The State of Recovery

An Analysis of Services Available to Individuals Struggling with Addiction in South Carolina

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The State of Recovery
An Analysis of Services Available to Individuals Struggling with Substance Use Disorder in South Carolina

Introduction

As a part of the settlement agreement that resolved *Anderson V. Comprehensive Care Centers, Inc.*,[1] South Carolina Appleseed received a c*y pres* award to create a community education program to educate the public about the dangers of using illicit drugs and the benefits of treatment. The Addiction Recovery Coordination Initiative also known as the "ARC Initiative" was developed to assist in the coordination of services, public and private, dedicated to helping individuals with drug substance use disorder. ARC seeks to build upon existing services by:

- Educating all South Carolinians about the dangers of substance use disorder;
- Assessing and analyzing the coordination of all services, public and private, available to people recovering from substance use disorder; and
- Serving as a resource for those suffering from substance use disorder and the people that help them.

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In furtherance of its mission, the ARC Initiative has created a website, **http://arc.scjustice.org,** to serve as a one stop shop for information about the services available to those facing addiction in South Carolina. The website includes information about treatment facilities, free clinics, shelters, transitional housing, support groups, food pantries, veterans' services, court diversion programs and non-profit organizations committed to assisting people in need. In addition, ARC has been tasked with analyzing the gaps that exist in current services and to develop a blueprint to close the service gap. The first section of the report creates a snapshot of drug use and abuse nationally and in South Carolina. The second details the causes of the problem and the final section offers solutions.

[1] *Anderson v. Comprehensive Care Centers, Inc*., Civil Action No. 2002-18-CP-1756, Court of Common Pleas, Dorchester, SC.

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Executive Summary

Substance use disorder (SUD) has plagued our nation and South Carolina. Millions of Americans and hundreds of thousands of South Carolina's battle drug dependency every day. Individuals suffering from SUD are at increased risk for other serious diseases, criminal activity, car crashes and a loss of productivity at the work place due to the illness. Afflicted adults families, friends and society as a whole are negatively impacted as well.

There is good news. SUD does not have to be a death sentence. Treatment provided by qualified professionals is effective, especially when combined with additional services that can stabilize the addicted individual's life. Currently, there are over 50 substance use disorder treatment facilities in South Carolina. Unfortunately, our treatment system is not as comprehensive, accessible, or affordable as necessary to ensure that everyone in need receives treatment. According to the South Carolina Department of Alcohol and Other Drug Addiction Services (SC DAODAS) an estimated 236,000 South Carolinians have SUD. However, only about 51,000 of those receive treatment.[2]

Traditional SUD treatment alone is not enough. To achieve the best drug treatment outcomes, external obstacles affecting recovery must also be addressed. This holistic approach to treatment requires us to deal with other issues like housing, healthcare, child care, employment and other stresses which may serve as triggers to addicted individuals. Moreover, we must also address the ripple effects that SUD causes in the lives of the addicted individual's family and friends. No one person is an island. Support from the addicted individual's family and friends and the community at large is a critical part of the overall recovery process.

Key Findings

- SUD is a chronic disease.
- Prevention is cheapest and most effective method of combating addiction.
- SUD statistics do not accurately reflect the actual level of drug abuse. Due to the illegality of drug abuse and the secrecy which surrounds it, much abuse goes unreported.
- Failure to make SUD treatment and recovery a priority has cost the state millions of dollars in criminal justice and healthcare expenditures. In addition, the state has lost millions of dollars in productivity.
- Treatment for SUD is not readily available to all South Carolinians. Currently more than 150,000 South Carolinians in need of SUD treatment do not receive it.
- SUD is rampant in South Carolina's prisons and prison treatment programs are woefully inadequate.
- There is a huge disparity in the sentencing of African-American and White South Carolinians for drug related crimes.
- Geographic location plays a key factor in determining service access, with rural areas falling behind urban ones.
- Diversionary programs designed to divert addicted individuals from prison to treatment work. They are reducing crime and are cost effective.
- Safe, affordable housing plays an important role in effecting positive outcomes.

