

South Carolina Department of Social Services

The Department of Social Services provides financial assistance to dependent children and makes welfare payments to the aged, needy, blind and the disabled. The Department aids commission clients who are unable to pay for food, shelter or medical care. They refer applicants when it is suspected that there is a substance abuse problem.

Veterans' Administration

The Veterans' Administration provides alcohol and drug abuse treatment services for veterans at the William Jennings Bryan Dorn Veterans' Hospital in Columbia and the Veterans' Administration Medical Center in Charleston. These hospitals provide detoxification, inpatient treatment including occupational counseling, aftercare and follow-up treatment. The VA also contracts with halfway houses for services for patients released from the veterans hospitals.

Private Treatment Centers

There are currently 323 private treatment beds designated for alcohol and drug abuse in South Carolina. The first private treatment center to open in the state was Fenwick Hall which has 35 beds and is located in Charleston County. Elliott White Springs Hospital opened a 28-bed chemical dependency unit in April 1980 in Lancaster County. The Lancaster Recovery Center at Elliott White Springs expanded to 41 beds in 1985. North Greenville Hospital opened a 12-bed facility one month after Elliott White Springs and has 40 beds. Charter Rivers Hospital opened its 80-bed psychiatric and addictions facility in Columbia in February 1983 and has 50 beds designated for alcohol and drug abuse patients. Coastal Carolina Hospital is a 47 bed alcohol and drug abuse treatment facility in Horry County near Conway. Bruce Hall, located in Florence, has 24 beds. Baker Hospital is an alcohol and drug treatment center located in Charleston. This hospital has 36 beds for alcohol and drug affected patients. Brierwood Hospital, near Greenville, opened in

1985 and is a 60-bed (35 for alcohol and drugs) facility providing adult psychiatric care and treatment for substance abuse and addictions for adults and adolescents. Cherokee Memorial Hospital opened an addictions unit with 15 beds during 1987. The appendix of this plan has a listing of both public and private inpatient alcohol and drug treatment facilities.

Alcoholics Anonymous

Alcoholics Anonymous (AA) is a self-help organization dedicated to the sobriety and lifestyle growth of its members. There are more than 150 active AA groups in South Carolina with approximately 2,000 members statewide. The State Commission coordinates its programs with the Recovering Community Relations Committee. County commissions work closely with AA and referals to AA programs are often components of treatment programs.

Narcotics Anonymous operates under the same principles as AA in dealing with the problems of persons addicted to drugs. Al-Anon is also a self-help group consisting of the family and friends of alcoholics who are seeking solutions to the problems that occur from living with an addicted person. Al-A-Teen provides support to adolescents who are experiencing problems related to their own or a family member's substance abuse problem. These groups also serve as a resource to county commission.

Professional Self-Help Organizations

A number of professional organizations have established assistance programs for their members who are experiencing problems with substance abuse. The South Carolina Nurses Association has established an Impaired Nurses Program. Lawyers Helping Lawyers is a group organized by the South Carolina Bar to assist attorneys with alcohol and drug abuse problems. The South Carolina Medical Association operates an Impaired Physicians Program whose objective is to rehabilitate doctors with substance abuse problems. Also, both the South Carolina Pharmaceutical Association and South Carolina Dental Association have established impaired practitioner programs.

The Alston Wilkes Society

The Alston Wilkes Society is an organization composed primarily of volunteers who assist adult and juvenile offenders, ex-offenders and the families of both. The Alston Wilkes Society estimates that approximately 70 percent of these individuals are also experiencing problems with alcohol and/or drugs. Assistance provided that agency includes counseling, job placement, and transportation. Alston Wilkes operates 15 employment service programs and two residential centers in South Carolina.

The Salvation Army

The Salvation Army operates 15 centers in South Carolina which provide temporary shelter and referrals to other assistance programs. The Salvation Army estimates that 25 to 30 percent of its clients have an alcohol or drug abuse problem. Referrals are made between county commissions and the Salvation Army. Local Salvation Army centers also refer persons with alcohol and drug abuse problems to the Adult Rehabilitation Center in Charlotte, North Carolina. This residential center

provides a three-month residential program based on a work therapy model which includes medical and psychiatric care. Residential programs are also provided by the Salvation Army in Greenville and Charleston. These programs are not designed specifically to serve alcoholics; however many of the residents are experiencing problems with alcohol and drug abuse.

Mothers Against Drunk Drivers (MADD)

Mothers Against Drunk Drivers is involved in public education and implements strategies to reduce the incidence of DUI and DUI-related fatalities. Twelve MADD Chapters have been established in South Carolina.

MADD has three primary objectives:

1. Increasing public awareness of problems caused by drinking and driving.

2. Providing assistance to the victims of DUI accidents.

3. Educating law makers on the problems caused by DUI and the public's concern with the impacts of drinking and driving.

SCCADA continues to cooperate with MADD in educational efforts concerning DUI.

Governor's Strategic Council on Drug Education, Enforcement and Treatment

The Governor has appointed this ten member council which is chaired by Mr. Parker Evatt, Commissioner of the South Carolina Department of Corrections. This council will oversee the implementation of the State and Local Law Enforcement Act of 1986. The three-fold purpose of the council is: (1) to develop the statewide law enforcement drug strategy; (2) to coordinate the drug law enforcement assistance funds with the other components of the Act; and (3) to monitor the implementation of the overall act. The council is comprised of representatives from the criminal justice, treatment and rehabilitation and education communities, as well as elected officials and community leaders.

In August 1987 the council submitted South Carolina's application for the $2.3 million in federal funds which will be available to the state for related programs.

Governor's Committee on Highway Safety

The Governor's Office of Highway Safety was created by legislation passed in April of 1967 by the South Carolina General Assembly, which empowered the Governor to act in compliance with federal legislation known as the Highway Safety Act of 1966. In addition to the main function of administering the federal grant programs, the Office of Highway Safety also serves as an informative source to the South Carolina General Assembly on highway safety issues and serves as a coordinating role to various groups on highway matters, most importantly, the Governor's Committee on Highway Safety.

The Highway Safety Program is administered at the federal level by two agencies under the Secretary of Transportation: the National Highway Traffic Safety Administration, NHTSA, and the Federal Highway Administration, FHWA.

The Omnibus Budget Reconciliation Act of 1981, Public Law 97-35, directed the Secretary of Transportation to determine which state and local highway safety programs had been the most effective in reducing accidents, injuries, and fatalities and to develop a process for funding

additional program areas. Through joint rule making action, the responsible agencies identified six NHTSA and FHWA safety programs for concentration of effort and provided for the continued eligibility of those programs for federal funding. They also established a mechanism by which additional programs identified by a particular state could be eligible for federal funding. National Highway Traffic Safety Program Areas are:

Alcohol Countermeasures
Police Traffic Services
Occupant Protection
Traffic Records
Emergency Medical Services
Safety Construction and Operational Improvements

Presently the Governor's Office has awarded highway safety grants under the alcohol countermeasures program to:

College of Charleston: Leadership Education - Alcohol, Drugs and Driving Safely
Clemson University: Awareness Program
Horry County Schools: Teens Drive Sober
Aiken TEC: Automotive Safety Pilot Project
Greenville TEC: Project 3-D

In addition, the Anderson Alcohol and Drug Abuse Commission has been awarded a grant for DUI prevention, and the Solicitor's Office in Charleston has been awarded a grant for DUI prosecution.

The State Highway Patrol has also been awarded funds for a project to assist in implementing DUI enforcement saturation teams which will be set up in various communities throughout the State. The program will include mobile BAC units to assist the teams in DUI apprehension.

Additionally several other police departments have been awarded DUI enforcement grants.

Other Citizens Groups and Community Organizations

A number of citizen groups have been established which serve as resources to the South Carolina alcohol and drug abuse system. Like MADD, the Citizens Against Substance Abuse (CASA) was established in response to alcohol-related traffic deaths. Toughlove is a support group for parents who are experiencing problems with their children, especially adolescents. Many of these adolescents are experiencing problems with drugs and/or alcohol. The organization attempts to educate parents on alcohol and drug abuse. Toughlove is promoted by SCCADA as a resource for parents whose children have substance abuse problems. Many counties have privately operated non-profit residential centers providing services to persons with substance abuse problems. Parents Task Forces have been established locally in many counties to educate parents and to contribute to the solution of substance abuse problems.

## D. Public/Private Sector Interface

In FY80, the SCCADA adopted a policy statement on "private sector involvement in alcoholism treatment." That statement affirmed the

private sector's "legitimate and necessary role in the system of alcohol and drug abuse services available to citizens of this state." Further, it acknowledged that "private sector involvement represents a significant addition to the existing service delivery system."

The policy delineated a two-fold responsibility for the SCCADA as the state alcohol and drug authority:

1. To ensure that services provided by private, non-profit and private for-profit programs meet all quality standards applicable to the public sector.

2. To encourage the development of referral linkages between private and public providers which will ensure continuity of care for those persons receiving services.

In the five years since the policy was adopted, growth in the private sector treatment capacity has been rapid and expansive.

The SCCADA, in an effort to promote a continuing dialogue between public and private interests and among private providers, has sponsored meetings with existing private programs and facilities which have led to the development of a state coordinating committee of private treatment providers. In meeting with these providers, SCCADA affirmed its role as the single state authority and clarified its expectations of private treatment providers, and identified those areas where it will seek to promote collaborative efforts to develop and maintain a system of services which will meet the needs of the citizens of South Carolina. This public/private sector policy is outlined in the appendix.

## E. Legislation

Many new laws have been enacted recently which have resulted from the impact that alcohol and drug abuse has had on South Carolina. In 1985, for example, the drinking age was raised from 19 years of age to 21 years, and stiffer penalties have been levied for the manufacture of drugs. In 1986, the Legislature passed three laws supported by SCCADA. These laws pertain to the use and manufacturing of false identification cards commonly used in illegal purchase of alcohol; involuntary commitment to institutions; and drug forfeiture. A fourth law, pertaining to happy hour, banning two for one sales of alcoholic drinks, was also enacted, although SCCADA supported only portions of the legislation.

From its beginning, the SCCADA has proposed and supported legislation aimed at combatting the problems of substance abuse. During the period of this plan, SCCADA will continue its role in shaping, influencing and supporting alcohol and drug abuse legislation.

The appendix includes a listing of alcohol and drug related legislation considered by the State Legislature during its 1987 session.

## CHAPTER III

## STATE APPROPRIATED FUNDS

While increased FY87 funding was significant, few new dollars were able to be made available in FY86, requiring SCCADA and the county authorities to seek ways to maximize the system's effectiveness and efficiency. The fact that this effort succeeded is documented by the following data. Clients served and services provided throughout the state continued to increase in FY86 with 39,322 clients served (up 9.8 percent from FY85) and 400,967 outpatient hours of services provided to clients (up 14.7 percent from FY85) despite limited new dollars.

The largest new appropriation to the agency for FY86-87 totalling $750,000 was earmarked for services for children recommended by the Children's Coordinating Cabinet. The funds provided for: 1) the placement with county alcohol and drug abuse authorities additional community-based adolescent counselors to provide services for youth, 2) the reopening of a 12-bed cottage for adolescent inpatient treatment at Morris Village, and 3) implementation of an interagency training project. Economic conditions precluded full funding of the recommendations by the Cabinet and less than half of the funds recommended by the Cabinet were appropriated.

SCCADA was appropriated $495,000 in new funds to begin the implementation in January, 1987, of the Involuntary Commitment Act revisions which were also enacted in separate action during the past legislative session. SCCADA, county alcohol and drug abuse authorities and the Department of Mental Health are working jointly on implementation. In addition, the $426,000 appropriated for the 4 percent cost-of-living increase for employees of county alcohol and drug abuse agencies enabled county agencies to address issues concerning competitive salaries and the retention of qualified and experienced staff.

Start-up funding for the Involuntary Commitment Act did not provide adequate support for the community-based detoxification services which are essential for successful implementation of this program. Full funding for FY87-88 was requested to ensure the availability of the full range of community treatment services. In addition to continuation of the funds appropriated for FY86-87 for structured day/night treatment programs, the full funding request included the following new requests: $575,000 for community-based detoxification services; $300,000 for outpatient counseling services; $46,190 for additional personnel and staff support for the Division of Community Support Services which is responsible for providing the training and technical assistance for all statewide treatment services included those directed to the implementation of the Involuntary Commitment Act. This request totaled $921,190.

The FY87-88 Appropriations Request included the following priorities.

FY87-88 BUDGET REQUEST SUMMARY

1. Provide funds to expand prevention services into schools and communities in 26 counties that are currently underserved. $506,000

2. Provide funds for full implementation of amendments to the Involuntary Commitment Act for alcoholics and drug addicts, enacted in 1986, and for support necessary for implementation of the Act. $921,190

3. Provide funds to make the School Intervention Program (ScIP) available in all public schools by adding 10 ScIP coordinators to provide services in 13 county authorities serving 19 counties and to provide educational and support services for all county authorities. $304,000

4. Provide funds for alcohol and drug abuse services for youth which were recommended by the Children's Coordinating Cabinet but for which funding was not provided, including expansion of the Teen Institute, increased availability of education materials, services to institutionalized youth, and college-based prevention programs. $579,500

5. Provide funds for cost-of-living salary increases for employees of county alcohol and drug abuse authorities to help maintain competitive salaries and reduce personnel turnover. $688,410

6. Provide funds for specialized education and prevention campaign to increase awareness of problems from and to deter the increasing use of cocaine. $213,000

7. Provide funds to 19 intervention specialists to fully staff Alcohol and Drug Safety Action Programs (ADSAP) and eliminate delays in services in 29 counties. $475,000

8. Provide one time funds to enhance SCCADA's word processing and data analysis capabilities ($28,000) and to assist county authorities to acquire information technology capabilities campatible with SCCADA's Management Information System in order to avoid need for additional employees for forms processing. $148,500

9. Provide one-time funds as an initial request in a five-year plan to improve the physical facilities of county alcohol and drug abuse authorities in order to meet new licensing standards and eliminate inappropriate client service settings. $687,000

10. Provide funds for contracted training, operation of the State's credentialing system, and related expenses that were eliminated in the Governor's half-percent veto of FY87 appropriations. $38,708

11. Provide funds for additional personnel to assist with processing and maintenance of records for the Alcohol and Drug Safety Action Program (ADSAP) and the Pre-Trial Intervention Program (PTI). $44,007

# CHAPTER IV

## FY87-88 COUNTY PLAN UNMET NEEDS

County commissions on alcohol and drug abuse are required annually to submit a plan for addressing alcohol and drug problems in their communities. Included in this plan is the agency's identification of unmet needs which usually require additional funding resources. The following is a compilation of the unmet needs sections of the 37 county commission plans for FY87-88. For discussion purposes this summary is organized into two groups: 1) county commissions with service areas whose 1986 projected population is less than 87,000 persons, and 2) those agencies with service areas whose population is projected to be more than 87,000 for 1986.

There are a total of 24 county commissions with service areas whose population is less than 87,000. The types of unmet needs and the number of county commission plans identifying such needs were:

| Unmet Needs | Number of Plans |
|---|---|
| Counseling Staff | 16 |
| Other Professional Staff | 16 |
| Prevention Specialists | 15 |
| Facility Construction or Renovation | 15 |
| Salary Upgrade | 12 |
| Staff for Involuntary Commitment | 11 |
| Administrative Support Staff | 10 |

Some county commissions requesting additional counseling staff indicated specific target populations: women, blacks, adolescents, indians, families, ADSAP clients, public drunks and youth facilities such as John De La Howe. A total of 14 full-time positions were requested, two part-time positions, and in three plans, the request was simply for additional resources.

Twenty plans stated a variety of other staffing needs in order of descending frequency: ScIP - 5 plans, ADSAP - 4 plans, OBI - 4 plans, EAP - 2 plans, "increased staffing" - 2 plans, and intervention family practice and a residential manager - one each.

Twelve county plans indicated a need for a total of 13 full-time prevention specialist positions. An additional three commissions indicated a need for additional resources in the prevention area.

Thirteen county plans stated facility needs involving the construction or purchase of new offices or the renovation and/or expansion of existing facilities. Two additional counties indicated other facility needs; one indicated the need for a satellite office and another stated that the halfway house needed renovation.

Twelve county plans noted a need to increase salaries of personnel. In some instances the priority was to improve salaries to keep up with inflation. In other instances the stated need was to upgrade all salaries to attract and retain qualified and experienced staff. Ten of the twelve counties rank salary increases as the number one priority.

Eleven plans identified the need for additional resources for involuntary commitment responsibilities. In about half the plans, the need was for full-time and part-time staff to provide counseling services and/or assessment and court related services (e.g. designated examiners). Other plans indicated a need for funds for structured outpatient programs.

Twelve counties stated their programs needed to purchase furniture, equipment, computers or printed materials. Three counties saw transportation as a unfunded problem and three indicated needs for detoxification services or programs. A shelter for abused families and a program for children of alcoholics were also mentioned. In summary the most frequently mentioned unmet need was for additional staffing including: intervention staff - 16 plans, counselors - 16 plans, prevention specialists - 15 plans, and other staff - 4 plans.

The other grouping of county plans for discussion purposes are those who serve catchment areas with populations exceeding 87,000. There are a total of 13 county commissions who fall into this grouping. The most frequently noted areas of unmet needs and the number of counties indicating such a need in the FY87-88 county plans were:

| Type of Unmet Need | Number of County Plans Indicating Need |
|---|---|
| Prevention/Education Specialists | 10 |
| Additional Counseling Staff | 10 |
| Facilities | 9 |
| Structured Outpatient Treatment/I.C. | 8 |
| Salaries | 7 |
| Detox | 5 |
| Computers | 4 |
| Funding Stability | 4 |

There were an additional 22 other unmet needs documented, however they varied greatly. Other areas cited in at least two plans were the need for inpatient treatment, clerical staff and equipment. Other needs listed in only one county plan were transportation (vehicle), a training position, a female halfway house, telephone equipment, a program for youths at a DYS facility, a formal public relations program, college programming, a library, and EAP program support.

If the ranking of all the priority unmet needs for the larger county commissions are examined, the following needs were ranked number one:

| Type of Unmet Need | Plans Ranking Number One |
|---|---|
| Salaries | 3 |
| Funding Stability | 2 |
| Facilities | 2 |
| Prevention/Education | 2 |
| Structured Outpatient Treatment | 1 |
| Computer | 1 |
| Half-way House | 1 |
| DYS Program | 1 |

If the top three priorities of the agencies is totalled, the following ranking is obtained:

| Type of Unmet Need | Plans Ranking As Number 1, 2, or 3 |
|---|---|
| Facilities | 7 |
| Additional Counselors | 7 |
| Salaries | 6 |
| Structured Outpatient Treatment/I.C. | 4 |
| Funding Stability | 4 |
| Prevention Education | 3 |
| Computers | 3 |
| Other | 5 |

The other category includes needs for detox, halfway house, and a program at DYS (one plan had no second or third priority).

The facility unmet needs include both new construction and renovation projects. In one instance, the commission indicated a need for a satellite office, the need for a new halfway house is noted in two plans and halfway house renovations is noted in another.