[2]SC DAODAS Accountability Report (2011) p.2

- Public transportation is critical in positive drug treatment outcomes, as many addicts no longer have drivers' licenses.

- Access to childcare both during and after treatment is needed for many women recovering from SUD.

Understanding Substance Use Disorder

SUD is a disease of the brain.[3] It is a chronic medical condition like type 2 diabetes, asthma, and hypertension. Although addiction typically begins with a purposeful choice, research shows that a physiologically based dependence soon sets in. In many cases addiction is more of a combination of genetic predisposition and environmental factors than a personal choice.

Understanding SUD's biological component can explain the difficulty of achieving and maintaining recovery. When addiction is treated as a long-term relapsing illness, recovery rates increase. In fact, success rates are comparable to those of other chronic diseases like hypertension and type 2 diabetes.[4]

Drugs contain chemicals that tap into the brain's communication system and disrupt the way nerve cells normally send, receive, and process information. This disruption is caused by imitating the brain's natural chemical messengers and by over stimulating the "reward circuit" of the brain. Drugs like marijuana and heroin have a similar structure to the brain's natural chemical messengers. This similarity allows the drugs to fool the brain's receptors and activate nerve cells to send abnormal messages.[5]

Drugs like cocaine or methamphetamine can cause nerve cells to release abnormally large amounts of natural neurotransmitters, mainly dopamine. They prevent the normal recycling of the brain chemicals needed to shut off the signaling between neurons. The result is a brain awash in dopamine. The overstimulation of this reward system produces euphoric effects in response to psychoactive drugs. This reaction sets in motion a reinforcing pattern that teaches people to repeat the rewarding behavior of abusing drugs.[6]

As drug use continues, the brain adapts to the large surges of dopamine by producing less dopamine or by reducing the number of dopamine receptors in the reward circuit. Thus, dopamine's impact on the reward circuit is lessened and so is the abuser's ability to enjoy the drugs. This decrease compels the addicted individual to keep abusing drugs in an attempt to bring the dopamine function back to normal. Unfortunately, it now takes larger amounts of the drug to achieve the same dopamine high—an effect known as tolerance.

Long term exposure to drugs results in significant changes to brain function. These changes outlast drug use. The drug induced brain changes may have behavioral consequences including compulsion to use drugs despite the risks. Criminal activity to support the habit can be part of the disease. The loss of the ability to resist the drug impulse often leads to frequent relapses.

You cannot predict whether a person will become addicted to drugs. Risk for addiction is influenced by a combination of factors like genetics, environment, and age. The more risk factors the greater the chance of addiction.[7]

- **Genetics**

  Genetics in combination with environmental influences account for about half of an individual's addiction vulnerability. Gender, ethnicity, and the presence of other mental disorders may also play a role in determining a person's risk for SUD.

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[3] Leshner, Alan I., *Addiction is a Brain Disease, Issues in Science and Technology*, (National Academy of Science, National Academy of Engineering, University of Texas at Dallas, Volume XVII Number 3, Spring 2001); http://www.drugabuse.gov/publications/drugfacts/understanding-drug-abuse-addiction.

[4] *Infofacts: Understanding Abuse and Addiction*, (National Institute on Drug Abuse, revised March 2011) http://www.drugabuse.gov/publications/drugfacts/understanding-drug-abuse-addiction.

[5] *Ibid.*

[6] *Ibid*.

[7] *Ibid.*

- **Environment**

  The world one lives in also plays a role in an individual's risk for addiction. Environmental factors include everything from family and friends to socioeconomic status and quality of life in general. Other factors include: peer pressure; stress; and physical and sexual abuse. Parenting can also influence the occurrence of drug abuse and the escalation to addiction.

- **Development**

  Although taking drugs at any age can lead to addiction, the earlier that drug use begins the greater the risk of serious addiction. Adolescent brains have yet to develop the areas that govern decision-making, judgment, and self-control. Thus, adolescents are especially prone to risk-taking behaviors like trying drugs.

Research shows that addicted brains may recover some of their former functions with prolonged abstinence. Due to the chronic nature of the disease, relapses are to be expected. They are a part of both the disease and the healing process.

Mental Illness and SUD

Mental illness affects millions of people in the United States regardless of age, race or gender. The National Institute of Mental Health (NIMH) found that one in four Americans experiences a mental health disorder within a given year. Additionally, NIMH found that about 6% or one in seventeen Americans suffer with serious mental illness.[8] The numbers are similar in South Carolina. According to the State Department of Mental Health (SCDMH), approximately one in four South Carolinians struggle with mental illness. SCDMH serves about 100,000 patients; approximately 33% are children or adolescents.[9]

Mental illness and SUD are closely linked. Like the chicken and the egg, it is very difficult to figure out which came first. Drugs of abuse often cause abusers to experience symptoms similar to those of mental illness. Correspondingly, symptoms of mental illnesses are similar to those of SUD. Regardless of which came first, scientists believe that drug abuse and mental illness are caused by overlapping factors such as brain deficits, genetics and/or exposure to stress or trauma.[10]

There is a high incidence of dual diagnosis between mental illness and SUD. The term dual diagnosis is often used interchangeably with the terms co-occurring disorders, co-occurring illnesses, concurrent disorders, co-morbidity, co-occurring disorder and dual disorder creating confusion.

According to the National Alliance on Mental Illness (NAMI), and the National Mental Health Association 53% of people with SUD have at least one serious mental illness. Moreover, 29% of mentally ill people abuse either alcohol or drugs.[11] In addition, roughly 50% of individuals with severe mental disorders are affected by substance abuse.[12]
SUD is common among individuals with the following psychiatric problems:

- Depressive disorders, such as depression and bipolar disorder.
- Anxiety disorders, including generalized anxiety disorder, panic disorder, obsessive-compulsive disorder, and phobias.

[8] Mental Illness Fact Sheet, National Alliance on Mental Illness, http://www.nami.org/Content/NavigationMenu/NAMIWALKS/Mental_Illness_Fact_Sheet_from_NAMI_website.pdf (October 2007)
[9] *Behind the Numbers: An Overview of State Budget Cuts and Their Impact on South Carolina's Children*, South Carolina Appleseed (2011) p.29.
[10] Mental Health America: Dual Diagnosis; http://www.mentalhealthamerica.net/index.cfm?objectid=c7df9405-1372-4d20-c89d7bd2cd1ca1b9
[11] National Alliance on Mental Illness, *Dual Diagnosis and Integrated Treatment of Mental Illness and Substance Abuse Disorder*, http://www.nami.org/Content/ContentGroups/Helpline1/Dual_Diagnosis_and_Integrated_Treatment_of_Mental_Illness_and_Substance_Abuse_Disorder.htm.
[12] *Ibid*.

- Other psychiatric disorders, such as schizophrenia and personality disorders.[13]

NIMH conducted a study of seven major psychiatric disorders and examined the correlation with substance abuse. The study found that:

- Antisocial personality disorder sufferers are **15.5%** more likely to have SUD than the public at large;
- Manic disorder sufferers are **14.4%** more likely to have SUD than the public at large;
- Schizophrenia sufferers are **10.1%** more likely to have SUD than the public at large;
- Panic disorder sufferers are **4.3%** more likely to have SUD than the public at large;
- Major depressive sufferers are **4.1%** more likely to have SUD than the public at large;
- Obsessive-compulsive disorder sufferers are **3.4%** more likely to have SUD than the public at large; and
- Phobia sufferers are **2.4%** more likely to have SUD than the public at large.[14]

The Epidemiological Catchment Area Survey (ECA) found that 42.7% of individuals with a primary addictive disorder had a mental disorder; and 14.7% of individuals with a primary mental disorder had an addictive disorder.[15] A NAMI study on dual diagnosis had similar results. It found that individuals with severe mental disorders were at a significant risk for developing a substance use disorder during their lifetime. The survey found that 61% of individuals with bipolar disorder suffer with substance abuse. That risk is more than five times the risk for the population at large. Contrary to the other survey, ECA found that 47% of schizophrenics had a substance abuse disorder. That makes their risk more than four times larger than the population at large.[16]

Mental illness is most effectively treated with a holistic approach to treatment. In addition to receiving treatment for their mental health illness, patients with a dual diagnosis need assistance with other aspects of their lives. They need help with housing, general health care, food assistance, childcare, transportation and a variety of other services. This is especially true of individuals who are at or near poverty and do not have the resources to combat all of the problems associated with mental illness and addiction.