In some plans the need for additional counselors specifically targets certain programs or populations including a family practice center, the black community, a state prison, and women.

Salary issues include: cost of living raises - 2 plans; salary upgrade and reclassification - 4 plans, and maintenance of existing compensation program - 1 plan.

Detox needs were cited in the Aiken, Anderson-Oconee, Horry, Lexington/Richland (expansion) and Sumter county commission plans.

In summary, when comparing the unmet needs for "small" and "large" agencies, there are strong similarities.

| | Percentage of Plans Indicating Need | | | |
|---|---|---|---|---|
| | "Smaller" Commissions | | "Larger" Commissions | |
| Unmet Needs | Rank | % | Rank | % |
| Additional Counseling Staff | 1 | 66 | 1 | 77 |
| Prevention Specialists | 2 | 62 | 2 | 77 |
| Facility Construction or Renovation | 3 | 54 | 3 | 69 |
| Salary Upgrade | 4 | 50 | 5 | 54 |
| Involuntary Commitment Support | 5 | 46 | 4 | 61 |

In conclusion, the top three priority areas in the county plans for FY87-88 were: 1) additional staff for treatment services, prevention programs, and support of the Involuntary Commitment Act implementation; 2) facility upgrade and 3) upgrading salaries. These priorities will not likely be completely addressed in the state appropriations bill for the upcoming year. Consequently SCCADA should:

1. Identify and emphasize cost efficient and effective means for providing intervention and treatment services and for implementing primary prevention programs.

2. Develop a statewide plan for upgrading facilities. The plan should identify alternate ways of financing and/or funding the facility construction or renovation. Although the state appropriations process is one means of funding these improvements, alternative local strategies need to be developed.

3. Study the current salaries of professional staff employed by county authorities to determine appropriate recommended minimum salary levels in order for these agencies to attract and retain qualified experienced staff. In addition, local agencies should review their own funding priorities to determine if they can upgrade their own classification and compensation programs.

4. Develop a statewide plan of action, based upon the systems' experience to date, for continued statewide implementation of the Involuntary Commitment Act. Cost efficient model programs for intervention, assessment, and court services for these clients needs to be identified.

# CHAPTER V

## PROGRAM GOALS, PROBLEMS AND RECOMMENDATIONS FOR ACTION

The planning process for the development of the FY88-89 plan involved all three divisions of SCCADA. In December 1986 the state plan coordinator met with the division directors to obtain their input and concurrence on the proposed planning process and timetable. The intent of the new process was to identify and forecast topics, issues or problems which need to be taken into consideration in developing the agency's appropriations request for FY88-89. In addition, the proposed planning process linked itself to the county planning process to take into account local priorities.

A list of topics and issues was reviewed and amended by the committee and is included in the appendix of this plan. The list included the top nine priorities from the agency's appropriations request for FY87-88 as well as other current issues affecting alcohol and drug abuse programs in South Carolina such as detoxification service needs.

A format for submitting the problem analysis sections by staff of each of the divisions was revised to include the rationale and goal of the particular functional area of the agency. The organizational framework for the problem analysis section follows the public health model of primary (with equal emphasis on agent, host and environmental strategies), secondary and tertiary prevention. Subsequent meetings of the three division directors and their staff were held to further discuss the planning process, and their divisional input and recommendations.

The following chapter summarizes the issues and topics identified through the aforementioned planning process.

## A. PRIMARY PREVENTION

### Rationale

Primary Prevention programs focus on developing personal and social competencies of the individual and modifying social systems to foster non-drug alternatives. Personal and social competencies are developed by providing learning and skill-developing experiences such as peer counseling, alternative recreational activities, and values clarification and decision-making skills training. Social systems are mobilized to change those factors which impact negatively on the environment relative to substance abuse. One example of this is the parent movement to shape our communities toward a drug-free culture.

### Programs

1. Primary Prevention Specialists
2. Public Awareness Campaign
3. THE DRUGSTORE Information Clearinghouse
4. Teen Institute
5. Cocaine Public Education
6. Help End Alcohol Related Tragedies (HEART)
7. Fetal Alcohol Syndrome Resource Network

PROGRAM: Primary Prevention Specialists

GOALS: To strengthen individuals and systems (families, schools, churches, etc.) with the knowledge and resources necessary to deal with stressful life conditions hence helping to prevent alcohol and other drug abuse.

To assist communities in developing prevention networks that can implement comprehensive supply and demand reduction strategies.

DESCRIPTION: Primary prevention programs provide the general public with: educational information regarding alcohol, drugs and other lifestyle issues which can adversely affect one's health, while promoting wellness and other positive lifestyle alternatives; alternatives to alcohol and drug misuse; and comprehensive, measurable goals and objectives that provide different approaches for diverse ethnic and social high risk groups.

PRESENT SITUATION: Primary prevention specialists are employed by almost every county commission to provide services to the public. The State Commission has placed a high priority on funding primary prevention specialist programs. In addition, in 1985, the Governor's Children's Coordinating Cabinet recommended that state funds be appropriated to establish 13 additional primary prevention projects. The State Commission's FY86-87 Appropriations Request included $242,952 for additional primary prevention services. This item in the request was not funded. The FY87-88 request ranked primary prevention specialists as its number one priority and asked for $506,000 to fund 22 prevention specialists.

During FY85-86, county commissions were involved in 12,329 prevention program events and provided more than 1.3 million contact hours of prevention activities to 306,696 individuals.

Presently new Federal funding is enabling the State Commission to contract with additional county commissions to employ prevention specialists to work in schools and communities and to focus on high-risk populations, such as children of addicted parents.

RECOMMENDATIONS FOR ACTION: Funding of additional primary prevention projects to establish and enhance primary prevention programming in all counties.

PROGRAM: Public Awareness Campaigns

GOAL: To increase the public's awareness of alcohol and other drug related problems, issues and programs by enhancing the agency's information-sharing capabilities through media campaigns, newsletters, other print and audiovisual communication devices and a toll-free information telephone number.

DESCRIPTION: Public awareness campaigns use a variety of media to provide the general public information regarding the problems of alcohol and drug use and abuse.

PRESENT SITUATION: The State Commission is currently responsible for providing information to the general public and to groups at high-risk of abusing drugs. The agency uses various communication devices to keep the state's residents abreast of local, state and national issues relevant to the use and misuse of alcohol and other drugs. For example, each year, the agency coordinates the state's involvement in annual nationwide media campaigns, such as "National Fetal Alcohol Syndrome Awareness Week" sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). In addition the agency coordinates special one-time projects or campaigns, such as the National Institute on Drug Abuse's Cocaine Abuse Prevention Campaign, "Cocaine. The Big Lie" and NIAAA's most recent media campaign targeting youth "Be Smart! Don't Start!" The agency is also responsible for conceptualizing and implementing media campaigns and other special projects designed specifically for South Carolina residents.

PROBLEM ANALYSIS: In recent years, there have been an increasing number of nationwide media campaigns coordinated in South Carolina by the SCCADA. Although the federal sponsoring agency or organization develops the program materials for such, federal funding limitations prohibit distribution of materials to state coordinators in sufficient quantities necessary to meet each state's information needs. Consequently, these campaigns place a financial burden on this agency to supply support materials to enhance these nationwide awareness efforts. In addition, the state's residents have additional information needs that are not always addressed through national campaigns. For example, during FY85-86, the SCCADA funded a statewide media campaign which addressed some of the unique problems related to the use and misuse of alcohol and other drugs among women. Although the agency currently develops and implements state-specific programs and assists with the

coordination of a variety of national efforts, additional funding is needed to enhance such public awareness programming. Because these media messages often prompt individuals to seek more extensive or specific information about a particular issue or problem, there is no mechanism in place, such as a toll-free telephone number, to respond to such inquiries from the public.

RECOMMENDATIONS FOR ACTION:

Increased funding to provide for additional public awareness campaigns, to provide for additional supplemental materials for public awareness campaigns and to provide for a toll-free telephone number for information about alcohol and drug abuse.

PROGRAM: THE DRUGSTORE Information Clearinghouse

GOAL: To expand the production and acquisition capabilities of THE DRUGSTORE Information Clearinghouse through increased funding for printed and audiovisual information/educational materials targeting South Carolina's youthful population.

DESCRIPTION: THE DRUGSTORE Information Clearinghouse provides both printed and audiovisual materials on alcohol and drug abuse for public information and educational programs.

PRESENT SITUATION: The provision of information on alcohol and other drug abuse information to the residents of South Carolina is an important part of the efforts of the SCCADA to educate the public. Through THE DRUGSTORE Information Clearinghouse, the SCCADA provides audiovisuals on alcohol and other drugs and life skills that range in suitability from primary school children to professionals in many disciplines. Printed materials are also available and address a multitude of issues, problems, programs and questions.

PROBLEM ANALYSIS: In recent years, there has been an increasing awareness of the problems related to the use and misuse of alcohol and other drugs in our society. With this increasing awareness has come an increased need for current and factual information targeting specific populations. In particular, the youthful population in our state has become more involved in and the recipient of a variety of alcohol and drug abuse primary prevention activities. As a result, this group has demonstrated an increased need for both printed and audiovisual informational materials. Although THE DRUGSTORE Information Clearinghouse has available a number of such materials targeting youth, there is a drastic need for more. Currently we are forced to limit requests for printed materials to a maximum quantity of 25 per request, a grossly inadequate supply for a school's alcohol/drug awareness event, for example. In addition, there is the need for new materials specifically targeting the youthful population, because the majority of our current holdings are geared toward the general population and are not youth-oriented.

RECOMMENDATIONS FOR ACTION: An increase in the funding for Clearinghouse in the amount of $30,000 as recommended by the Children's Coordinating Cabinet.

PROGRAM: Teen Institute

GOAL: To promote peer-to-peer alcohol and drug abuse prevention programs by students enrolled in high schools and to promote peer assistance programs among middle schools.

DESCRIPTION: The Teen Institute process begins with a week long, intensive training and social experience during the summer months and continues for one year at the student's school. Teen Institute participants take leadership roles in their schools implementing peer-to-peer prevention activities including drug free dances, educational programs, individual support and peer assistance programs with middle schools.

PRESENT SITUATION: There are approximately 340 public and private high schools in the state. During FY86-87, a total of 50 high school teams were trained to develop and deliver alcohol and drug abuse prevention projects in their schools and communities. These projects included skits dealing with substance use/abuse issues facing teenagers, exhibits, bill boards and other school/community educational events. For FY87-88 SCCADA plans to provide training and support for 80 teams of high school students and adult advisors, and to support related school and community events. During the past year the Greenville County Commission sponsored mini-Teen Institute programs.

PROBLEMS: As currently funded and staffed, the Teen Institute can provide training and support for a maximum of 80 high school teams. This includes two week-long residential summer sessions and administrative support of the teams as they implement their prevention projects in their schools and communities. Ideally the Teen Institute and county alcohol and drug abuse commissions should be able to serve all high schools wishing to participate. However this could be accomplished only through additional staffing and funding. In addition, there is a need to explore the possibility of implementing a similar program for serving both the middle and junior high school population and college age students.

RECOMMENDATIONS FOR ACTION:

1. Increase funding to provide for four Teen Institutes.
2. Determine the most feasible method of expanding the current Teen Institute program.

3. Determine the feasibility of expanding the Teen Institute program regionally and the concept into middle and junior high schools and colleges.

PROGRAM: Cocaine Public Education Campaign

GOAL: To reduce the incidence of cocaine use and abuse in South Carolina

DESCRIPTION: The Cocaine Public Education Campaign is designed to increase the public's knowledge of the dangers of the use through conferences, educational programs and public service media campaigns.

PRESENT SITUATION: Cocaine is one of the most powerfully addictive drugs of abuse. The National Institute of Drug Abuse's latest study of drug use among high school seniors has found that seniors in the class of 1985 are using cocaine at an unprecedented level. Seventeen percent have tried cocaine, 13 percent have used the drug in the past year and 7 percent in the past month. Cocaine use is up in 1985 among virtually all of the sub-groups of seniors examined: among males and females; college bound and non-college bound; and those of rural and urban areas.

In the past five years in South Carolina, there has been a 732 percent increase in admissions of persons suffering primarily from cocaine addiction or abuse to programs operated by county commissions. Cocaine related arrests have increased almost 500 percent from 1980 to 1985.

PROBLEMS: The price of cocaine continues to drop and the street supply has continued to increase despite local, state and national interdiction efforts. More dangerous forms of the drug such as crack and freebase are being marketed to very vulnerable populations at small doses but at more affordable prices. There is a need to continue to educate the public regarding the serious consequences of using this very addictive drug.

RECOMMENDATIONS FOR ACTION:

1. A statewide conference to provide state-of-the-art technical information to professionals and decision-makers on the scope of the problem and potential solutions.
2. Expansion of Employee Assistance Programs to provide to the work place an effective means of interventing with employees experiencing a variety of drug and alcohol problems including the development of effective policies, supervisor training, employee education and identification, and appropriate referral of troubled employees.

3. Expansion of server intervention programs to address the problem of cocaine and the added problems of combined alcohol and cocaine use by customers and employees of establishments which serve alcoholic beverages. The Help End Alcohol-Related Tragedies (HEART) Program is uniquely equipped for this expansion due to the high proportion of cocaine abusers who also abuse other drugs including alcohol.
4. A high intensity media campaign including news releases, public service announcements for electronic media and other means which would be specifically designed to alert the public to the problem of use of this drug and its consequences.

PROGRAM: Help End Alcohol Related Tragedies (HEART)

GOAL: To modify the environment in which drinkers consume alcoholic beverages in such a way that it reduces consumption and the incidence of driving under the influence.

DESCRIPTION: The HEART public education program is designed to increase employee knowledge regarding the problems of drinking and driving and to provide alcoholic beverage servers with information about various methods of intervention and prevention.

PRESENT SITUATION: In 1984, the Governor's Office of Highway Safety provided funds to SCCADA for a HEART project which was conducted in cooperation with the South Carolina Hotel and Motel Association and the South Carolina Restaurant Association. A total of seven one-day workshops were conducted in locations throughout the state including Greenville, Charleston, Greenwood, Columbia, Myrtle Beach, Hilton Head, and Florence. The workshops provided participants with educational materials and an instructional manual to assist them in training their own employees and co-workers. The project also provided for the development and production of radio and television public service announcements. Press kits were also distributed and a 45 minute video tape was provided for on-site training. Approximately 700 persons were trained by this project.

In 1985 SCCADA made funds available for local programs in Myrtle Beach, Hilton Head, Charleston and Columbia which provided training for 1,400 servers. During 1987 the Alcohol Beverage Control Commission provided funds to SCCADA to train 2,500 servers.

PROBLEM: Although the HEART program can be effective in achieving its goal, presently there does not exist a secure funding base for HEART training programs. There is a need to obtain permanent funding for this statewide program.

RECOMMENDATIONS FOR ACTION: SCCADA should secure a permanent funding mechanism to continue and expand the HEART program to provide annual training for 2,500 servers and to provide promotional and customer education materials.

PROGRAM: Fetal Alcohol Syndrome Resource Network

GOAL: To reduce the incidence of Fetal Alcohol Syndrome and Fetal Alcohol Effects by coordinating the prevention efforts among interested agencies and organizations.

PRESENT SITUATION: In April 1987, a statewide network was convened to deal with the problems of Fetal Alcohol Syndrome and Fetal Alcohol Effects. Fetal Alcohol Syndrome (FAS) includes serious defects associated with maternal alcohol consumption, including facial disfiguration, small head and body size, and mild to moderate retardation. FAS children are born to women who chronically abuse alcohol during pregnancy. It is estimated that one in every 750 babies born in the U.S. suffers from FAS brought on by their mother's drinking while pregnant. Fetal Alcohol Effects include less severe symptoms, associated with moderate to heavy drinking, including lower birth weight, increased incidency of miscarriage, later development of behavioral problems, and impaired physical development. FAE can occur even in infants of women who are considered social drinkers.

Dr. Pete Johnson, Coordinator of Alcohol and Drug Studies at the USC School of Medicine is the chairman of the network. The group is composed of medical school professors, genetic counselors, health educators, substance abuse prevention specialists and members of volunteer health agencies. The purpose of the network is to promote efforts and programs designed to prevent Fetal Alcohol Syndrome and other related conditions. Additionally the network is developing plans for the state's activities relative to National FAS Awareness Week in April of each year.

PROBLEMS: There is a need to improve the coordination of prevention efforts and the availability of information on FAS and FAE in South Carolina. Many different individuals and agencies are in a position to impact this problem through prevention programs. However, prior to the establishment of the network, this coordinating effort was non-existant.

RECOMMENDATIONS FOR ACTION: The State Commission should continue to support the efforts of the Fetal Alcohol Syndrome Resource Network. Their prioritized activities for FY87-88 are:

1. Sponser a statewide conference in the summer of 1988.
2. Provide an information network and resources for OB/GYNs, head nurses, family practitioners and others.
3. Present and participate in a workshop on FAS for network members.
4. Promote a poster contest in middle and/or high schools in 1988.
5. Develop radio and television public service announcements and programs on FAS and FAE.
6. Provide materials to all obstetrical offices.
7. Provide information to state and local associations for physicians, nurse practitioners, lamaze instructors and others.
8. Prepare articles for newspapers, magazines and posters.
9. Prepare similar materials for high risk groups.
10. Establish a FAS speaker bureau.
11. Promote an SC ETV series on FAS.

## B. SECONDARY PREVENTION (INTERVENTION)

### Rationale

Secondary prevention (intervention) programs are designed to confront persons whose alcohol and drug abuse are causing problems for the individual, the family, the public, the schools and/or the employer. The purpose of the intervention is to confront the person with an objective view of the consequences of their alcohol or other drug abuse and the future consequences of continued abuse. Since denial of the problems associated with alcohol or other drug abuse are so frequent, intervention programs help to educate the abuser and facilitate their entry into treatment programs. Public agencies such as law enforcement, the schools, and correctional agencies participate in the intervention process. Private and public employers can also serve as an intervener to assist the troubled employee deal with the problems of substance abuse.

### Programs

1. School Intervention Program (ScIP)
2. College and University Program
3. Employee Assistance Program
4. Alcohol and Drug Safety Action Program (ADSAP)
5. Offender Based/Intervention (OBI)

PROGRAM: School Intervention Program

GOAL: To prevent or reduce alcohol and drug use and other negative behaviors among students and their families.

DESCRIPTION: The School Intervention Program (ScIP) provides intervention and treatment services to students in grades 7-12 who have been identified as being at high-risk for substance abuse or other problems and prevention services to the schools.

PRESENT SITUATION: There are about 280,000 students enrolled in the public school system in grades 7-12. ScIP is available in all 46 counties through the county commissions on alcohol and drug abuse. There are approximately 50 full-time ScIP intervention specialists and during FY85-86, 4,891 clients and family members enrolled in the program. In addition, during that year almost 10,000 public school teachers were trained on how to identify students who were at risk for alcohol and drug abuse. Since adolescents are at such high-risk to begin a life long pattern of alcohol and other drug abuse, there is a need to provide these services to many more students and teachers.

PROBLEM: Although the ScIP has been shown to be an effective and productive approach to alcohol and drug abuse intervention in the schools, funding in a number of counties is inadequate to fully meet the needs of their school populations and make ScIP programs available in all public schools. The Children's Coordinating Cabinet recommended expansion of ScIP to make it available in all public schools. To accomplish this goal, the equivalent of ten new ScIP coordinators are needed by 13 county commissions to provide additional services in 19 counties. In addition, each of the 37 county authorities currently providing ScIP services are in need of additional funding to assist in the provision of educational and follow-up support services for ScIP clients and their families who have completed basic educational and/or treatment services.

RECOMMENDATIONS FOR ACTION: Increase funding for additional ScIP intervention specialists and for additional counseling resources to provide educational and treatment services to the increasing number of students and families referred to the program.

PROGRAM: College and University Program

GOAL: To lower the rate of high-risk alcohol and other drug use in college and university populations in South Carolina.

DESCRIPTION: SCCADA's college and university program is designed to assist campus administration throughout the state to develop prevention strategies and intervention programs targeted at high risk student populations.

PRESENT SITUATION: There are 33 public colleges and universities in the state with a student population of 104,000 of which about 41,000 are under the legal age for possession and/or consumption of alcoholic beverages. In addition to these campuses, there are 26 private campuses (two-year, four-year and graduate level) with a student population of 24,000, about 13,000 of which are under 21 years of age. Research has shown that 80 to 95 percent of college and university students are consumers of alcoholic beverages.

The college campus is historically and traditionally been a site for high-risk alcohol use as well as a site for experimentation and use of other psychoactive drugs. Primary prevention efforts on college and university campuses should focus not only on issues of supply and demand but should prepare these populations to make informed decisions not only to use or abstain, but on high-risk and low-risk choices if use if chosen.

In South Carolina very few campuses currently have established intervention programs for high risk students. The intervention concept found to be very successful in business and industry and in high schools in South Carolina can be easily adapted for a campus population. Their concept is based on performance and includes a policy-backed intervention program with treatment programs available-not only for alcohol and other drugs but for any problem which may endanger a student's successful completion of a college education.

PROBLEM ANALYSIS: A majority of South Carolina colleges and universities currently have policies regarding the use or non-use of alcohol or other drugs. But few have policies or programs which go beyond this very basic stage. These policies are examples of primary prevention activities which attempt to control the host, agent and environment. They alone are far from sufficient. Currently there are two full-time campus prevention coordinators in the state. The

higher education amendments of 1986 requires all campuses which receive federal funds for student aid to certify that it has an operational drug prevention program that is determined by the institution to be accessible to any office, employee or students at the institution by July 1, 1987.

RECOMMENDATIONS FOR ACTION:

1. It is recommended that an additional three full-time campus prevention coordinators be hired to develop comprehensive programs in these designated high campus concentration areas. These are Lexington/Richland, Orangeburg and Charleston. It is further recommended that federal funds by sought to fund these positions. These coordinators will be responsible for coordination of the prevention projects and intervention programs which are currently being developed. County commissions with colleges or universities in their service areas should promote prevention on those campuses.
2. There should be funding provided for an annual conference on college and university prevention programming.
3. Funds should be provided for incentive grants to local commissions and higher educational institutions to implement prevention programs.
4. Campuses should be encouraged to identify a person responsible for alcohol and other drug programming. A network of these campus representatives should be established.

PROGRAM: Employee Assistance Program

GOAL: To restore to an acceptable level of performance any employee whose productivity has deteriorated as a result of excessive or abusive use of alcohol or other drugs and/or personal problems.

DESCRIPTION: The Employee Assistance Program provides educational information, training, technical assistance, intervention and treatment services for employees of government and private business and industry who are experiencing personal or job performance problems.

PRESENT SITUATION: The Research Triangle Institute estimates that drug abuse cost the U.S. economy $60 billion in 1983. The consequences of drug abuse on the job range from lost productivity, to accidents and injuries, to thefts and bad decisions. Since 1975, about 50 train accidents have been attributed to drug or alcohol impaired workers. In those mishaps, 37 people were killed, 80 were injured, and more than $34 million worth of property destroyed. Federal experts estimate that between 10 and 23 percent of all U.S. workers use dangerous drugs on the job. Marijuana is the most common drug in the workplace, but cocaine, with 4.5 million regular users in the U.S., is on the rise.

To help put impaired workers on the road to rehabilitation, about 50 percent of the Fortune 500 industrial corporations have established in-house Employee Assistance Programs. Increasingly companies are requiring urine tests of applicants. Effective Employee Assistance Programs have helped reduce absenteeism, medical claims, accidents, while increasing productivity.

In South Carolina, more than 395 organizations have implemented employee assistance program agreements with county commissions on alcohol and drug abuse. Consequently more than 120,000 employees are covered by these programs. In addition, the county commissions provided direct services to more that 1,200 troubled employees referred to their agencies during the past year.

RECOMMENDATIONS FOR ACTION:

1. The SCCADA will promote increased employee assistance programming throughout the 301 system by recommending creative strategies for impacting businesses and industries in the state.

2. The SCCADA will coordinate the development, implementation and maintenance of interface activities with appropriate public and private agencies, organizations and programs in order to enhance programming for the state's troubled employees.

PROGRAM: Alcohol and Drug Safety Action Program

GOAL: To reduce future incidents of driving under the influence by those persons convicted of DUI and completing the ADSAP Program.

DESCRIPTION: The Alcohol and Drug Safety Action Program (ADSAP) provides intervention, assessment, educational and treatment services to persons enrolling in the program due to a condition of their sentence and/or to meet the Department of Highways and Public Transportation's relicensing requirements to successfully complete the program as required by law.

PRESENT SITUATION: The county commissions on alcohol and drug abuse are certified by SCCADA to operate ADSAP programs. All of the commissions receive intervention funds from SCCADA for the program, and are allowed to charge fees for services as established by state law. During 1986, 18,276 drivers were convicted of driving under the influence and during FY85-86, 14,717 persons entered services through the ADSAP program.

PROBLEM ANALYSIS: While the number of ADSAP clients has increased every year, from 7,500 in FY79-80 to over 14,000 in FY85-86, the number of intervention specialists who provide services to these clients has not kept pace. SCCADA has identified 29 counties with immediate critical needs for additional ADSAP personnel. The number of clients per intervention specialist in some of these counties is more than twice the state average. Intervention specialists provide the assessment, placement, and case management services critical to the effectiveness of ADSAP. Shortages of intervention specialists may create unacceptably long delays before clients are admitted to the program.

RECOMMENDATIONS FOR ACTION: Funds should be provided for additional intervention specialist positions to meet ADSAP programming needs.

PROGRAM: Offender Based Intervention

GOAL: To reduce the incidence of substance abuse among adult and juvenile offenders.

DESCRIPTION: The Offender Based Intervention Program provides intervention, assessment, educational and treatment services targeted specifically to adult and juveniles with alcohol and other drug abuse problems who have become involved with the criminal justice system.

PRESENT SITUATION: Offender Based Intervention specialists employed by the county commissions are responsible for contacting criminal justice agencies to establish policies and procedures for identifying and referring offenders with substance abuse problems to the local treatment agencies. Once the appropriate offender is referred by the police, the solicitor's office, judge or probation officer, he or she is interviewed, assessed and placed in an appropriate educational and/or treatment program.

Presently 17 commissions have contracts with SCCADA for state funds to support Offender Based Intervention. Although most commissions provide intervention and treatment services to offenders under this program, some agencies have been more successful than others in targeting programs at this kind of client. During FY85-86, 4,427 persons received services through the Offender Based Intervention Program.

PROBLEM ANALYSIS: Many offenders with substance abuse problems are not being required to participate in intervention educational and treatment programs as they should be. A significant number of offenders arrested, prosecuted and convicted of various crimes have serious alcohol and drug abuse histories. However, the state has not been able to fully implement a statewide system to insure that these types of offenders are confronted with and receive treatment services for their drug abusing behaviors. The absence of statewide funding with required guidelines for Offender Based Intervention services results in missed opportunities for the criminal justice agencies to coerce substance abusing offenders into education and treatment programs. As a result of inadequate funding, intervention specialists are not available in all counties to work with criminal justice agencies to get alcohol and drug offenders into treatment programs. Another problem is that while many offenders that are charged with

the possession of marijuana would be appropriate referrals for the program, few enter since the present law allows them to simply forfeit bail. Consequently there is not requirement or incentive for these offenders to enter an educational or treatment program for drug abuse.

RECOMMENDATIONS FOR ACTION:

1. The state should increase funding for Offender Based Intervention specialists so that every commission would be able to provide intervention services to at least 10 percent of the adult and juvenile offender population in their catchment area.
2. There should be statewide standards and guidelines for Offender Based Intervention programs which are adopted by each commission.

## C. TERTIARY PREVENTION

Treatment services along a continuum from crisis intervention to long-term residential care should be available for all state residents who may need them. These services should be affordable, accessible, and appropriate to the needs of the patient. All services should meet generally accepted quality standards.

Issues and Programs

1. Third Party Reimbursement
2. Involuntary Commitment Implementation
3. Training
4. Detoxification
5. Alcohol and Drug Treatment Facility for Inmates
6. Acquired Immune Defficiency Syndrome (AIDS) and Substance Abuse

TITLE: Third Party Reimbursement

GOAL: To increase both the amount of benefits and range of eligible services for alcohol and drug treatment reimbursed by third party providers.

EXPLANATION: A comprehensive system of treatment services cannot be supported solely by government revenues and first party payments. A key to making treatment both affordable and accessible is the development of third party reimbursement mechanisms.

PRESENT SITUATION: Third party reimbursements presently constitute a very small percentage of public sector treatment program revenues in South Carolina. Private facilities, which serve a more affluent clientele, receive more revenue from insurance carriers, but still report that inappropriate benefit ceilings preclude full reimbursement for treatment costs. Private insurance coverage for alcoholism and drug addiction, while steadily improving, remains inconsistent, and most carriers increase premium cost for those desiring coverage. In many policies, benefits are payable only in a general hospital. For many persons, medical insurance is not ever available, unless they qualify for government sponsored programs such as Medicaid or Medicare. Benefits from these programs are quite limited, restricted both by age and income eligibility requirements and by exclusion of most non-medical providers from eligibility for reimbursement.

PROBLEMS: It is unfortunate that improved alcohol/drug treatment benefits are viewed as an additional cost by carriers, justifying a premium increase to policy holders. This ignores several reputable studies which have demonstrated that families and patients who have received alcoholism treatment consumed less health care services after treatment than the average employee. Because of the perception of increased cost, most carriers do not market alcoholism treatment coverage actively and purchasers do not seek it out. A related problem is that many policies continue to limit coverage to traditional health care settings, e.g. general hospitals, thereby excluding more cost-efficient alternatives such as day treatment programs and subacute detoxification facilities.

Getting a concerted effort by public and private providers for improved insurance coverage has been hampered to a degree by differences in perceived need. Private providers have been more concerned

with removal of benefit ceilings, while public providers have stressed the need to expand the range of treatment settings which qualify for reimbursement.

ALTERNATIVE SOLUTIONS:

Many states have mandated carriers to include alcohol and drug treatment benefits in all policies marketed in the state. Others have required that all policies offer an option to purchase. SCCADA has consistently opposed mandated coverage but has discussed required option legislation with the South Carolina Department of Insurance. Consensus has been that without a major effort to educate employers on the cost benefits of purchasing alcoholism treatment coverage, required option legislation would have little impact.

Changes in the federal Medicaid program during FY88-89 hold promise for many public outpatient treatment programs to qualify for reimbursement as providers of case management and treatment/ rehabilitation services.

Any attempt to raise ceilings on reimbursement for inpatient treatment must be accompanied by efforts to offer private carriers a choice of lower cost alternatives. To do this, there must be appropriate quality assurance mechanisms, e.g. licensing regulations, personnel certification, utilization review, to assure carriers that there money is well spent. In the absence of legislation to mandate coverage in specified settings, any strategies to improve benefit levels must deal directly with major carriers and large employers.

RECOMMENDATIONS FOR ACTION:

1. SCCADA should submit a proposal to the Health and Human Services Finance Commission for the inclusion in the State Medicaid Plan of outpatient counseling services provided by public alcohol and drug treatment agencies.
2. The Department of Health and Environmental Control should promulgate its licensing standards for outpatient chemical dependency treatment programs. These standards should clearly delineate day treatment programs as an alternative to inpatient care.
3. New licensing standards should be developed by DHEC for free-standing detoxification centers, which are currently classified as community residential care facilities.
4. SCCADA should enhance its quality assurance efforts with all subcontractors, stressing

compliance with agency treatment standards, credentialing of all service delivery personnel, and the institution of outcome evaluation studies to determine service effectiveness.

5. SCCADA should continue to work with private providers to determine joint strategies with which to effect change in the alcohol/drug treatment benefits now offered by insurance carriers.

PROGRAM: Involuntary Commitment Implementation

GOAL: To develop the range of services necessary to implement South Carolina's new Involuntary Commitment Act for alcoholics and drug addicts.

EXPLANATION: For the past several years more than 2,000 persons with alcohol/drug diagnoses were admitted annually to state psychiatric institutions. Under legislation which took effect January 1, 1987, these persons may now be committed involuntarily to facilities licensed to treat addictive illness. An estimated one-third of this population can be treated in the community without first being institutionalized.

PRESENT SITUATION: Implementation began January 1, 1987, so available data are limited. SCCADA received an appropriation of $495,000 to expand outpatient counseling capability, initiate five structured intensive day treatment programs, and to improve existing detoxification services. Planning and preparation included probate judges, law enforcement personnel, county alcohol and drug abuse authorities, and mental health center staff. After one month, the state's inpatient resources were being fully utilized and psychiatric facilities were being asked to take the overflow. Deflection of patients into community resources clearly needs to be increased.

PROBLEMS: Funding for community-based services for the first six months is less than one-half of projected yearly cost. Full annualization is essential in FY88. Some services, particularly structured intensive day treatment, have been slow to start, placing additional stress on state and patient facilities. Community-based detoxification facilities are not accessible to all areas of the state. Triage of patients must be improved to identify those persons who can be managed effectively in the community. Ambiguity in the law itself has led to a reluctance on the part of some judges to commit directly to outpatient treatment. A decision by the Department of Mental Health to utilize beds at Morris Village for committed patients, rather than establishing a program in a renovated building at Crafts-Farrow State Hospital, has reduced space for voluntary admissions by 24 beds.

ALTERNATIVE SOLUTIONS: Use of state psychiatric facilities for spillover is an obvious, if undesirable, alternative. However, addiction-specific treatment must be provided to

prevent warehousing of patients. Development of outpatient detoxification services may help when family support systems are intact. This would relieve some pressure on community detoxification facilities. Greater use of outpatient alternatives is imperative. This can only happen if such services are fully funded in FY87-88. The South Carolina Code may also need to be amended to make clear the court's authority to commit to outpatient treatment. Consideration must be given by courts and triage personnel to use private facilities for patients with insurance coverage. On balance, however, the vast majority of persons committed to treatment will be seen in public programs and facilities which must be adequately funded to provide the intensity of care this population will require.

RECOMMENDATIONS FOR ACTION:

1. Full FY87-88 annualization of funds appropriated for start-up implementation during January-June 1987.
2. SCCADA should initiate at least five more structured intensive outpatient treatment programs in counties generating high numbers of involuntary patients.
3. Community-based detoxification capability should be expanded in the Pee Dee region. Outpatient and social setting models should be encouraged.
4. The involuntary commitment statute should be amended to give courts a clear authority to commit directly to outpatient care as appropriate.

TITLE: Training

GOAL: To provide training necessary to ensure necessary levels of competence within the alcohol/drug treatment system and to enhance the responsiveness of related health care systems to alcohol and drug problems.

EXPLANATION: For a system to offer quality services, its workers must possess the needed skills and competencies. Because alcohol/drug problems are so closely correlated with other health and social problems, workers and other agency systems must be prepared to deal with persons who manifest these problems.

PRESENT SITUATION: In FY85-86, the SCCADA delivered 22,179 hours of training to 1,084 persons. Staff of county alcohol and drug abuse authorities represent the major target audience, but representatives of numerous other public and private agencies are included in this number. A yearly training calendar is developed using input from the evaluation of previous offerings, a formal needs assessment conducted with county authorities, and direction afforded by agency program priorities. SCCADA staff resources for training have steadily diminished, but the availability of consultant monies has permitted the delivery of much training under contract with external resources.

PROBLEMS: Physicians are the providers of primary health care who are perhaps best able to identify and confront chemically dependent patients. Yet many physicians are ill-prepared educationally and attitudinally to do this. Because most physicians are in private practice, continuing education efforts are difficult to implement. Training delivered during a doctor's formal education experience holds the most promise.

Increasingly, treatment programs are being asked to target specific underserved populations. In FY87, South Carolina has turned its attention primarily to youth and women. If effective treatment for chemical dependence is to be offered these populations, then clinicians must receive further training in how to deal with the needs and developmental issues unique to each group. A one-dimensional chemical dependence treatment model will not be sufficient.

Although only a few persons suffering from AIDS have sought alcohol and drug treatment in South Carolina at this time, the number will certainly grow.

Intravenous drug users are known to be a high-risk population. No one knows how many intravenous drug users already in treatment may already have been infected by the AIDS virus. A critical training need is that of equipping alcohol/drug clinicians to deal with both AIDS victims and with those persons at high-risk of infection.

ALTERNATIVE SOLUTIONS:

Two strategies hold the most promised for expanding the amount of training taking place in South Carolina without stretching SCCADA staff resources to the breaking point.

1. Placement of training/educational specialists on the faculty of existing professional school programs. This holds particular promise for physician training.
2. Greater reliance on a training of the trainers model in which selected representatives of state and local agencies are given intensive training with the expectation they will then train other front-line personnel in their respective agencies.

RECOMMENDATIONS FOR ACTION:

1. Each of the state's family practice residency training programs should be invited to participate in a program whereby a counselor from the local alcohol and drug authority is outstationed at the hospital to collaborate with physicians in identification, confronting and treatment of chemically dependent patients.
2. SCCADA will continue to emphasize training in adolescent and women's issues, but with a greater effort to broaden impact through a training of the trainers approach.
3. Training which focuses on AIDS and counseling the AIDS patient will be a top priority in FY87-88.

PROGRAM: Detoxification

GOAL: To provide detoxification services to persons suffering from acute withdrawal from drug abuse through an easily accessible, regional network of detoxification centers.

DESCRIPTION: There is an increasing demand for detoxification services in South Carolina. The passage of the Involuntary Commitment Act, the development of new programs, and the identification, referral and intervention of an increasing number of persons with substance abuse problems will require additional funding of detoxification centers and innovations in the way detoxification services are provided for the public.