SUD and Crime

SUD use and crime are inextricably interwoven in a dysfunctional relationship that often ends in misery or death. Many addicts turn to crime to feed their habits. Drugs and crime are linked in multiple ways. First, it is a crime to use, possess, manufacture, or distribute illicit drugs. Second, drugs effect the user's behavior by generate violence and other illegal activity. Chronic exposure to drugs can alter brain chemistry thereby affecting judgment, self-control and other inhibitors. Consequently, some people with SUD are more likely to commit crime.

Due to the zeal with which we prosecute violations of our drug laws, the United States leads the world in the number of people incarcerated in Federal and State correctional facilities. In 2008, for the first time one in every 100 adults was in prison or jail in America.[17] Currently, there are more than 2 million people in American

[13] *Ibid*.
[14] *Ibid*.
[15] Epidemiologic Catchment Area (ECA) Survey (administered 1980-1984), and the National Comorbidity Survey (NCS), administered between 1990 and 1992.
[16] National Alliance on Mental Illness, *Dual Diagnosis and Integrated Treatment of Mental Illness and Substance Abuse Disorder*, http://www.nami.org/Content/ContentGroups/Helpline1/Dual_Diagnosis_and_Integrated_Treatment_of_Mental_Illness_and_Substance_Abuse_Disorder.htm
[17] Warren, Jenifer, *One in 100: Behind Bars in America 2008* (Pew Center on the States**,** 2008) p.3

prisons or jails. Approximately one-quarter of those people held in prison or jail have been convicted of a drug offense. The United States incarcerates more people for drug offenses than any other country. With an estimated 6.8 million Americans struggling with SUD, the growth of the prison population is driven largely by incarceration for drug offenses.[18] Moreover, 17% of State and 18% of Federal prisoners committed their crime to obtain money for drugs.[19]

In 2004 there were 170,535 federal prisoners and 1,244,311 individuals incarcerated in State penal systems. 55% of the federal prisoners were held for drug law violations and 21% of state prisoners were held for drug law violations.[20] In 2004, 18% of federal inmates said they committed their current offense to obtain money for drugs. The numbers were similar for state inmates. 16% of all state inmates said they committed their offenses to earn money for drugs. Accordingly, 9.8% of all people who committed violent crimes, 30.3% of those who committed property crimes and 26.4% of those who committed drug crimes, did so to feed their drug habits.[21] Of the 13,689,220 arrests in the United States in 2009 1,663,589 or 12.1% were for drug-related offenses. Between 1980 and 2009 the adult drug arrest rate grew 138%.[22] In 2008, of the 14,005,615 arrests in the United States 1,702,537 or 12.1% were for drug related offenses.[23] Of the inmates residing in federal prisons in September 2011, more than half (101,929 or 50.4%) were serving sentences for federal drug offenses—including simple possession.[24]

Drug use and crime are closely linked in South Carolina as well. There were a total of 220,337 arrests in South Carolina in 2006.[25] Of the 220,337 arrests 37,495 or 17% were for drug related offenses.[26] In fact, drug law violations topped the list of offenses people were arrested for in South Carolina in 2006. Of the 238,081 arrests in South Carolina in 2005, 36,030 or 15% of them were for drug law violations.[27] Once again, arrests for drug crimes were the largest category of arrests.

Economic Impact of Drugs

The rampant abuse of drugs in America has placed a huge economic burden on our society. In 2007 alone, the estimated cost of illicit drug use in the United States was $193 billion. This figure includes direct and indirect costs related to productivity, crime, and health.[28]

According to the National Drug Intelligence Center (NDIC), drug abuse costs the United States $120 billion in lost productivity each year. Productivity is lost through the incapacitation of abusers. Incapacitation can result from reduced motivation, confinement in treatment programs, hospitalization, or incarceration. Incarceration costs the economy about $48 billion annually and drug-related homicides costs another of $4 billion in productivity.[29]