PRESENT SITUATION: Detoxification is an integral component of treatment services currently being delivered in South Carolina. Each local program in the 301 system routinely utilizes this treatment resource. Consequently, the 301 system acknowledges that detoxification, the physical withdrawal process of reducing the level of chemical in the person's system to the point where participation and rehabilitation can be achieved, is an important and vital element in the overall treatment of individuals dependent on alcohol and other drugs. It is further acknowledged that while the duration of detoxification varies depending on the drug(s) involved, it is but one phase of the treatment and rehabilitation continuum available to encourage recovery from addiction.

Detoxification services in South Carolina are formally defined in the South Carolina State Health Plan as a service for persons who are in acute need of medically supervised withdrawal from alcohol and/or drugs, with capacity to provide screening for medical complications of alcoholism and/or drug abuse and structured programs of counseling and referral for further rehabilitative care.

The two major objectives of detoxification in the 301 system, therefore, are 1) supervised withdrawal and 2) initiation of rehabilitation through referral through a substance abuse treatment program. Detoxification in the 301 system most often occurs through an inpatient treatment program utilizing medication to assist the withdrawal process, referred to as subacute detoxification. There are currently five sub acute detoxification centers operating within the 301 system, located in Greenville, Lexington/Richland, York, Orangeburg and

Charleston. "Social setting" detoxification (occurs without the use of drugs) is also being utilized in the 301 system. Patients are screened upon entry for need of medical attention, and transfer agreements are maintained for emergency medical services as needed. Social setting detoxification services are offered in Newberry and Marion/Dillon Counties.

Outpatient drug-assisted detoxification is being piloted as a more cost-efficient alternative to inpatient detoxification. This method is currently being utilized by only one agency in South Carolina, the Clarendon Commission on Alcohol and Drug Abuse.

During FY86, there were 4,798 detoxification admissions in the 301 system, up three percent over the FY85 admissions. The subacute detoxification method was used in 95 percent of the cases.

Detoxification services are also being offered through private hospital and treatment centers. Data from private hospitals for 1986 are incomplete. However, in 1985 3,248 persons received detoxification services outside the 301 system.

There are 158 detoxification beds available statewide, 95 public and 63 private beds. HSA Region II has 53 detoxification beds (42 public and 11 private); HSA Region IV has 46 detoxification beds (26 public and 20 private); HSA Region I has 45 detoxification beds (27 public and 8 private); and HSA Region III has 14 detoxification beds (2 public and 12 private).

PROBLEM ANALYSIS:

There are thousands of alcoholics and other individuals suffering from the misuse and abuse of alcohol and drugs in South Carolina who may require detoxification services each year. Accordingly, the availability of detoxification services is vital to identification and appropriate humane treatment of alcohol and other drug abusers. Unfortunately, the demand for these services appears to be creating a shortage of beds, especially since January 1, 1987, when the state's new Involuntary Commitment Act (to treatment facilities) became effective.

While the long term impact of the Involuntary Commitment Act cannot be accurately projected at this time, initial reports from detoxification facilities in the 301 system during FY87 indicate that utilization will increase for the fourth straight year.

The demand for detoxification services in the 301 system peaked in FY80 when there were 120 beds available, including 15 beds located in Region III at Florence. However, since FY83, there has been a steady increase in detoxification bed utilization. Moreover, enactment of the Involuntary Commitment Act will likely drive utilization rates still higher. Higher utilization rates at public detoxification facilities will compound the problems already being faced by Region III and other pocket service areas which need easier access to detoxification services.

The number and location of public detoxification services in South Carolina also suggests the need for expanding the state's detoxification capacity. Currently the two public detoxification beds in Region III (representing a 12 county area) are grossly insufficient to meet both the present and anticipated demand for these services. It is interesting to note here, that in FY81 when the Florence Commission provided detoxification services to Region III clients, 596 from the region received public detoxification services statewide (467 persons received services through the Florence Commission). However, in FY83, after the Florence Commission closed its detoxification facility, only 204 persons from Region III received services in the 301 system statewide; with the Lexington/Richland (119) and Charleston (77) Commission's detoxing the bulk of these clients. The problem is that many clients from Region III are not receiving detoxification services at facilities outside the region since the Florence Commission detox center closed and, the situation has remained basically the same since that time.

The 12 private beds in Region III are under-utilized (Bruce Hall, 44 percent occupancy, Coastal Carolina, 24 percent occupancy). However, the cost of treatment at these facilities is prohibitive to the vast majority of 301 system clients as is generally true of private hospitals elsewhere in South Carolina generally.

The advent of structured outpatient programming may also further impact on public detoxification beds availability. This program, which was designed to fill the void between traditional inpatient treatment programs and less intensive outpatient treatment, may likely have to incorporate detox, and, therefore, necessitate the need for additional beds as well as create additional demands.

ALTERNATIVE SOLUTIONS:

1. The most cost effective solution would be greater reliance on "social setting" detoxification. The two facilities currently on-line in Marion and Newberry enjoy high utilization. Accordingly, consideration should be given to expanding these facilities. Clients requiring more intensive care could be treated through an agreement with area hospitals, many of which are seeking ways of creating needs for under-utilized beds;

2. Contracting with local hospitals directly for detoxification services. This concept would allow local 301 agencies to make referrals to area hospitals on an as needed basis;

3. Utilizing outpatient detoxification when possible or applicable. This program would allow great flexibility for each program director and also be without the cost associated with inpatient or social setting detoxification;

4. Build more facilities--optimum locations for new detoxification services would include Florence, Darlington and Horry in Region III; and Beaufort or Colleton in Region IV;

5. Expanding the capacity of current free-standing subacute detoxification facilities in the 301 system.

RECOMMENDATIONS: It is recommended that a study be conducted to determine the feasibility of developing a system of social setting detoxification programs across the state, to augment existing resources. Expansion of this social setting facilities in Newberry and Marion should be given full consideration.

PROPOSED PROGRAM: Department of Corrections Alcohol and Drug Treatment Facility

GOAL: To provide an intensive treatment experience for inmates who have significant histories of alcohol and drug abuse.

EXPLANATION: The Board of Corrections endorsed a proposal for a 48-bed residential treatment facility for inmates serving sentences under the jurisdiction of the Department of Corrections.

PRESENT SITUATION: More than 9,000 inmates are serving sentences in state correctional facilities. Many of these offenders have significant histories of alcohol and drug abuse, however the department does not currently operate an intensive, therapeutic treatment program for these types of inmates. During FY86, 43 percent of the inmates admitted to the Department of Corrections indicated that their offense was committed while under the influence of alcohol and/or drugs. Thirty-nine percent of these new admissions acknowledged that they have a substance abuse problem. Although the Department of Corrections employs more than 40 social workers, and many inmates participate in individual and group counseling, AA and NA, the severity of the addictions problem for many of the inmates warrants a more intensive treatment approach.

In the fall of 1986, representatives of the State Commission on Alcohol and Drug Abuse, the Department of Corrections and the Department Parole and Community Corrections met to discuss the feasibility of establishing an alcohol and drug treatment center for inmates serving sentences under the jurisdiction of the Department of Corrections. An interagency committee was appointed to develop a plan for a treatment program for inmates housed in a separate facility. In October 1986, the Board of Corrections endorsed the proposal by Representative John Tucker of Anderson County to establish the center. Consequently, the Department of Corrections requested that the Joint Bond Review Committee approve its using $307,000 of construction funds left over from one of their building projects to build a 48-bed dorm at the Watkins Pre-release Center in Columbia. However, the committee placed the request on hold pending the appropriation of new funds for the operation of the unit. The Department of Corrections then submitted a supplemental budget request for $899,884 for funding of the 48-bed center. In late March representatives of the

Department of Corrections and the State Commission appeared before the Corrections Subcommittee of the Senate Finance Committee to request $224,971 in state funds. This amount would provide the 25 percent cash match required for applying for Federal Narcotic Assistance Funds which the Governor's Office anticipates receiving this year. Although the subcommittee recommended this project for funding, the full Senate Finance Committee did not adopt the proposal. In April 1987 the Budget and Control Board approved the Department of Corrections use of the $307,000 in construction funds, but made it conditional that $620,000 in federal funds be obtained for the project. No new state funds were approved for the project. Consequently, funding for this project during FY87-88 is unlikely.

RECOMMENDATION FOR ACTION:

The Department of Corrections and the State Commission should continue their efforts to secure funding for this pilot program.

ISSUE: Acquired Immune Defficiency Syndrome (AIDS) and Substance Abuse

EXPLANATION: AIDS is a condition characterized by a defect in the body's natural immunity to disease; it weakens the body's natural defense against certain illnesses that normally do not affect healthy people. AIDS is caused by the human immunodeficiency virus (HIV) although not all individuals infected with the virus contract the disease. Research indicates that suppression of the immune system by other factors may increase the likelihood that the individuals infected with HIV will develop AIDS. According to the most current research, intravenous drug users are the second highest at risk population for contracting AIDS with over 25 percent of all AIDS cases occurring among his population. Poor judgement in terms of personal health and sexual habits often accompany chemical dependency thereby increasing the risk of contracting both the HIV infection and subsequently the disease itself.

PRESENT SITUATION: In South Carolina since 1982, there have been 135 cases of AIDS reported as of May 31, 1987; 83 of these victims have died and 24 of the AIDS cases have been intravenous drug users. The South Carolina Department of Health and Environmental Control believes that the cases of AIDS/HIV infection in South Carolina are under reported. The governing board of SCCADA formally adopted the agency's policy on alcohol and drug abuse services to AIDS victims on January 18, 1987 (see appendix). Shortly thereafter, the agency appointed an interdivisional advisory group to assist in planning AIDS policy implementation strategies. To date, accomplished strategies include: designation of staff in each county alcohol and drug abuse commission to coordinate AIDS policy development and programming; scheduling and delivery of SCCADA inservice staff training and staff training of county alcohol and drug abuse authorities; selection and preparation of educational materials; and coordination with the Department of Health and Environmental Control.

The system with the most contact with intravenous drug users, other than the legal and medical systems, is the alcohol and drug abuse treatment system. Therefore, alcohol and drug treatment agencies, because of the health risks related to the highly contagious nature of the disease, are obligated to develop AIDS prevention, education, intervention and treatment strategies for intravenous and other drug users.

PROBLEMS:

Comparatively speaking, South Carolina ranks 27 in reported AIDS cases among the states of the U.S. The state is rural which poses many of the familiar problems related to service accessibility and outreach programming. The influx of migrant laborers and seasonal workers also increases the challenge to alcohol and drug abuse agencies and other health care providers to provide AIDS education, prevention and treatment services. In South Carolina, as is the case nationally, the fear of the results and consequences of AIDS antibody testing being reported to employers, insurance carriers, families and others poses its own barriers.

Since alcohol and drug abuse treatment agencies offer a central location of contact with a high risk population not otherwise easily accessible, it is incumbent that these programs incorporate AIDS education into treatment processes. In addition, greater statewide emphasis on family counseling, grief counseling and "survival skills" counseling, must be included in training of alcohol and drug abuse service providers.

RECOMMENDATIONS FOR ACTION:

1. The SCCADA should continue to coordinate and provide AIDS education and training to staff of county alcohol and drug abuse authorities in South Carolina.
2. To the extent possible, SCCADA should appropriately modify existing approved curricula to include AIDS information in primary and secondary prevention programs as well as coordinate with and make maximum use of all available resources at the Department of Health and Environmental Control.
3. SCCADA should provide consultation and technical assistance to all county alcohol and drug abuse authorities in the development, review and evaluation of AIDS related policies and procedures.
4. SCCADA should explore appropriate legislation to address the existing public health problem of alcohol and drug abuse that is now further compounded by the AIDS virus.

D. SYSTEM SUPPORT

To provide a level of financial support to maintain existing treatment services and to provide the necessary intra-structure of administrative support.

Issues

1. Salary Upgrade
2. Facility Upgrade
3. Automation of County Commissions (MIS)

ISSUE: Salary Upgrade

GOAL: To enable county commissions to provide salaries which will attract and retain qualified, experienced and competent professional administrative, intervention and treatment staff.

EXPLANATION: The county authorities on alcohol and drug abuse need personnel who are capable of providing the best possible services for the public who are at risk or are experiencing problems with alcohol and drug abuse.

PRESENT SITUATION: The county commissions on alcohol and drug abuse employ approximately 480 full-time and 539 part-time employees. These personnel include secretaries, bookkeepers, intervention specialists, treatment counselors, prevention/education specialists, group leaders, and managers. The alcohol and drug abuse agencies require skilled, experienced professionals to be successful in providing effective intervention and treatment services to the public.

PROBLEMS: During the past few years it has become increasingly difficult for the county commissions to hire and retain qualified professional staff. The job market for these types of employees has become more competitive, particularly with the increase in the number of private and nonprofit inpatient and outpatient agencies. In addition, state employees have continued to receive regular annual cost of living increases. However, the staff of county commissions are not state employees and do not receive the raises granted to state employees. As a result it is becoming more difficult for the commissions to hire and retain the quality staff so important to effective service delivery. For FY87-88, the General Assembly appropriated funds for a 4 percent cost of living salary increase for the county commissions. However, this was the first time the State had appropriated such an increase, and there is no mechanism to insure that cost of living increases will be granted on a regular basis. In addition many local agencies need to upgrade the entire salary structure to bring them up to a competitive level with both the public and private sector. A means of upgrading salaries and implementing a regular, annual cost of living adjustment for county commissions staff is needed to minimize staff turnover and help them retain competent personnel.

RECOMMENDATIONS

FOR ACTION:

The State Appropriations Request for FY88-89 should include a request for additional funds to enable the State to assist county commissions to upgrade staff salaries to meet the minimums recommended by the SCCADA in its model classification system.

The State Appropriations Request for FY88-89 should include a request for an across-the-board five percent cost-of-living adjustment for all personnel.

A method of insuring future regular annual cost of living increases should be developed and implemented by the state and local commissions on alcohol and drug abuse.

ISSUE: Facility Upgrade

GOAL: To provide administrative, treatment, residential and detoxification facilities for all programs operated by the county commissions on alcohol and drug abuse.

EXPLANATION: Many of the alcohol and drug treatment facilities, including the administrative and counseling offices, detox centers, and halfway houses, are in need of repair or new facilities.

PRESENT SITUATION: South Carolina's alcohol and drug abuse service delivery system is little more than 10 years old even though its facilities are much older. In the developing years of the Act 301 System, funds were limited and emphasis was placed on developing effective staff and quality services, rather than on facilities. Many programs began in rented or inherited residences, stores and empty county office space. As funding increased, dollars went to services and SCCADA was unable to provide funds for buildings and maintenance. As a result, many present facilities are in varying states of disrepair and most agencies have outstripped space needs as a result of increased client loads. Some of the need is to meet licensing standards, minimum health and safety requirements and accessibility needs of the handicapped. SCCADA and the Council of County Alcohol and Drug Abuse Authorities are identifying long-range needs for facility upgrades for which funding will be requested on a prioritized basis in future years.

RECOMMENDATIONS FOR ACTION: SCCADA should undertake a study of local commission facilities to determine statewide needs, both present and future. In addition alternative funding mechanisms for capital improvements should be explored.

ISSUE: Automation of County Commission Information Systems

GOAL: To facilitate the automation of county commission's management and client information systems.

EXPLANATION: The county authorities on alcohol and drug abuse are at various stages of computerization of their record keeping. There is a need to insure that a coordinated, planned approach between SCCADA and the local programs occur.

PRESENT SITUATION: Six of the commissions have purchased and implemented an automated data processing system. The Lexington/Richland Alcohol and Drug Abuse Council and the Charleston Substance Abuse Commission have both purchased small main frame computers. The Anderson/Oconee Commission on Alcohol and Drug Abuse has a mini-computer. The Spartanburg, Tri-County and Florence Commissions have micro-computers. The larger systems are used for accounting, billing, budgeting and client information. The micro-computers are used primarily for accounting and budgeting purposes. Presently the Florence Commission has contracted with a consultant to develop software for a client management package. A number of other county commissions are interested in using this package.

PROBLEM ANALYSIS: With the increasing workload, the commissions need to implement more efficient methods of handling paperwork. In addition, automation can improve the efficiency of transmitting information to the State Office. This includes their submission of client data, plans, budgets and expenditure reports.

RECOMMENDATIONS FOR ACTION: SCCADA should continue to encourage and assist the county authorities on alcohol and drug abuse to computerize their record keeping systems. SCCADA should provide technical assistance to insure that those agencies who do decide to automate, select a system which is appropriate for their agency, reasonable in cost, is flexible enough for future growth, and can communicate with the state management information system.

## CHAPTER VI

## PRIORITIES FOR THE FY88-89 APPROPRIATIONS REQUEST

On August 27, 1987, the State Commission on Alcohol and Drug Abuse made its budget request for FY88-89 to the Budget and Control Board. The following is a summary of SCCADA's funding priorities:

1. Provide funds for implementation of a standard classification and compensation system for county alcohol and drug abuse authorities in order to bring 480 individuals currently below the minimum compensation levels up to these minimum levels. $1,295,000

2. Provide funds for cost-of-living increases for county alcohol and drug abuse personnel. $677,586

3. Provide funds for additional personnel for intervention, treatment and Medicaid programs and to support the agency's training efforts. $171,867

4. Provide funds to expand from two to four the number of Teen Institutes held each year in order to make the program available to teams from 200 high schools. $130,000

5. Provide funds to partially reinstate reductions made in FY88 through the Governor's veto in June 1987 and the reduction announced in January 1987. $205,860

6. Provide funds for 19 intervention specialists to fully staff Alcohol and Drug Safety Action Programs (ADSAP) and eliminate delays in services in 29 counties. $475,000

7. Provide funds to enhance SCCADA's use of information technology to improve efficient in internal operations and management of services at both the state and local levels. $261,791

8. Provide funds to fully implement the Involuntary Commitment Act for alcoholics and drug addicts enacted in 1986. $660,000

9. Provide funds to make the School Intervention Program (ScIP) available in all public schools by adding 12 ScIP coordinators to provide services in 12 county alcohol and drug abuse authorities serving 15 counties. $300,000

10. Provide funds to expand primary prevention services into schools and communities in 26 counties currently underserved by adding 14 primary prevention specialists. $350,000

11. Provide funds for purchase of printed and audiovisual educational materials for use by schools, youth groups and the general public. $30,000

12. Provide funds to expand prevention programs for institutionalized youth to institutions currently unserved but which have youthful populations considered to be at high risk for alcohol and drug abuse. $271,000

13. Provide funds to develop educational materials and inservice training for county alcohol and drug abuse authority personnel on prevention and detection methods as well as precautionary measures to be used when working with intravenous drug users, a high-risk group for transmission of the AIDS virus. $45,000

14. Provide one-time funds to improve the physical facilities of five county alcohol and drug abuse authorities in order to meet licensing standards and eliminate inappropriate client service settings. $417,500

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# A P P E N D I X

APPENDIX A
THE 301 AGENCIES IN SOUTH CAROLINA

ABBEVILLE
Abbeville County Commission
on Alcohol and Drug Abuse
111 South Main Street
Abbeville, S.C. 29620

AIKEN
Aiken County Commission on
Alcohol and Drug Abuse
214 Newberry Street, SW
Aiken, South Carolina 29801

ALLENDALE
Allendale Commission on
Alcohol and Drug Abuse
P. O. Box 594
Allendale, South Carolina 29924

ANDERSON
Anderson/Oconee Alcohol and
Drug Abuse Commission
212 S. Main Street
Anderson, South Carolina 29624

BAMBERG
Tri-County Commission on
Alcohol and Drug Abuse
Mid Town Office Plaza
Bamburg, South Carolina 29003

BARNWELL
Barnwell County Commission on
Alcohol and Drug Abuse
P. O. Box 1042
Barnwell, South Carolina 29812

BEAUFORT
Beaufort County Commission on
Alcohol and Drug Abuse
P. O. Box 311
Beaufort, South Carolina 29901

BERKELEY
Berkeley County Commission on
Alcohol and Drug Abuse
P. O. Box 758
Moncks Corner, South Carolina 29461

CALHOUN
Tri-County Commission on
Alcohol and Drug Abuse
111 West Bridge Street
St. Matthews, South Carolina 29135

CHARLESTON
Charleston County Substance
Abuse Commission
P. O. Box 2635
Charleston, South Carolina 29403

CHEROKEE
Cherokee County Commission on
Alcohol and Drug Abuse
200 West Montgomery Street
Gaffney, South Carolina 29340

CHESTER
Chester County Commission on
Alcohol and Drug Abuse
P. O. Box 636
Chester, South Carolina 29706

CHESTERFIELD
Tri-County Mental Health Center
P. O. Box 471
Chesterfield, South Carolina 29709

CLARENDON
Clarendon County Commission on
Alcohol and Drug Abuse
P. O. Box 361
Manning, South Carolina 29102

COLLETON
Colleton County Commission on
Alcohol and Drug Abuse
P. O. Box 1037
Walterboro, South Carolina 29488

DARLINGTON
Darlington County Commission on
Alcohol and Drug Abuse
510 East Carolina Avenue
Hartsville, South Carolina 29550

DILLON
Marion/Dillon County Commission on
Alcohol and Drug Abuse
104 East Harrison Street
Dillon, South Carolina 29536

DORCHESTER
Dorchester County Commission on
Alcohol and Drug Abuse
535 North Cedar Street
Summerville, South Carolina 29483

EDGEFIELD
Greenwood/Edgefield/McCormick
Commission on Alcohol & Drug Abuse
400 Church Street
Edgefield, South Carolina 29824

FAIRFIELD
Fairfield County Substance
Abuse Commission
P. O. Box 388
Winnsboro, South Carolina 29180

FLORENCE
Florence County Commission on
Alcohol and Drug Abuse
P. O. Box 4881
Florence, South Carolina 29502

GEORGETOWN
Georgetown County Alcohol and
Drug Abuse Commission
123 Winyah Street
Georgetown, South Carolina 29440

GREENVILLE
Greenville County Commission on
Alcohol and Drug Abuse
3336 Buncombe Road
Greenville, South Carolina 29609

GREENWOOD
Greenwood/Edgefield/McCormick
Commission on Alcohol & Drug Abuse
1132 Spring Street
Greenwood, South Carolina 29646

HAMPTON
Hampton County Commission on
Alcohol and Drug Abuse
P. O. Box 885
Hampton, South Carolina 29810

HORRY
Horry County Commission on
Alcohol and Drug Abuse
P. O. Box 136
Conway, South Carolina 29526

JASPER
Jasper County Commission on
Alcohol and Drug Abuse
P. O. Box 1362
Ridgeland, South Carolina 29936

KERSHAW
Kershaw County Commission on
Alcohol and Drug Abuse
P. O. Box 416
Camden, South Carolina 29020

LANCASTER
Lancaster County Commission on
Alcohol and Drug Abuse
P. O. Box 1627
Lancaster, South Carolina 29720

LAURENS
Laurens County Commission on
Alcohol and Drug Abuse
P. O. Box 843
Laurens, South Carolina 29360

LEE
Lee County Commission on
Alcohol and Drug Abuse
P. O. Box 302
Bishopville, South Carolina 29010

LEXINGTON
Lexington/Richland Alcohol and
Drug Abuse Council
134 North Hospital Drive
West Columbia, South Carolina 29169

MARION
Marion/Dillon County Commission on
Alcohol and Drug Abuse
103 Court Street
Marion, South Carolina 29571

MARLBORO
Marlboro County Commission on
Alcohol and Drug Abuse
100 West Main Street
Bennettsville, South Carolina 29512

McCORMICK
Greenwood/Edgefield/McCormick
Commission on Alcohol & Drug Abuse
Post Office Box 337
McCormick, South Carolina 29835

NEWBERRY
Newberry County Commission on
Alcohol and Drug Abuse
P. O. Box 738
Newberry, South Carolina 29108

OCONEE
Anderson/Oconee County Commission on
Alcohol and Drug Abuse
210 North Second Street
Seneca, South Carolina 29678

ORANGEBURG
Tri-County Commission on
Alcohol and Drug Abuse
P. O. Box 1365
Orangeburg, South Carolina 29116-1365

PICKENS
Pickens County Commission on
Alcohol and Drug Abuse
134 North Main Street
Pickens, South Carolina 29671

RICHLAND
Lexington/Richland Alcohol and
Drug Abuse Council
P. O. Box 50597
Columbia, South Carolina 29250

SALUDA
Saluda County Alcohol and
Drug Abuse Commission
P. O. Box 157
Saluda, South Carolina 29138

SPARTANBURG
Spartanburg Alcohol and
Drug Abuse Commission
Post Office Box 1251
Spartanburg, South Carolina 29304

SUMTER
Sumter County Commission on
Alcohol and Drug Abuse
P. O. Box 39
Sumter, South Carolina 29150

UNION
Union County Commission on
Alcohol and Drug Abuse
P. O. Box 844
Union, South Carolina 29379

WILLIAMSBURG
Williamsburg County Commission on
Alcohol and Drug Abuse
P. O. Box 506
Kingstree, South Carolina 29556

YORK
York County Council on
Alcohol and Drug Abuse
P. O. Box 4437
Rock Hill, South Carolina 29731-4437

FY86 Occupancy Rates of Substance Abuse Facilities

| Facility | | Percent Occupancy | Beds |
|---|---|---|---|
| HSA Coastal Carolina Hospital | total- | 46.9 | 98 |
| | alcohol- | 27.7 | 53 |
| | psych- | 69.6 | 45 |
| Charter Rivers | total- | 72.7 | 80 |
| | alcohol- | 45.8 | 57 |
| | psych- | 139.5 | 23 |
| Brierwood | total- | 63.3 | 60 |
| | alcohol- | 58.8 | 45 |
| | psych- | 77.0 | 15 |
| Fenwick Hall | total- | 85.8 | 40 |
| | alcohol- | 64.5 | 32 |
| | psych- | 171.0 | 8 |
| Palmetto Center | total- | 75.2 | 48 |
| Holmesview Center | total- | 88.0 | 40 |
| North Greenville Hospital | total- | 76.9 | 48 |
| Elliott White Springs | total- | 57.6 | 45 |
| Bruce Hospital | total- | 53.5 | 30 |
| Baker Hospital | total- | 32.9 | 44 |
| Morris Village | total- | 75.5 | 173 |

STATE PLAN UPDATE
POSSIBLE TOPICS/ISSUES/PROBLEMS FOR ANALYSIS/DISCUSSION

Chapter IV: Funding (Note: Items 1-10 are from the Agency Appropriations Request for FY88)

| Staff Assignment | | Unmet Needs |
|---|---|---|
| _____ | 1. | Expansion of prevention services. |
| _____ | 2. | Full implementation of Involuntary Commitment Act. |
| _____ | 3. | Expansion of ScIP. |
| _____ | 4. | Full implementation of Children's Coordinating Cabinet recommendations. |
| _____ | 5. | Cost of living increases. |
| _____ | 6. | Education campaign on cocaine. |
| _____ | 7. | Additional ADSAP intervention specialists. |
| _____ | 8. | Management Information Systems. |
| _____ | 9. | Capital improvements for local commissions. |
| _____ | 10. | Statewide training and credentialing system. |
| _____ | 11. | Detoxification resources for HSA III. |
| _____ | 12. | Inpatient treatment program for the Department of Corrections. |
| _____ | 13. | Demonstration Projects |
| | | a. MUSC<br>b. Outpatient Detox<br>c. Women Initiatives<br>d. Appalachian Health Council, etc. |
| _____ | 14. | Client management system automation by county commissions. |
| _____ | 15. | DHEC Licensing Standards. |
| _____ | 16. | Training |
| _____ | 17. | Body fluids legislation. |
| _____ | 18. | Increased penalties for DUS |

_____ 19. Potential funding resources

a. Third party reimbursement
b. HMOs
c. Medicaid
d. Medically indigent assistance fund
e. Federal funds
   (1) Highway Safety
   (2) Bureau of Justice Assistance
   (3) Human Services Integration Project
f. ABC
g. Surtax

_____ 20. Demand reduction strategies.

_____ 21. AIDS

_____ 22. Revision of problem estimation methodology.

_____ 23. Raising the drinking age evaluation.

_____ 24. DUI follow-up evaluation.

_____ 25. ScIP Implementation Program Report

_____ 26. Teen centers

_____ 27. Certificates of need for alcohol/drug facilities

_____ 28. State Health Plan

_____ 29. Memorandums of agreement

_____ a. DP & CC
_____ b. DOE
_____ c. DMH
_____ d.
_____ e.
_____ f.

PROPOSAL
FOR AN
ALCOHOL AND DRUG TREATMENT UNIT
WATKINS PRE-RELEASE CENTER

## Introduction

A committee comprised of representatives of the Department of Corrections, the Department of Parole and Community Corrections and the State Commission on Alcohol and Drug Abuse met to develop this plan for the treatment unit.

## Problem Statement

During FY86, 43 percent of the inmates admitted to the Department Corrections reported that they committed their offenses while under the influence of alcohol and/or drugs. Three hundred fifty of the incoming inmates were admitted for DUI offenses.

## Impact Statement

This facility and program will provide the Department of Corrections with the capability to implement an intensive, inter-disciplinary, short-term, residential treatment program for inmates with alcohol and drug problems. In addition, the program will include a statewide system for aftercare services to continue the treatment process for inmates released from the unit. This system will utilize the resources of both state and local agencies and organizations, including AA, NA and other volunteer groups.

The goal of this program is to reduce the recidivism of offenders with alcohol and drug abuse problems.

## Facility

It is being proposed a 48-bed male dormitory be built at Watkins Pre-Release Center in Columbia. Attached to this building will be offices and activity areas for staff and inmates for a comprehensive alcohol and drug treatment program.

Recommended components for these offices and activity areas are:

1) Fourteen private offices for treatment counselors and administrative staff.

2) Five sound proof group rooms. Two of the rooms should be large enough to accommodate 25 to 30 persons each. A one-way mirror should be installed in one of the rooms for training purposes.

3) A lounge large enough to accommodate 50 persons which will be used during the day and evenings.

4) A multi-purpose building for AA/NA meetings, community meetings, recreational activities and weights/exercise area.

The existing cafeteria will serve the new dorm.

Program

The alcohol and drug abuse program will be a voluntary, highly structured, residential treatment program. Female inmates will be transported to the unit from the Women's Correctional Center.

The projected length of the program will be 60 days; however, the inmate's time in the program will be contingent upon his/her progress in treatment.

The program activities will be scheduled for seven days a week and will include orientation and educational sessions, individual and group therapy, lectures, films, as well as other treatment approaches developed by the staff. When possible, involvement of families will be a part of the program. The 60-day program will be divided into several defined phases including: assessment/evaluation, orientation, education, treatment, discharge and institutional or community-based aftercare.

Referrals to the Program

Referrals of inmates to the unit can be made by the Reception and Evaluation Center or other institutions based upon the needs of the inmate and the program selection criteria. Priority will be given to inmates as they near eligibility for work/pre-release. Referral to the unit would require the recommendation by both the institutional classification officer and the social worker and is subject to approval by the institution warden. Acceptance to the program would depend upon treatment unit staff and the superintendent of the Watkins Pre-Release Center.

An objective of the program is to schedule inmates in such a manner to facilitate the continuity of treatment programming back to the community. Additionally, scheduling would follow a logical sequence of pre-release and work release activities leading to placement in the community-based programs such as extended work release, probation, and parole.

Aftercare

Aftercare programming will occur for inmates leaving the unit and returning to correctional facilities as well as for those released to probation, parole and community-based programs. For inmates going back to correctional facilities, institutional case management will ensure appropriate utilization of Vocational Rehabilitation, AA/NA and other treatment/social work services important to the success of the inmate.

Inmates released to community-based programs (extended work release, probation and parole) will be referred to local treatment agencies for continuing alcohol and drug treatment services. In addition, other local programs such as Vocational Rehabilitation, AA and NA will be utilized. Case management for probationers and parolees will be provided by the Department of Parole and Community Corrections.

## Staffing

In order to provide the intensive, seven-day-a-week treatment regimen desirable, the following treatment staffing is proposed.

Six alcohol and drug counselors
One social worker (family program coordinator)
Three administrative support staff
One medical technician
Two activity therapists
One psychologist

In addition, the unit will contract with a licensed psychologist for consultant services to provide a totally independent, periodic assessment of the treatment program. The facility will also expand their contract with the Department of Vocational Rehabilitation to provide assessment and aftercare services.

Staffing would include recovering persons. AA and NA volunteers would be utilized in the treatment process.

## Drug Testing

Based upon 60 inmates participants and weekly testing at $7 per test, total cost for drug testing will be about $22,000 per year. It is recommended that these tests be used only for program purposes by treatment staff and not for disciplinary actions. Written guidelines for drug testing should be established.

## Department of Corrections

The Department of Corrections proposes to use construction monies for the building of the 48-bed dorm and space for the unit - both offices and program areas. However, the use of these funds for this project is subject to the approval of the Budget and Control Board and the Joint Bond Review Committee.

In addition, the Department of Corrections will provide for a unit manager to oversee the program and eight correctional officers to provide security.

PROPOSED 48-BED ALCOHOL AND DRUG TREATMENT FACILITY
SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
WATKINS PRE-RELEASE CENTER
COLUMBIA, SOUTH CAROLINA

PROGRAM PHASES

| IDENTIFICATION AND REFERRAL | INPATIENT TREATMENT PROGRAM | AFTERCARE PROGRAM<br>CORRECTIONAL FACILITIES | <br>COMMUNITY PROGRAMS |
|---|---|---|---|
| Inmates meeting classification requirements who have identified alcohol and drug abuse problems will be referred to the Watkins Alcohol and Drug Treatment Center. Assessments will help to identify inmates who show promise of responding favorably to the treatment program. | Inmates will participate in a 30 to 60-day program divided into several defined phases: assessment/evaluation, orientation, education, treatment, discharge and institutional or community-based after-care planning. | Institutional case management will ensure appropriate utilization of Vocational Rehabilitation, AA/NA and other treatment/social work services important to the continued rehabilitation of the inmate. | Inmates released to community-based programs (extended work release, probation and parole) will be referred to local treatment agencies for continuing alcohol and drug treatment services. These local programs include Vocational Rehabilitation, County Probation Offices, AA/NA, and County Commissions on Alcohol and Drug Abuse. |



| CORRECTIONAL FACILITIES | ALCOHOL/DRUG TREATMENT CENTER | CORRECTIONAL FACILITIES | COUNTY COMMISSIONS ON ALCOHOL/DRUG ABUSE |
|---|---|---|---|

1 TO 3 YEARS

TR/hco/4-3-87(4)

Budget Summary - Treatment Component Only

| Number | Position | Grade | Salary Mid-Point | Total |
|---|---|---|---|---|
| 5 | Counselors | 29 | $22,840 | $114,200 |
| 2 | Counselors | 32 | 25,693 | 51,386 |
| 2 | Administrative Support Specialist B | 20 | 16,047 | 32,094 |
| 1 | Administrative Support Specialist C | 22 | 17,355 | 17,355 |
| 1 | Medical Technician I | 27 | 21,118 | 21,118 |
| 2 | Activity Therapist I | 24 | 18,773 | 37,546 |
| 1 | Psychologist II | 32 | 25,693 | 25,693 |
| | Salaries | | | $299,392 |
| | Fringe (at .19%) | | | 56,884 |
| | Total | | | $356,276 |

Five counselors (Social Worker III, Bachelor's Degree plus three year's experience), two counselors (Social Worker IV, Master's plus three year's experience).

Contract Psychologist

12 hours/month X 12 months/year @ $75 per hour = $10,800/year

Expanded Contract - Vocational Rehabilitation

$20,000

Travel

12 staff X $300 = $3,600
2 staff X $1,200 = 2,400

Total $6,000

Training

14 staff X $300 each/year = $4,200

Office Supplies

14 staff X $300 each/year - $4,200

Equipment

$74,000

# The Alcohol Policy Bill of Rights

## Preamble

Alcoholic beverages, when used, pose potential risks to the health and safety of individuals, communities and society. Public policies regarding alcohol availability and consumption should be designed to minimize the risk of misuse. The following principles are offered to serve as a guide:

1. ***Abstinence is always an acceptable choice.***

2. ***Alcohol consumption considered to be high risk is actively discouraged.***

   The South Carolina Commission on Alcohol and Drug Abuse has developed guidelines to help identify those persons likely to engage in high-risk consumption. In accordance with these guidelines, individuals possessing or performing any of the following characteristics or behaviors should abstain from the use of alcoholic beverages:

   - a personal history of addiction to chemicals;
   - driving or operating machinery;
   - current use of other central nervous system depressants or any other psychoactive drugs;
   - younger than the legal purchase age of 21 (except in the presence of a parent or legal guardian or in religious ceremonies);
   - during pregnancy or when considering pregnancy;
   - a strong family history of depression or alcoholism; or
   - has experienced a very stressful day.

   (Sources: National Institute on Alcohol Abuse and Alcoholism, Prevention Research Institute, Inc. and South Carolina Commission on Alcohol and Drug Abuse)

3. ***Alcohol consumption considered to be low risk is acceptable.***

   The South Carolina Commission on Alcohol and Drug Abuse has developed guidelines for the low-risk consumption of alcoholic beverages. In accordance with these guidelines, individuals who are **not** at high risk may choose to:

   - abstain;
   - consume no more than three drinks* at any given setting, 0-4 days per week;
   - consume no more than two drinks* at any given setting, 0-6 days per week; or
   - consume no more than an average of one-and-one-half drinks* daily.