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[18] Justice Policy Institute, *Substance Abuse Treatment and Public Safety*, (Washington, DC: January 2008)
[19] Mumola, Christopher J., and Karberg, Jennifer C., *Drug Use and Dependence, State and Federal Prisoners, 2004*, (Washington, DC: US Dept. of Justice, Oct. 2006) (NCJ213530), p. 1.
[20] *Ibid*. p. 4.
[21] BJS, *Drug Use and Dependence, State and Federal Prisoners 2004,(* NCJ 213530 October 2006) and *Substance Abuse and Treatment, State and Federal Prisoners, 1997* (NCJ 172871, January 1999)
[22] Snyder, Howard N., PhD, *Arrest in the United States*, 1980-2009; http://www.bjs.gov/index.cfm?ty=pbdetail&iid=2203
[23] 2008 Crime in the United States, Department of Justice, www.fbi.gov
[24] Sacco, Lisa N. and Finklea, Kristin M., *Synthetic Drugs: Overview and Issues for Congress*, (Congressional Research Service Washington, DC: Library of Congress October 28, 2011) p.11.
[25] South Carolina State Budget and Control Board, *South Carolina Statistical Abstracts, Total South Carolina Arrests by Race Sex and Charge (2006*), http:abstract.sc.gov
[26] *Ibid.*
[27] South Carolina State Budget and Control Board, *South Carolina Statistical Abstracts, Total South Carolina Arrests by Race Sex and Charge (2005*), http:abstract.sc.gov
[28] US Department of Justice National Drug Intelligence Center, *The Economic Impact of Illicit Drug Use on American Society* (April 2011)
[29] *Ibid*.

Drug related crime costs the United States an estimated $61 billion a year, of which $56 billion is spent on the criminal justice system. NDIC estimates that drug-related healthcare expenses cost the United States more than $11 billion a year. This figure includes direct and indirect costs related to services like: emergency care, treatment and prevention services.

The Scope of the Problem

National Statistics[30]

The most commonly cited source that catalogues drug use in America is the National Survey on Drug Use and Health (NSDUH). NSDUH provides data on the prevalence, patterns, and treatment admissions for substance use among people age 12 and older. The survey is conducted yearly by the Substance Abuse and Mental Health Services Administration (SAMHSA). It is the largest government survey of its kind.

According to NSDUH, illicit drug use in the United States has risen to its highest level in nine years. In 2010, an estimated 22.6 million Americans aged 12 or older admitted using drugs within one month of the survey. This estimate represents 8.9% of the population aged 12 or older. Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically. The rate of illicit drug use among people aged 12 or older in 2010 (8.9 %) was similar to the rate in 2009 (8.7 %), but higher than the rate in 2008 (8%).[31]

Drug Prevalence by Age

The current rate of illicit drug use varies by age, but dramatically increases among older youths. In 2010, the rate increased from 4.0% for young people aged 12 and 13 to 9.3% for young people aged 14 and 15. The rate for people aged 16 and 17 was 16.6%. The highest rate of current illicit drug use was among 18 to 20 year olds 23.1%, with the next highest rate among 21 to 25 year olds 20.5%. Thereafter, the rate generally declined with age, although not all declines were significant. For instance, the rate was 14.8% among those aged 26 to 29, 12.9% among those aged 30 to 34, and 1.1% among those aged 65 or older.[32]

In 2010, adults aged 26 or older were less likely to be current users of illicit drugs than youths aged 12 to 17 or young adults aged 18 to 25 (6.6 vs. 10.1 and 21.5%, respectively.) However, there were more current users of illicit drugs aged 26 or older (12.8 million) than users aged 12 to 17 (2.5 million) and users aged 18 to 25 (7.3 million) combined.[33]

Drug Prevalence and Race

African-Americans

Since 2002 illicit drug use among African Americans has gone up. The past month rate of drug use among African-Americans jumped from 9.7% in 2002 to 10.7% in 2010. This one percentage point increase is disheartening because it dipped to 8.7% in both 2003 and 2004. According to researchers, the difference between the 2010 estimate and the 2003 and 2004 estimates is statistically significant.