   (Sources: National Institute on Alcohol Abuse and Alcoholism, Prevention Research Institute, Inc. and South Carolina Commission on Alcohol and Drug Abuse)

4. ***Heavy alcohol consumption is discouraged in all situations.***

| * Beverage | Ethanol by Volume | Average Drink | Absolute Ethanol per Drink |
|---|---|---|---|
| Beer | 4.5% | 12 oz. | .54 oz. |
| Distilled Spirits | 40% | 1.5 oz. | .60 oz. |
| Wine | 12% | 5 oz. | .60 oz. |

(Source: National Clearinghouse for Alcohol Information)

These four principles are demonstrated in the following rights for all citizens of our nation:

## I
## The Right to Know

Consumers have the right to accurate and easily accessible information about alcohol, including the rights to:

A. alcohol warning and beverage ingredient labeling, so the consumer knows the potential health risks of alcohol;

B. prominent display of information about health risks related to alcoholic beverages (e.g. posters);

C. equal time for public health counter-advertising to provide accurate and balanced information in the media about alcohol; and

D. the elimination of misleading alcohol advertising.

## II.
## The Right to Safe Communities and Roadways

Citizens have the right to collective protection from negative behaviors of individuals under the influence of alcohol, including the rights to:

A. certain and swift enforcement of strict DUI laws;

B. mandated server intervention programs and liability information to ensure that those selling and serving alcoholic beverages are minimizing the risks that patrons will harm themselves or others;

C. local and state alcoholic beverage regulations that control the number, location and types of alcoholic beverage outlets so that high-risk settings are prohibited;

D. adequate funding of the Alcoholic Beverage Control Commission and strict enforcement of all alcohol availability laws; and

E. insurance incentives for safe and sober driving.

## III.
## The Right to Health-Enhancing Alcohol Pricing

Society has the right to alcohol prices which minimize health risks and which accurately reflect the health and social costs associated with alcohol consumption, including the rights to:

A. adequate tax rates, so that high-risk alcohol consumption is discouraged and the price of alcohol reflects the true cost of alcohol problems to society; and

B. equalized tax rates applied to all forms of alcoholic beverages, so that the public knows all forms of alcohol pose risks to health.

## IV.
## The Right to Protect Our Youth

Society has the right and responsibility to take measures to halt the epidemic of alcohol-related deaths and injuries among youth, including the rights to:

A. adequate funding for alcohol prevention/education programs;

B. adequate enforcement of the state's minimum-age purchase law; and

C. an end to alcohol promotions aimed at youth, including alcohol promotional activities on college or university campuses.

## V.
## The Right to Safe Workplaces

Employees have the right to workplaces free of pressures to consume alcohol, including the rights to:

A. an end to the pressure to use alcohol as a part of conducting business;

B. an end to federal tax subsidies for corporate alcohol use;

C. an end to government subsidies for alcohol in the armed forces; and

D. adequately funded employee assistance programs for all employees seeking help in overcoming alcohol problems.

## VI.
## The Right to Health Services

Citizens have the right to adequate health services for the alleviation of suffering associated with alcohol-related problems, including the rights to:

A. effective, low-cost recovery services available to the entire public; and

B. assistance programs that provide financial reimbursement and emotional and medical support for the victims of alcohol-related incidences.

*Adapted by the South Carolina Commission on Alcohol and Drug Abuse from the Alcohol Policy Bill of Rights as developed by the Alcohol Policy Council of the National Association of Public Health Policy*

*Adopted January 18, 1987, by the South Carolina Commission on Alcohol and Drug Abuse*

**South Carolina Commission on Alcohol and Drug Abuse**
**3700 Forest Drive**
**Columbia, South Carolina 29204**
An EEO/Affirmative Action Employer

# MEMORANDUM OF AGREEMENT

## Statement of Purpose

The South Carolina Commission on Alcohol and Drug Abuse (SCCADA) and the South Carolina Department of Mental Health (SCDMH) have both been vested with major responsibilities for the provision of services to persons with identified problems of alcohol and drug abuse. Both agencies recognize that these responsibilities can be most effectively carried out in a climate where unity of purpose and a spirit of cooperation prevail. In a period of current resource limitation, it becomes all the more important to identify those areas where mutuality can be stressed, separate responsibilities clearly delineated, and sharing of resources actively promoted. The following memorandum of agreement is intended as a major step in this direction. It is further hoped that the document will provide a model for continued cooperation between the autonomous county alcohol and drug abuse authorities and the Earle E. Morris, Jr. Alcohol and Drug Addiction Treatment Center.

### A. Data Exchange

SCCADA and SCDMH agree to the exchange of available data on a regular basis to assist in the planning and coordination of statewide treatment services for alcohol and drug abusing clients. Such information shall include, but not be limited to, admission/discharge data, demographic characteristics of the population receiving service, and trend data of drugs and abuse. Reports will be provided on an annual basis covering clients receiving services in county alcohol and drug programs, community mental health centers (alcohol and/or drug-related diagnosis only), and Morris Village. Mental Health Center statistics will be provided by the Division of Community Mental Health Services. When planning requirements dictate a more frequent exchange of information, each agency pledges its (fullest) efforts in furnishing the data required.

The SCDMH agrees to invite the Director of SCCADA's Division of Planning, Evaluation, and Grants Management or his designee to sit as a member of the Department's Committee on Research and Human Rights.

### B. Training

Both SCCADA and SCDMH offer extensive training opportunities for personnel at all levels of responsibility in their respective programs. Each agency is committed to the idea of promoting a greater awareness of training opportunities under the other's sponsorship, leading to an increased sharing of training resources. To this end, both agencies and their respective training components agree to the following:

1. *A meeting will be held annually between representatives of the SCCADA Division of Community Support Services, the SCDMH Staff Development Office, and the Morris Village Program Development and Training Office. This meeting, convened in alternate years by Morris Village PD&T and by SCCADA, will serve to identify training needs and resources in the area of addictions, to eliminate inappropriate duplication, and to coordinate training schedules.*

2. *The SCCADA Division of Community Support Services and the SCDMH Staff Development Office agree to the exchange of training calendars twice yearly, as soon as schedules are firmly established.*

3. *SCDMH and SCCADA will continue to work cooperatively to insure compliance of their training programs to meet the need of both agencies' addictions counselors for the requirements of the Addictions Counselor Certification Review Board.*

4. *Morris Village and SCCADA agree to exchange training personnel to conduct specific workshops where appropriate.*

5. *SCCADA and SCDMH agree to the exchange of a specified number of training slots at no charge (or a nominal fee only) to participants in programs conducted by the SCCADA Division of Community Support Services will continue to make slots available in each of their training programs, on a space available basis, with the full knowledge that cross-fertilization between the two agencies' people and ideas is mutually beneficial and productive.*

C. *Planning*

*Recognizing that a careful and rational planning process is essential to the provision of a coordinated response to the prevention, intervention, and treatment needs in alcohol and drug abuse, SCCADA and SCDMH agree to the following:*

1. *The director of SCCADA will designate a staff member to serve on the SCDMH Advisory Committee to the State Mental Health Plan.*

2. *The Department of Mental Health shall be represented on the State Plan Task Force which assists SCCADA in the development of the State Alcohol and Drug Abuse Plan.*

*In addition, both agencies agree to inform the other of specific monies which may become available at the federal or state level for funding of alcohol and drug abuse services. When issuing a request for proposal, each will insure that all pertinent information is provided as appropriate to the other for those projects in which the agency/department has a legitimate interest in proposal development. All exchange of information concerning financial assistance and proposal development shall be coordinated through the Director, SCCADA Division of Planning, Evaluation and Grants Management, and the Director, Morris Village, for appropriate routing of such information. Additionally, community mental health centers shall have timely access to this information.*

D. *Implementation of SCCADA Advisory Role to SCDMH*

*Paragraph 44-51-210 of Chapter 51, Article 1 of the South Carolina Code of Laws stipulates that the Department shall cooperate with SCCADA to insure that its treatment effort is part of the overall complete state plan for alcohol and drug abuse. The paragraph further states that "the commission on Alcohol and Drug Abuse shall serve in an advisory capacity on matters concerning the implementation of the provisions of this Article."*

*In order to insure the effective implementation of this legislation, SCDMH agrees to inform SCCADA of significant changes and progress in the structure, organization and extent of its treatment service delivery. Liaison at the state level between the Department and the Commission on matters pertaining to treatment of alcohol and drug abuse clients shall be determined at the discretion of the Commissioner of SCDMH and the Director of the SCCADA.*

E. *Promotion of Effective Interagency Referral Procedures*

*SCCADA and SCDMH recognize that county alcohol and drug authorities currently represent the largest single source of referrals to Morris Village and, conversely, that Morris Village is the largest single provider of intensive inpatient treatment in the State. To enhance continuity of care between community-based services and those provided at Morris Village, SCCADA and SCDMH agree to the following steps designed to improve the flow of referral information:*

1. *SCCADA will encourage local alcohol and drug agencies which currently have medical capability to provide a medical history and physical examination information on all clients being referred in accordance with all applicable confidentiality regulations or laws.*

2. *SCCADA will actively promote the consistent transmission by local alcohol and drug authorities of client referral information needed by Morris Village.*

3. *SCCADA will seek to have Morris Village enter into a "qualified service organization agreement" with local alcohol and drug agencies as allowed in specified federal confidentiality regulations for alcohol and drug abuse patient records (42CFR Part 2).*

4. *SCDMH will refer the resident back to the referring local alcohol and drug agency, provided the resident is in agreement with this aftercare plan.*

5. *SCDMH will encourage local programs to follow-up with discharged Morris Village residents who have been referred to them.*

6. *Both SCCADA and SCDMH agree to encourage the development of Memoranda of Agreement between service providers. Within SCDMH, the Assistant State Commissioner, Division of Planning and Programs will serve in the primary review capacity and will review all Memoranda of Agreement prior to their implementation.*

F. *Intervention, Including Preventive Intervention*

*The SCCADA and SCDMH are both involved in a variety of early intervention efforts. The objective of such programs is to identify individuals who are manifesting indications of developing alcohol and drug abuse problems or behavioral and psychological disorders. These individuals may evidence difficulties with work-related activities, social interactions, relationships, personal habits, etc., or they may exhibit frank signs of medically definable mental illness.*

*Recognizing that effective intervention programs will identify persons who require a variety of community services, the SCCADA and the SCDMH agree to the following:*

1. *Efforts will be made to encourage local alcohol and drug programs and community mental health centers to develop working agreements for intervention programming whenever plans for new intervention programs are initiated.*

2. *SCCADA will seek SCDMH input into the design of intervention programs through soliciting participation in the following activities:*

   a. *Membership on the Intervention Advisory Committee--a SCCADA committee which reviews all intervention programs.*

   b. *Membership on the School Advisory Committee--a body charged with review of all SCCADA school-based activities such as ScIP and other school-based prevention and/or intervention programs.*

3. *Both SCCADA and SCDMH are actively involved in providing employee assistance and occupational programs for business and industry. The SCCADA and SCDMH will encourage communication between local alcohol and drug commissions and community health centers as they continue to develop and market prevention and intervention programs to meet the needs of local employees and employers.*

G. *Prevention*

*The SCDMH and the SCCADA promote programs that enhance healthy development and effective living skills. These programs aim at preventing the development of alcohol and drug abuse and mental and emotional disorders.*

*SCCADA and SCDMH have cooperated in the development and implementation of several primary prevention programs such as peer facilitation, the Columbia Outdoor Alternatives Program and information programs on drug use by the elderly. Both agencies are members of the South Carolina Primary Prevention Council and are actively involved in the development and delivery of Carolina's Primary Prevention Conference. SCCADA and SCDMH agree to continue the cooperative development of primary prevention programs.*

*The above agreements will be reviewed annually by the State Commissioner of Mental Health, South Carolina Department of Mental Health, and the Director, South Carolina Commission on Alcohol and Drug Abuse.*

William D. Hall M.D.
*William S. Hall, M.D.*
*State Commission of Mental Health*
*South Carolina Department of Mental Health*

William J. McCord
*William J. McCord, Director*
*South Carolina Commission on Alcohol and Drug Abuse*

*Review Date*

*WLB/ew*
*2/26/85*

MEMORANDUM OF AGREEMENT BETWEEN
THE SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH AND
THE SOUTH CAROLINA COMMISSION ON ALCOHOL AND DRUG ABUSE

## Purpose

It is the purpose of this memorandum of agreement to specify the specific roles and responsibilities of the two agencies in identification and treatment of citizens of the State who are seriously and chronically addicted to alcohol or other drugs.

## Objectives

1. To develop community-based identification, triage, treatment planning and delivery and follow-up;

2. To ensure continuity of care across the two agencies and across the community and centralized treatment programs;

3. To ensure that all serious, chronically addicted persons are identified and served in the local communities of the State;

4. To provide for the operation of a central treatment program, administered by the Division of Alcohol and Drug Abuse of the South Carolina Department of Mental Health, for involuntary treatment of persons when necessary.

## General

It is agreed that, by virtue of its responsibility for institutional services, the South Carolina Department of Mental Health has primary responsibility for all seriously and chronically addicted persons. It is further agreed that funding for specific programs operated by each agency will be appropriated to the responsible agency. Memoranda of agreement and contracts may be executed among the State and local agencies, including payment provisions, for additional treatment services currently not available.

## Responsibilities

South Carolina Department of Mental Health. It is the responsibility of the South Carolina Department of Mental Health to be responsible, through the community mental health system, for assuring services in the least restrictive setting possible for all persons of the State exhibiting symptoms of serious, chronic addiction. Specifically, the Department is responsible for:

1. Establishment of a network with other agencies, organizations, law enforcement, hospitals and health care professionals which will assure timely identification of persons seriously and chronically addicted;

2. Establishment of an effective triage process in every county which includes staff of the local community mental health center and local 301 commission with the Probate Judge;

3. Treatment planning, case management and service delivery, when designated in the triage process, to all seriously, chronically addicted individuals;

4. Ensuring admission to the appropriate community, regional and central treatment program, liaison with the program to which admitted and follow-up/discharge planning and services;

5. Provision of 24-hour emergency services to evaluate, treat and provide appropriate disposition of seriously and chronically addicted individuals; and,

6. Operation of a thirty-bed central treatment program to treat chronic, seriously addicted persons who have resisted community treatment programs and have been determined by the local mental health center to be appropriate for involuntary centralized treatment due to an inability to treat locally.

South Carolina Commission on Alcohol and Drug Abuse. It is the responsibility of the South Carolina Commission on Alcohol and Drug Abuse, through the local 301 Commissions, to provide education and preventive services and to provide community and regional services to persons of the State exhibiting symptoms of serious, chronic addiction. Specifically, the Commission is responsible for:

1. Timely identification of persons seriously and chronically addicted through its system and networks with other agencies, organizations, law enforcement, hospitals and health care professionals;

2. Participation in the triage process in every county with the staff of the local community mental health center and Probate Judge;

3. Treatment planning, case management and service delivery, when designated in the triage process, to seriously, chronically addicted individuals;

4. Referral to the local community mental health center, for evaluation and disposition, of all persons who are suspected of being in need of involuntary hospitalization in a facility of the South Carolina Department of Mental Health;

5. Operation of regional detoxification programs capable of providing services to persons both voluntarily and involuntarily admitted to the program; and,

6. Provision of all appropriate services to persons who are not seriously, chronically addicted and are not in need of mental health services.

The South Carolina Department of Mental Health and the South Carolina Commission on Alcohol and Drug Abuse agree to joint responsibility to:

1. Fully disclose clinical and demographic information to each other including a "qualified service organization agreement" as specified in Federal Confidentiality Regulations for alcohol and drug abuse patient records (42 CFR Part Two) between each community mental health center and local 301 commission which serve common geographic areas;

2. Determine through the triage process the local agency which will provide case management and treatment services to each individual identified as seriously, chronically addicted;

3. Fully disclose to each other information concerning staff, program and other resources available in each county;

4. Cooperate fully with each other in acceptance of persons for treatment into programs under the purview of each;

5. Share training opportunities and resources with staff of each other;

6. Provide all client services and consultation and triage at no charge to the other agency;

7. Accept clients referred by the other agency into services without regard for ability to pay and with fees charged to the client based on ability to pay.

Implementation

The South Carolina Department of Mental Health and the South Carolina Commission on Alcohol and Drug Abuse agree to ensure the effective implementation of this agreement at the State, regional and local levels through all necessary means of policy development, conditions of contracts with and grants-in-aid to local agencies and other managerial discretion.

Agreed to this 13 day of June, 1986.

Joseph J. Bevilacqua, Ph.D.
State Commissioner
S.C. Department of Mental Health

William J. McCord
Director
S.C. Commission on Alcohol and Drug Abuse

A COOPERATIVE AGREEMENT BETWEEN
THE SOUTH CAROLINA COMMISSION ON ALCOHOL AND DRUG ABUSE
(SCCADA)
AND
THE SOUTH CAROLINA DEPARTMENT OF PAROLE AND COMMUNITY CORRECTIONS
(SCDPCC)

Purpose: To promote and facilitate the referral, treatment and follow-up of alcohol and drug abusing adults under the supervision of the South Carolina Department of Parole and Community Corrections. These referrals are made for the purpose of reducing the incidence and lifestyle-related problems associated with alcohol and drug abuse.

Specific Objectives:

Major objectives of this Cooperative Agreement are:

1. To develop improved procedures for providing services to probationers/parolees with problems of alcohol and drug abuse.

2. To develop improved case finding and assessment procedures to quickly identify probationers/parolees in need of alcohol and drug abuse treatment services.

3. To develop standardized guidelines for referral, feedback, and follow-up of probationers/parolees in need of substance abuse services.

4. To develop methods for improved case management for mutual clients.

The Parties to this Agreement will foster the cooperative interface between offices of Parole/Community Corrections and Agencies on Alcohol/Drug Abuse statewide in meeting these objectives.

Responsibilities:

The South Carolina Commission on Alcohol and Drug Abuse will:

1. Foster the provision of prevention, intervention, and treatment services to those adults with alcohol and drug abuse problems under the supervision of Parole and Community Corrections.

2. Encourage local alcohol and drug programs to sign a formal agreement with County Parole and Community Corrections offices to facilitate working arrangements between local agencies. This document should include standard guidelines for referral.

3. Work cooperatively toward full implementation of the specific objectives outlined in this Agreement.

The South Carolina Department of Parole and Community Corrections will:

1. Designate appropriate staff within its local offices to serve as liaison for coordination of inter-agency services.

2. Supply pertinent social/assessment related information to the referral agency.

3. Provide all its legal and customary services to clients within its jurisdiction.

4. Coordinate probation and parole services to facilitate evaluation and treatment of clients in need of these services.

5. Work cooperatively toward full implementation of the specific objectives outlined in this Agreement.

The South Carolina Commission on Alcohol and Drug Abuse and the South Carolina Department of Parole and Community Corrections will jointly:

1. Provide opportunities for periodic joint planning and problem solving at the state and local level.

2. Develop annually in May at the state level a plan of action designed to improve identification of, referral of and early intervention services to probationers/parolees having alcohol and drug abuse problems.

3. Meet annually in May to assess progress of the effectiveness of this Agreement and the joint annual plan of action and make revisions as necessary. This meeting will be initiated by the South Carolina Commission on Alcohol and Drug Abuse during the even years and by Parole and Community Corrections in the odd years.

4. To develop a training program which will foster cooperative interface between the two agencies and local counterparts.

5. To develop standard guidelines for referral and follow-up and a plan for implementation.

This Agreement may be altered, modified or rescinded as may be necessary by the Director of the SCCADA and the Director of the SCDPCC.

The Director of the SCCADA and the Director of the SCDPCC will take appropriate action within their respective Agencies to insure effective implementation of the terms of this Agreement.

On behalf of the SCCADA and SCDPCC, agreed this 9th day of Sept, by the undersigned.

S. C. Commission on Alcohol and Drug Abuse

Executive Director

S. C. Department of Parole and Community Corrections

Executive Director

# A COOPERATIVE AGREEMENT BETWEEN THE SOUTH CAROLINA COMMISSION ON ALCOHOL AND DRUG ABUSE (SCCADA) AND THE SOUTH CAROLINA DEPARTMENT OF EDUCATION (SDE)

## PURPOSE

To define the working relationship between the South Carolina Commission on Alcohol and Drug Abuse and the South Carolina State Department of Education. Both agencies are vested with responsibilities for the provision of services to public school students. Both agencies recognize that these responsibilities can be most effectively carried out in a relationship where mutuality can be stressed, separate responsibilities clearly delineated, and sharing of resources actively promoted. This agreement is intended to further the spirit of cooperation that currently exists between the two state agencies and will hopefully provide a model for further cooperation between the autonomous county alcohol and drug abuse authorities and the school districts.

## SPECIFIC OBJECTIVES

The major objectives of this cooperative agreement are:

1. To further improve methods for preventing alcohol and drug use and abuse among students.
2. To further improve methods of identification, intervention, and treatment of alcohol and drug abuse among students.
3. To assist county alcohol and drug abuse authorities and school districts in implementing relevant state laws, requirements, and programs.

## RESPONSIBILITIES

The South Carolina Commission on Alcohol and Drug Abuse will:

1. Encourage the use of alcohol and drug abuse curricula approved by the State Department of Education.
2. Assist the State Department of Education in satisfying requests for pamphlets and films.

3. Contract with county alcohol and drug abuse authorities for statewide intervention services (and treatment where indicated) through the School Intervention Program (ScIP). ScIP is designed to identify students with potential or active alcohol and/or drug-related problems in the school system and to intervene before substance abuse problems mature. Components of ScIP are:

   a. Policy - A model policy between the county alcohol and drug abuse authority and the school district regarding alcohol and drug abuse.

   b. Training - For teachers and staff on problem recognition and program operation.

   c. Referral - From the school to ScIP of problem students.

   d. Assessment - Determination of the extent of the problem and services needed.

   e. Services - Provision of ScIP education and/or treatment services.

   f. Follow-up - Reporting back to the school on the student's status.

4. Encourage and contract with, as funds are available, county alcohol and drug authorities for primary prevention services that may also be available to school districts.

5. Coordinate with the State Department of Education as appropriate events that impact on the schools.

6. Encourage county alcohol and drug abuse authorities to develop cooperative agreements with school districts for intervention services.

The South Carolina Department of Education will:

1. Coordinate with the South Carolina Commission on Alcohol and Drug Abuse as appropriate events that impact on the state and county alcohol and drug abuse system.

2. Continue participation on the South Carolina Commission on Alcohol and Drug Abuse School Advisory Committee.

3. Encourage the use of the School Intervention Program (ScIP) by the local school districts as an option for identifying students with potential or active alcohol and/or drug-related problems and to intervene before substance abuse problems mature.

4. Encourage school districts to develop cooperative agreements with the county alcohol and drug abuse authorities for intervention services.

The South Carolina Commission on Alcohol and Drug Abuse and the South Carolina Department of Education will:

1. Engage in periodic joint planning and problem solving at the state and local level.

2. Recommend annually to school districts possible dates for Alcohol and Narcotics Education Week.

3. Develop annually at the state level a plan of action designed to foster cooperative efforts of prevention, intervention, and treatment of alcohol and drug abuse within the public schools. This effort will be initiated by the South Carolina Commission on Alcohol and Drug Abuse during the even years and by the State Department of Education in the odd years.

4. Appoint a joint agency committee to carry out the goals and objectives of this agreement. This committee will:

   a. Be comprised of eight (8) members, four (4) from each agency, to be appointed by their respective agencies.

   b. Be chaired on even years by the State Department of Education and on odd years by South Carolina Commission on Alcohol and Drug Abuse. On alternate years, the vice-chairperson shall be a member of the other agency. The chairperson shall preside over committee meetings, appoint committee members to a mutually agreed upon subcommittee, develop the agenda, arrange the meeting, and notify members. In the chairperson's absence, the vice-chairperson shall perform these duties.

   c. Hold quarterly meetings on the second Wednesday of each quarter. (January, April, July, and October).

   d. Require a quorum for any action requiring a committee vote.

This agreement may be rescinded as necessary by either agency upon written notification to committee members, and may be modified as necessary through mutual agreement by both agencies.

The Director of the South Carolina Commission on Alcohol and Drug Abuse and the State Superintendent of Education will take appropriate action within their respective agencies to ensure effective implementation of the terms of this agreement. On behalf of the South Carolina Commission on Alcohol and Drug Abuse and the State Department of Education, agreed this 28th day, January month, 1985 year of by the undersigned.

SOUTH CAROLINA COMMISSION ON ALCOHOL AND DRUG ABUSE

William J. Nelson

Director

SOUTH CAROLINA DEPARTMENT OF EDUCATION

Charlie G. Williams

State Superintendent of Education

# APPENDIX

## RELEVANT STATE LAWS

**44-49-40.** Powers and Duties of South Carolina Commission on Alcohol and Drug Abuse

The commission shall:

(1) plan, coordinate, and cooperate in educational programs for schools, communities, and general public designed to prevent and deter misuse and abuse of controlled substances; (5) evaluate procedures, projects, techniques, and controls conducted or proposed as part of educational programs on misuse and abuse of controlled substances.

**44-49-60.** Adult Alchoholic Education Program

The South Carolina Commission on Alcohol and Drug Abuse shall:

(1) appoint a supervisor of adult education for the prevention of alcoholism, who shall be responsible for activating and implementing an adequate alcoholic education program for the citizens of this state above high school age.

**Act 512, of 1984, Part II, Permanent Provisions, Division II, Subdivision B, Sub-Part 4, Alcohol and Drug Abuse in Schools**

**Section 1.** The South Carolina Commission on Alcohol and Drug Abuse shall establish a program to provide alcohol and drug abuse intervention, prevention, and treatment services for the public schools of the state. The Commission shall provide staff and support necessary to administer the program. Funds for this program must be annually appropriated by the General Assembly from the Education Improvement Act of 1984 Fund as it determines appropriate. The appropriated funds must be forwarded to the South Carolina Commission on Alcohol and Drug Abuse from the Education Improvement Act of 1984 Fund in the manner the State Treasurer shall direct.

**59-29-20.** Required Subject: Nature and Effects of Alcoholic Drinks and Narcotics

The nature of alcoholic drinks and narcotics and special instruction as to their effects upon the human system shall be taught in all the grammar and high schools of this state which receive any state aid whatsoever and shall be studied and taught as thoroughly and in the same manner as all other required branches in such schools, as may be required by the State Board of Education. The State Board of Education shall provide for the enforcement of the provisions of this section.

59-29-30. Required Subject: Alcohol and Narcotics Education Week

Each public school of this state shall designate one week during the school year for the observance of Alcohol and Narcotics Education Week. During this week, each district Board of Trustees shall require the school principal, or other designated persons, to have each class from the sixth grade upward instructed for each 30 minutes on three days concerning the risks and dangers involved in the use of alcoholic beverages and narcotics. The principal, or other such designated person, shall also have at least one assembly session during the week of not less than 45 minutes, at which time the subject of the dangerous effect of alcohol and narcotics shall be presented.

The District Board of Trustees shall each year inform the State Board of Education of the week each public school in its district has designated as Alcohol and Narcotics Education Week, and the State Baord of Education shall, through the Department of Education, provide suitable printed materials and other aids for use in the observance of the week.

59-29-40. Required Subject: Films Depicting Nature of Alcoholic Drinks and Narcotics: Special Instruction as to Their Effect

Films depicting the nature of alcoholic drinks and narcotics and special instructions as to their effect upon the human system shall be taught in all the junior high and high schools of this state and shall be studied and taught as thoroughly and in the same manner as all other required branches in such schools, as may be required by the State Board of Education. Such films shall be presented at orientation programs of all state-supported institutions of higher learning. The South Carolina Television Center shall make available to such schools and institutions television programs and films with commentary relative to such subject matter and the school shall require each student enrolled therein to view such program or film. The State Board of Education or the college or university officials, as the case may be, shall provide for the enforcement of the provisions of this section.

A COOPERATIVE AGREEMENT BETWEEN
THE SOUTH CAROLINA COMMISSION ON ALCOHOL AND DRUG ABUSE (SCCADA)
and
THE SOUTH CAROLINA DEPARTMENT OF LABOR (SCDOL)

PURPOSE

To define the working relationship between the South Carolina Commission on Alcohol and Drug Abuse and the South Carolina Department of Labor. Both agencies are vested with responsibilities for the provision of services to the employed citizens of South Carolina and to the organizations which employ them. Both agencies recognize that these responsibilities can be most effectively carried out in a relationship where common interests are stressed, separate responsibilities are clearly delineated, and sharing of resources are actively promoted. This agreement is intended to further the spirit of cooperation that currently exists between the two state agencies and provides a model for further cooperation between the autonomous county alcohol and drug abuse authorities and the area labor conciliators.

SPECIFIC OBJECTIVES

The major objectives of this cooperative agreement are:

1. To educate employers of South Carolina about the benefits of Employee Assistance Programs.

2. To improve methods for preventing alcohol and other drug use and abuse among employees.

3. To improve methods of identification and referral of employees troubled by the use and abuse of alcohol and other drugs.

4. To reduce avoidable job displacement due to inappropriate disciplinary actions for alcohol and drug problems.

RESPONSIBILITIES

The South Carolina Commission on Alcohol and Drug Abuse will:

1. Co-sponsor a conference highlighting state government's services to business and industry by contributing human resources and finances as funds are available.

2. Assist the South Carolina Department of Labor in responding to requests for information on Employee Assistance Programs.

3. Co-host with appropriate county commissions on alcohol and drug abuse meetings in the seven South Carolina Department of Labor areas to acquaint labor conciliators with facilities, personnel, and capabilities of county commissions on alcohol and drug abuse.

The South Carolina Department of Labor will:

1. Coordinate with the South Carolina Commission on Alcohol and Drug Abuse as appropriate events occur that impact the alcohol and drug abuse system of the state.

2. Encourage the use of SCCADA's Employee Assistance Program by business and industry as an option to discharging employees whose performance has deteriorated due to personal reasons.

3. Encourage business and industry to implement Employee Assistance Programming by collaborating with EAP personnel of county alcohol and drug commissions.

The South Carolina Commission on Alcohol and Drug Abuse and the South Carolina Department of Labor will:

1. Engage in periodic joint planning and problem solving meetings at the state level.

2. Develop annually a plan of action designed to foster cooperative efforts and the extension of Employee Assistance Program benefits to all employed citizens of South Carolina. The annual plan will begin July 1 and end June 30.

3. Each appoint a primary liaison who will be responsible for jointly developing a draft of the annual plan and coordinating the resources necessary to execute the terms of the plan.

This agreement may be terminated by either agency upon 30 days written notification, and may be modified as necessary through mutual agreement by both agencies.

The Director of the South Carolina Commission on Alcohol and Drug Abuse and the Commissioner of the South Carolina Department of Labor will take appropriate action within their respective agencies to ensure the effective implementation of the terms of this agreement. On behalf of the South Carolina Commission on Alcohol and Drug Abuse and the South Carolina Department of Labor.

Agreed this 29 day of May, 1987:

South Carolina Commission on Alcohol and Drug Abuse

William J. Cook
Director

South Carolina Department of Labor

E. L. McGowan
Commissioner

BC/caa/5/12/87(3)

# RECOMMENDATIONS OF THE ALCOHOL AND DRUG OFFENDER COMMITTEE

It is well established that there is a high correlation between substance abuse and crime. Alcohol and drug abuse affects the criminal justice population in many ways. It is a direct cause of such crimes as public drunkenness and driving under the influence. In other situations, alcohol and drug abuse may occur in conjunction with the commission of a crime. Finally, substance abuse is present in the lives of many persons who commit crime.

The criminal justice system can serve as an effective intervening point to deal with this problem. At each stage in the processing of the substance abusing offender through the criminal justice system, there are many opportunities for state and local agencies to implement alcohol and drug intervention programs to deal with drug abuse. These programs can serve as an alternative sentence or they can be implemented along with traditional sanctions.

South Carolina should expand the use of health/legal intervention strategies and provide additional resources for treating substance abusing offenders. Only through these and other related efforts can the state hope to arrive at a long-term solution to the alcohol/drug-crime problem.

## Recommendations

The Alcohol and Drug Offender Committee--

1. Endorses the recommendations of the statewide Public Drunkenness Study.

2. Recommends that the Pre-trial Intervention Association and the Solicitors' Association jointly develop statewide guidelines for the education and training of personnel to encourage the identification and referral of defendants with alcohol and drug problems.

3. Recommends that the Magistrates' Association adopt statewide policies which would encourage the identification and referral of drug abusing defendants appearing before them for pre-trial release or adjudication. In addition it is recommended that the association promote training on alcohol and drug abuse as it pertains to defendants appearing in their courts.

4. Endorses the recommendations of the Children's Coordinating Cabinet concerning alcohol, drugs and youth, especially those which would strengthen programs for children at high risk and those in the juvenile justice system.

5. Recommends the use of pre-sentence investigations for circuit court judges to assist in the identification and referral of defendents with alcohol and drug abuse problems.

6. Recommends that the Department of Parole and Community Corrections implement a program of urinalysis for selected drug offenders under their jurisdiction for monitoring purposes.

7. Recommends that a short-term, residential addictions treatment facility be established by the Department of Corrections primarily for inmates who are not eligible to be furloughed to residential treatment programs outside the Department of Corrections.

8. Recommends that the Department of Corrections and alcohol and drug treatment agencies develop a statewide referral network to help insure that all inmates with alcohol and drug abuse histories who are released from correctional facilities are referred to local agencies for assistance after release.

10. Recommends that all alcohol and drug treatment agencies enter into memorandums of agreement with the appropriate criminal justice agencies to help improve inter-agency communication and cooperation in the provision of services to drug abusing offenders.

11. Supports continued funding for adult beds and additional funding for Morris Village to increase beds available for the treatment of youth with alcohol and drug abuse problems.

12. Encourages criminal justice agencies to provide or secure training for their personnel regarding the handling and treatment of alcohol and drug abusers.

13. Recommends that an annual conference be held for both criminal justice officials and alcohol and drug treatment staff regarding health/legal intervention for adult and juvenile offenders.

14. Supports amendments to the Drug Forfeiture Law which would increase the state's ability to seize the assets of drug traffickers to provide additional resources to the state for alcohol and drug programs for the criminal justice system.

15. Recommends that the Governor's Office establish a permanent high level panel of criminal justice executives, elected officials and alcohol and drug treatment experts to provide a continued forum for the development of a comprehensive state policy regarding alcohol, drugs and crime. This panel should review on an annual basis the current efforts of the state's criminal justice and drug treatment agencies to deal with drug-related crime. In addition, the panel should make recommendations to the state's leaders regarding policy and funding decisions which would assist the state in becoming more effective in dealing with alcohol and drug related crimes.

cba/11/12/85

COUNTY COMMISSIONS ON ALCOHOL AND DRUG ABUSE
SELECTED CLIENT REFERRAL SOURCES

| | FY 84-85 | FY 85-86 | FY 86-87 |
|---|---|---|---|
| Self | 7,544 | 8,307 | 9,401 |
| Percent | .25 | .26 | .26 |
| Magistrates | 2,645 | 3,157 | 4,075 |
| Percent | .09 | .10 | .11 |
| Law Enforcement | 2,442 | 2,512 | 2,886 |
| Percent | .08 | .08 | .08 |
| Schools | 3,514 | 3,733 | 3,863 |
| Percent | .12 | .12 | .11 |
| Solicitor | 1,435 | 1,469 | 1,433 |
| Percent | .05 | .05 | .04 |
| Relative | 1,646 | 1,503 | 1,792 |
| Percent | .05 | .05 | .05 |
| DYS | 854 | 1,099 | 1,360 |
| Percent | .03 | .03 | .04 |
| State Probation | 879 | 1,098 | 1,449 |
| Percent | .03 | .03 | .04 |
| Psychiatrist/Physician | 380 | 357 | 371 |
| Percent | .01 | .01 | .01 |

Percentage refers to proportion of all referral sources.

COUNTY COMMISSIONS ON ALCOHOL AND DRUG ABUSE
CLIENTS ENTERING PROGRAMS

| | FY 84-85 | FY 85-86 | FY 86-87 |
|---|---|---|---|
| ADSAP | 10,309 | 11,110 | 12,365 |
| Drug Diversion | 172 | 352 | 451 |
| Offender Based | 2,945 | 3,049 | 3,314 |
| School Intervention | 4,328 | 4,891 | 5,014 |
| Occupational | 1,171 | 1,108 | 1,393 |
| College | 140 | 44 | 42 |
| Outpatient | 6,023 | 6,280 | 7,942 |
| Detox | 4,631 | 4,798 | 5,404 |
| Residential | 455 | 409 | 461 |
| Total Males | 23,096 | 24,385 | 27,458 (75%) |
| Total Females | 7,170 | 7,767 | 9,078 (25%) |
| Total thru Age 17 | 4,460 | 5,090 | 5,743 (16%) |
| Total Age 65 and over | 531 | 505 | 664 (2%) |
| Total Employed Full-time | 14,623 | 15,622 | 17,910 (49%) |

COUNTY COMMISSIONS ON ALCOHOL AND DRUG ABUSE
CLIENTS ENTERING PROGRAMS

| | FY 84-85 | FY 85-86 | Percent Change |
|---|---|---|---|
| Total White | 21,926 | 22,967 | + 4.7 |
| Total Black | 8,206 | 9,034 | + 10.1 |
| Total Other | 134 | 151 | + 12.7 |

PRESENTING DRUG PROBLEM

| | | | |
|---|---|---|---|
| Alcohol | 19,123 | 20,151 | + 5.4 |
| Other Drugs | 4,347 | 4,637 | + 6.7 |
| Non Drugs/Alcohol | 6,796 | 7,364 | + 8.4 |
| TOTAL | 30,266 | 32,152 | + 6.2 |
| (Poly Drug) | 5,497 | 6,157 | + 12.0 |

# of legislative interest

SOUTH CAROLINA COMMISSION ON ALCOHOL AND DRUG ABUSE

1987 LEGISLATIVE SESSION
June 12, 1987

Below are listed bills that have been introduced in the 1987 legislative session that are related to alcohol and drug abuse or other health issues. We will furnish this newsletter bi-monthly to keep you informed of the progress of these bills. If you have any questions concerning any of these bills, please call Jean Popowski at SCCADA telephone: 734-9520.