White Americans

Among Whites, the percentage using illicit drugs in the past month has crept up as well. It was 8.5% in 2002 and increased to 9.1% in 2010. In 2003 the prevalence rate of among Whites bottomed out at 8.3%. Although the differences between the 2003 and 2010 rates might not seem large, researchers tell us that they were statistically significant.

[30] This report was completed in April 2012. All of the statistics in this report are for the most recent years available.
[31] All statistics in this section are from the *2010 National Survey on Drug Use and Health*, http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm.
[32] *Ibid.*
[33] *Ibid.*

Latino Americans
Illicit past month drug use among Latino has seen a sharp increase. Although the rate of Latinos using illicit drugs was 7.2% in 2002, it bottomed out to 6.2% in 2008. Since that time the percentage of illicit drug use increased almost two percentage points to 8.1% in 2010. This increase is statistically significant.

Past-Month Illicit Drug Use Rates by Race[34]

	2002	2003	2004	2005	2006	2007	2008	2009	2010
African Americans	9.7%	8.7%	8.7%	9.7%	9.8%	9.5%	10.1%	9.6%	10.7%
Whites	8.5%	8.3%	8.1%	8.1%	8.5%	8.2%	8.2%	8.8%	9.1%
Latinos	7.2%	8%	7.2%	7.6%	6.9%	6.6%	6.2%	7.9%	8.1%

Drug Prevalence and Employment Status

Among unemployed adults aged 18 or older in 2010, 17.5 % were current illicit drug users, which was higher than the 8.4% of those employed full time and 11.2% of those employed part time. However, most illicit drug users were employed. Of the 20.2 million current illicit drug users aged 18 or older in 2010, 13.3 million (65.9 %) were employed either full or part time.

Treatment Statistics

"Treatment-need" is defined as having a drug addiction or receiving treatment at a specialty facility (hospital inpatient, drug rehabilitation, or mental health centers) within the past 12 months. Of the 20.5 million people aged 12 or older who needed substance abuse treatment in 2010, only 1 million people or 5% reported that they received the needed treatment. In 2009, 23.5 million people aged 12 or older needed treatment for SUD. That figure represents 9.3% of all people 12 or older.

Another survey found that both the United States population aged 12 and older and the number of SUD related admissions among the same age group increased 11% between 1998 and 2008. Although there were more alcohol related substance abuse admissions during the same ten year period, alcohol admissions were declining while illicit drug admissions increased. In 2008 there were 1.8 million SUD related treatment admissions. Forty-one percent of these treatment admissions involved alcohol abuse and 20% of the admissions were for heroin and other opiate-related admissions and another 17% of admissions were related to marijuana use.

Treatment Statistics – South Carolina
In 2008, 29,895 South Carolinians aged 12 and older were admitted to a treatment facility for substance use. Although there were more primary admissions for alcohol abuse than any other type of substance, 50.7% of the alcohol admissions had a secondary drug problem. Among illicit drugs, more people were admitted to treatment for marijuana abuse than any other drug. Marijuana was the primary cause of 19.9% or 5,978 of all substance abuse admissions and methamphetamine was the primary cause of 1.9% or 587 substance use admissions.[35]

Drug Abuse and the Penal System - Nationally
Going to prison does not mean that a drug abuser will stop using and abusing drugs. Although drug use is illegal, drugs routinely find their way into all of our prisons, both federal and state. Despite common knowledge that illicit drugs are readily available in prisons there are few statistics on the prevalence of substance abuse in prison. In fact, the Bureau of Justice Statistics does not collect this information.

[34] Substance Abuse and Mental Health Services Administration, *2010 National Survey on Drug Use and Health*, http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm.
[35] US Department of Health and Human Services, *Treatment Episode Data Sets (TEDS) 1998-2008 State Admissions to Substance Abuse Treatment Services* (December 2010) p. 128.