1. S.25 (Lourie): Amends §56-5-2950 by including in the Implied Consent Law the analysis of blood and urine samples of a defendant charged with DUI. Enrolled for ratification.
2. S.81 (Mitchell): Adds §27-21-40 that provides for confiscated scales, beakers, burners to be donated to public school districts in the county where seized. Tabled in House Judiciary.
3. S.86 (Mitchell): Amends §56-1-360, providing for notice to be effected by certified mail to notify of driver's license suspension. In Senate Transportation Committee.
4. S.89 (Lourie): Amends §56-1-460, significantly increasing penalties for driving under suspension, and repeals §56-9-70. Passed - R120, Act 84.
5. S.100 (V. Smith): Amends §56-5-2945 by requiring mandatory driver's license suspension for conviction of felony DUI. Passed - R118, Act 82.
6. S.101 (Fielding): Amends §56-5-2990 by creating a misdemeanor offense for failure to enroll in the ADSAP program within nine months of notice of driver's license suspension. In Senate Transportation Committee.
7. S. 102 (V. Smith): Adds §44-53-375 defining "crack cocaine" and provides penalties for possession, distribution, manufacture, etc. of crack cocaine; amends §44-53-440 and §44-53-445 providing for separate criminal penalties for persons distributing "crack" to a person under 18 or within one-half mile radius of a school. Passed - R181.
8. S.113 (Land and others): Adds §56-5-6510 requiring mandatory use of seat belts by all occupants of a motor vehicle. In Senate Transportation.
9. S.161 (Garrison): Amends 50-21-110 by establishing the offense of boating under the influence of alcohol and/or drugs and provides for implied consent of operation of watercraft to testing of body fluids. In House Judiciary.
10. S.312 (Pope): Joint resolution to direct the ABC Commission not to enforce Regulation 7.98 relating to prohibition of a sale of beer and wine to persons who remain in a motor vehicle during the transaction. In Senate Judiciary Committee.
11. S.348 (Applegate and others): Amends §56-5-2990, South Carolina Code of Laws, relating to suspension of the driver's license of a person convicted of DUI, so as to provide that the license may not be reinstated until 90 days following successful completion of the ADSAP program. In Senate Transportation Committee.
12. S.357 (T. P. Leventis): Adds §56-1-745 and 56-5-2995 so as to suspend the driver's license of a person under 18 until his 18th birthday who is convicted of a traffic offense carrying four points or more, and to suspend the license of a person under the age of 21 until his 21st birthday who is convicted of DUI or a narcotics or controlled substance offense; further amends 1976 Code by adding §44-53-670 to require clerks of court to report narcotic/controlled substance convictions of persons under 21 years to the South Carolina Department of Highways and Transportation. In Senate Transportation Committee.
13. S.477 (T. W. Mitchell): Adds §61-5-53 so as to prohibit the granting of a minibottle license to those organizations which discriminate on the basis of race, religion or sex. In Senate Judiciary Committee.
14. S.636 (Long): Relating to penalties for DUI, so as to increase the penalties and delete the provision allowing the court to suspend fines, including the exception for the first offense. In Senate Judiciary.
15. S.704 (Lourie and others): "South Carolina Safer Highways Act of 1987," a comprehensive highway traffic safety package containing 44 separate items relating to highway traffic safety, railroad safety, DUI measures, increased penalties for violation of present laws related to highway safety, mandatory driver's education, etc. In Senate Transportation.
16. S.710 (Lourie and others): Adds §56-5-2946 to the South Carolina Code of Laws, requiring a investigation by the local law enforcement agency, SLED and the ABC Commission, into any injury or death to a person under 21 years of age, where use of an alcoholic beverage is suspected, to determine the source of the alcoholic beverage. Passed - R190.
17. S.734 (Judiciary Committee): Statewide Grand Jury. Passed - R208.
18. H.2044 (Hayes): Amends §20-7-370 and §20-7-380 relating to unlawful purchase or possession of beer or wine or liquor so as to make this section inapplicable to minors acting as an agent of a law enforcement agency. In House Judiciary Committee..
19. H.2050 (Kirsh and others): Adds §55-1-100 to provide that it is unlawful to operate or act as a crew member of any aircraft while under the influence of alcohol or drugs. Passed - R145, Act 105.

20. H.2052 (Lockemy): Amends §61-5-50 relating to the requirements for granting licenses for the sale of alcoholic beverages for on-premise consumption, so as to provide that proximity of locations to churches restrictions do not apply to businesses if churches within the distance limitations consent to a location in writing. In House 3-M Committee.
21. H.2086 (Bradley): Amends §56-5-2950 relating to the implied consent laws so as to reduce the required percentage by weight of alcohol from .10 to .08. In House Judiciary Committee.
22. H.2108 (Koon and Felder): A House resolution to request that the members submit voluntarily to a drug test during the first week of the session of the General Assembly and to provide that all data and information derived are confidential. In House Rules Committee.
23. H.2127 (Aydlette): Adds §64-13-885 providing that no person under 21 years old may enter any establishment authorized to sell alcoholic beverages for on-premise consumption unless accompanied by a parent or legal guardian. Tabled in House Judiciary.
24. H.2130 (Hayes, Fair, Hearn): Adds Article 2 to Chapter 3 of Title 56, South Carolina Code of Laws, so as to authorize the South Carolina Department of Highways and Transportation to enter into the driver's license compact. Passed - R107, Act 72.
25. H.2201 (Tucker and Huff): Amends §56-5-2945 relating to penalty for felony DUI, so as to increase the penalty. Passed - Signed by Governor April 28, 1987 - R93, Act 58.
26. H.2202 (Tucker): Amends §17-22-110, South Carolina Code of Laws, increasing fees charged for Pretrial Intervention Program to $300. Passed - R90, Act 57.
27. H.2233 (Beasley and Fair): Adds §56-5-2935 so as to permit a preliminary screening test to determine whether an arrest should be made for DUI; provides for bodily fluid testing under the Implied Consent Statute. Companion bill to S.25. Tabled in House Judiciary Committee.
28. H.2074 (Kohn): "South Carolina Clear Indoor Air Act" provides for misdemeanor offense of smoking in non-designated public places or public meetings. House 3-M Committee.
29. H.2296 (Rudnick and others): Increases penalties for unlawful purchase or possession of liquor by minors and a person falsely representing his age. Passed - R96, Act 61.
30. H.2426 (M. L. Fair): Amends §56-5-2945 by providing for immediate revocation of a driver's license for persons charged with felony DUI, and if convicted of felony DUI, suspension to run 18 months after completion of sentence. Tabled in House Judiciary Committee.
31. H.2521 (D. M. McEachin): Attempts to repeal Chapter 52, Title 44, South Carolina Code of Laws, relating to alcohol and drug abuse commitments. Tabled in House 3-M Committee.
32. H.2552 (Tucker and others): Amends Title 16, Code of Laws of South Carolina, by adding §16-3-80 so as to make it a felony offense to administer to, or aid or assist in administering to, or to cause to be taken by any person any unlawful controlled substance as specified in §44-53-370, which results in the death of that person. In House Judiciary.
33. H.2625 (Wilkins and others): Relating to driver's license, by adding §56-1-356 so as to provide that any person who is convicted of or pleads of an offense in General Sessions Court which as part of the punishment to be imposed requires that his driver's license be revoked or suspended, shall surrender his license to the clerk of court upon verdict or plea. Passed - enrolled for ratification.
34. H.2659 (Fair): Adds §16-17-750 to the South Carolina Code of Laws. Provides for felony charge and penalties against practicing homosexuals or users of illegal intravenous drugs to give blood for a period of 10 years following cessation of these practices. Tabled in House Judiciary Committee.
35. H.2668 (Aydlette): Adds §56-1-143 to the South Carolina Code of Laws requiring that driver's licenses issued to persons under the age of 21 be a different color than for those 21 and older, and provides that this license expire on applicant's 21st birthday. Tabled in House Committee on Education and Public Works.
36. H.2676 (Wilkins and others): Amends §44-53-445, South Carolina Code of Laws, relating to distribution of a controlled substance within a certain proximity of a school, so as to make the offense a felony; provide different penalties for a person convicted of this offense who is under the age of 21 at the time the act was committed. In Senate Judiciary.
37. H.2739 (Snow and others): A joint resolution to conduct a pilot project in Charleston, Greenville and Richland counties to test the effectiveness of ignition interlock devices on motor vehicles of persons convicted of second offense DUI. In House Judiciary Committee.
38. H.2796 (J. C. Johnson and others): To amend Title 65 South Carolina Code of Laws, relating to driving under the influence of intoxicating liquor or drugs by adding §56-5-2941 so as to provide that any person arrested for a first offense violation of DUI must surrender his driver's license to the arresting officer at the time of arrest. In House Judiciary Committee.
39. H.2801 (Sharpe and others): Relating to motor vehicle traffic accidents so as to provide that drivers of all vehicles involved in accidents resulting in bodily injury or death must be given a chemical test of their breath for the purpose of determing the alcoholic content of their blood. In House Judiciary.
40. H.2852 (McElveen and others): Adds §56-56240 so as to provide for the confiscation and forfeiture of a motor vehicle driven by persons convicted of a second and subsequent DUI offense, or a first or subsequent offense for felony DUI. In House Judiciary Committee.
41. S.782 (Verne Smith, McLeod, Setzler): A concurrent resolution commending Bill Routh for his faithful and tireless service to the state and congratulating him upon his retirement. WE WILL MISS YOU BILL!

NOTE: Bills that have passed and are enrolled for ratification will be ratified on June 25, 1987, during the one-day session of the General Assembly. They will be assigned a ratification number at that time. To obtain a copy of any of these bills, call 734-2056 (Legislative Bill Room) and they will be happy to send one to you.

JP/ADMIn/6-12-87

## SCCADA Policy Regarding Public/Private Sector Interface

1. The SCCADA is committed to the most cost-efficient and cost-effective allocation of financial resources in meeting the treatment needs of the state's population. To this end, it will work closely with the South Carolina Department of Health and Environmental Control in arriving at a realistic methodology for determining bed need, and it will actively oppose efforts to increase bed capacity beyond the level specified in the State Health Plan.

2. The SCCADA will continue its efforts to ensure that all services rendered by private providers meet applicable licensing and regulatory requirements which now apply to the public sector.

3. The SCCADA, in responding to citizens' request for information about private sector services, will provide objective information about the full range of options available. No program will be recommended which has failed to comply with present or future licensing/regulatory requirements.

4. The SCCADA will work actively to promote referral linkages between public and private treatment providers, thereby, ensuring continuity of care for those persons needing services.

5. The SCCADA will work to ensure that treatment services are delivered in the least restrictive, lowest cost setting consisting with the needs of the patient. To this end, efforts will continue to work with third-party payers to extend the range of eligible treatment settings and providers so that reimbursement practices do not dictate choice of treatment.

## SCCADA Expectations of Private Providers

1. The SCCADA will expect any private agency or facility to meet all licensing requirements for chemical abuse treatment programs as promulgated by the South Carolina Department of Health and Environmental Control.

2. SCCADA asks that speciality units and general hospitals, which are presently exempt from licensing requirements as chemical abuse treatment programs, be required to meet all standards promulgated by the South Carolina Department of Health and Environmental Control. SCCADA staff will request such action by DHEC.

3. The SCCADA asks the treatment personnel in any treatment agency or facility voluntarily meet the standards of the state's credentialing system for clinical counselors.

4. The SCCADA expects that private treatment providers will involve county alcohol and drug abuse commissions, which have the statutory authority and responsibility for the coordination of alcohol and drug services in that county of jurisdiction, and the planning and implementation of new services.

5. SCCADA asks that private providers of inpatient treatment services make active use of public agency outpatient treatment capabilities as an aftercare alternative.

6. SCCADA asks that all private providers make a commitment to serving a reasonable number of persons whose resources are insufficient to pay the cost of treatment. Further, private providers are asked to publicize their thoughts on admissions of medically indigent persons

among public alcohol and drug abuse commissions to guide them and make an appropriate referral.

Areas for Public/Private Collaboration

1. The SCCADA will continue to serve as host/convener for the State Coordinating Committee of Private Treatment Providers, believing this to be an effective means for continuing dialogue in problem resolution.

2. The SCCADA will work with private sector representatives to develop a mutually acceptable strategy for improving insurance benefits available to persons receiving treatment for alcoholism/drug addiction.

3. The SCCADA will issue a standing invitation to the State Coordinating Committee of Private Treatment Providers to send a representative to all meetings of the SCCADA Board of Directors.

4. SCCADA will ensure that a representative of the private sector serves as a member of the State Credentialing Advisory Committee.

5. SCCADA will actively seek the input of the private sector in the development of the State Plan on Alcohol and Drug Abuse.

6. The SCCADA will work closely with the private sector to identify ways in which private sector resources can be channelled to meet the needs of presently underserved populations, e.g., women, adolescents, elderly.

In summary, SCCADA believes that private and public agencies must operate in an atmosphere of close collaboration, not grudging co-existence.

## A Policy Statement on Employee Drug Testing

The problem of the use and abuse of alcohol and other drugs in the work place is staggering. According to the latest research data from the National Institute on Drug Abuse, 65 percent of the young adult population 18 to 25 years old in the United States (representing those just entering the work force) have used illicit drugs. Of this same group, 44 percent have used drugs within the past year. The Alcohol, Drug Abuse, and Mental Health Administration estimates that alcohol and drug abuse costs nearly $100 billion in lost productivity each year.

The human cost to society and the social, economic and legal cost to business have created a need by employers to implement a system to combat the multi-faceted problems that are created by alcohol and drug use and abuse. The consensus by the federal government, as documented in the President's Commission on Organized Crime Report, 1986, and many members of the business community is that action must be taken. Employee Assistance Programs (EAPs) were initiated by a few far-sighted companies in the 1950s as a more positive way to manage employees with alcoholism than dismissing them or ignoring their problems. By 1980, the number of EAPs had grown to over 60 percent of Fortune 500 companies. Recent action, however, has called for the implementation of testing for the presence of drugs (including alcohol) as a component of an EAP or as a separate management action in and of itself.

Employers in South Carolina are becoming increasingly aware of the issues as well as the problems and stresses caused by alcohol and other drug abuse by all levels of employees, both on and off the job. As indicated by inquiries to the South Carolina Commission on Alcohol and Drug Abuse (SCCADA), they are beginning to grapple with how to handle the problem. At the present, only a few South Carolina businesses test workers or perspective employees for drug use, but experts predict the practice will increase as more employers try to keep drugs out of the work place. There is a need, then, for a policy statement which can provide logical and rational guidelines on fair and judicious practices in response to the problems of drug use at the work place in South Carolina.

The SCCADA views drug use at the work place as a problem which must be addressed clearly and decisively in a fair and equitable manner with due consideration of the rights of the employer, employee and the general public.

SCCADA acknowledges that restrictions enumerated in the first 10 amendments to the Constitution, known as the "Bill of Rights," apply to actions by the government or "state action" but not to intrusion by private individuals or private industry. For example, a law would have to be passed by the South Carolina General Assembly before state government employees could be tested for drugs; whereas, private industry has the ability to test at its own will.

Therefore, it is recommended that every South Carolina business and industry consider developing a policy on employee drug use that meets the basic standards for an Employee Assistance Program. The SCCADA has established more than 400 EAPs with businesses and industries, governmental agencies and systems of higher education. These programs have achieved success ratios in excess of 90 percent.

The SCCADA recommends that the following standards be established for all EAPs: a policy adopted and promoted by management; procedures adopted and promoted by management; training for supervisors and all management personnel; employee education to promote awareness; maintenance visits to provide ongoing consultation; assessment to ensure that the appropriate professional help is provided for the troubled employees; treatment for alcohol and drug abuse delivered by credentialed personnel; and an evaluation to provide a programmatic review at least once a year.

Further, it is the SCCADA philosophy that testing for early identification and referral is an effective tool. It should be understood, however, that appropriate circumstances and timing for tests are vital considerations.

Drug testing is appropriate and legally defensible if there is a reasonable suspicion based on specific facts that an employee is engaged in substance abuse. It is recommended that random tests -- spot checks throughout an entire work force -- be limited to jobs for which it is essential that employees be entirely free of any effects of drug use -- for instance electrical linemen, nuclear plant workers, public transportation drivers, etc. -- in order to ensure the safety of the public.

The SCCADA further recommends that:

1. Companies which adopt drug testing do so as one component of an EAP.

2. Companies which adopt drug testing use the most rigorous procedures possible to ensure the integrity of test, safeguarding both samples and test results because of risks and consequences to both employers and employees.

3. Only certified laboratories should be involved in the drug-testing program.

4. A positive test in all instances should be immediately followed by a re-test. Furthermore, all positive results from an initial test should be re-confirmed by the most exacting tests such as gas chromatography/mass spectrometry methods before any action is taken.

5. Breath testing for alcohol and blood testing for alcohol and drugs should also be considered along with urine testing.

It is strongly advised that all South Carolina businesses/industries currently involved or considering involvement with drug testing:

1. Establish company policy through an Employee Assistance Program to coordinate drug testing and other related programs.

2. Participate in training on the effects of alcohol and drugs on performance.

3. Participate in training on "non-invasive" case finding (i.e., measures based on behavior and appearance).

In summary, the South Carolina Commission on Alcohol and Drug Abuse places a high priority on reducing the problems of alcohol and other drug abuse in the work place. To this end, SCCADA will continue to commit fiscal and human resources necessary to address this problem.

## Policy Statement on Tobacco

Nicotine, as found in cigarettes and other tobacco products, is also a highly addictive drug. For this reason, plus its relationship to other drugs, the use of nicotine products, primarily cigarettes, is of particular importance to SCCADA.

Due to the high dependence-producing properties of cigarettes, smokers tend to have a more regularized pattern of abuse with a higher number of occasions of use than users of other drugs. This pattern is of significance because of the relationship that exists among adolescents experimenting with cigarettes, alcohol and marijuana, the three major drugs of use by adolescents. The National Institute on Drug Abuse, in its ongoing study of drug use among high school students initiated in 1975, has found cigarette smoking to be a predictor of use of alcohol and marijuana. Hence, the practice by public institutions of providing smoking areas for students may also be correlated with problems of drug use since they provide a location for potential users to gather.

Cigarette smoking on the part of one or both parents has also been found to have predictive qualities for alcohol and drug use on the part of their children. Thus, SCCADA views efforts to raise the awareness of adults to the potential harmful effects of tobacco as beneficial to alcohol and drug prevention.

Within the adult population, the relationship between tobacco and other drugs is not completely known. However, the interaction between alcohol consumption and tobacco is particularly striking in terms of cancer of the mouth, pharynx and larynx where the total risk is increased in a synergistic manner. Studies have indicated that alcohol consumption and heavy smoking produced up to a 15 fold increase in the risk of oral cancer, compared with the chances of people who neither drank nor smoked.

Of importance also is the percentage of persons entering treatment for addiction who have multiple addictions with tobacco addiction being frequently seen in combination with alcohol addiction. The recovery process from addiction is a difficult one.

Hence, SCCADA views efforts to reduce harmful exposure to addictive substances as in the best interests of the public's health.