An estimated 1.5 million adults, aged 18 or older, were on parole or other type of supervised release from prison at some time during 2009. More than one quarter, or 27%, were current drug users. Approximately 20% of these people admitted to current use of marijuana and 9.8% admitted abusing psychotherapeutic drugs.[36] The drug use rates of parolees were higher than those of the general public. While 27% of parolees admitted illicit drug use only 8.7% of the general public admitted similar use. For marijuana, the usage rate for parolees was 20.6% compared the general public's rate of 6.7%.[37]

An estimated 5.4 million adults aged 18 or older were on probation at some time during the 2010. 29.9% were current illicit drug users, with 23% reporting current use of marijuana and 10.5% reporting current nonmedical use of psychotherapeutic drugs. These rates are higher than those reported by adults not on probation during the same period. While 29.9% of probationers admitted abusing drugs only 8.3% adults of non-probationers admitted using illicit drugs. 23% of probationers and 6.4% of non-probationers admitted using marijuana.[38]

Drug Use and the Penal System – South Carolina

According to the South Carolina Department of Corrections (SCDC), there were approximately 23,306 people incarcerated in South Carolina's prisons and jails in 2011.[39] In 2010, South Carolina had an incarceration rate of 495 state inmates per 100,000 residents which ranked 10th in the nation.[40] There is a huge disparity between African-Americans and Whites among the state's prison population. Although African-Americans amount to only about 28% of the state's population, they represent the 66% of the male prison population and 43% of the females in prison.[41]

African-Americans are disproportionately represented among new admissions to South Carolina's penal system. 4,406 or 40.5% African-American males were admitted to the prison population in fiscal year 2011. Only 2,541or 23.3% of new prison admittees were White males. However the disparity in prison admissions among women of different races was not as large. 454 or 4.2% of women admitted to prison in FY11 were African-American and 584 or 5.4% were White.[42]

Drugs

Marijuana

Over the history of United States marijuana has often been confused with hemp. Botanically, they are both a part of the same genus, cannabis. Cannabis plants containing less than one percent of psychoactive cannabinoids (THC) are called "hemp." Hemp can be used in the production of about 25,000 different industrial products. Cannabis plants containing 10 to 20% THC are known as "marijuana." Hemp has been cultivated in the United States since the foundation of the colony at Jamestown. Marijuana began to be cultivated in the 19th century.

Of the 21.8 million Americans aged 12 or older who were current users of illicit drugs in 2009, 16.7 million or 77% of them were marijuana users. Marijuana is easily the most popular drug in the United States.[43] It was used by 76.8% of current illicit drug users and was the only drug used by 60.1% of them.[44] Between 2007 and 2010,

[36] Psychotherapeutic drugs are prescription-type medications with legitimate medical uses as pain relievers, tranquilizers and stimulants.
[37] Substance Abuse and Mental Health Services Administration *2010 National Survey on Drug Use and Health*, http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm..
[38] Substance Abuse and Mental Health Services Administration *2010 National Survey on Drug Use and Health*, http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm..
[39] South Carolina Department of Corrections, *Profile of Inmates Institutional Count* (as of June 30, 2011) www.doc.sc.gov.
[40] South Carolina Department of Corrections, *Profile of Inmates Institutional Count* (as of June 30, 2011) www.doc.sc.gov.
[41] South Carolina Department of Corrections, *Profile of Inmates Institutional Count FY11,* www.doc.sc.gov (as of June 30, 2011).
[42] South Carolina Department of Corrections, *Admissions to SCDC Base Population FY11,* www.doc.sc.gov.
[43] Office of National Drug Control Policy, *2010 National Survey on Drug Use and Health* , http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm.
[44] Substance Abuse and Mental Health Services Administration, *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings* (2011), http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm.

the rate of use increased from 5.8 to 6.9 %, and the number of users increased from 14.4 million to 17.4 million.[45] In 2010, marijuana was the most commonly used illicit drug, with 17.4 million current users.[46]

In 2010, 9 million people aged 12 or older were current users of illicit drugs other than marijuana (or 39.9% of illicit drug users aged 12 or older). Current use of other drugs excluding marijuana was reported by 23.2% of illicit drug users and 16.7% used both marijuana and other drugs. The number and percentage of persons aged 12 or older who were current users of marijuana in 2010 were similar to 2009 estimates. The 2010 estimates were higher than those in 2002 through 2008.[47]

According to a 2011 report funded by National Institute of Drug Abuse (NIDA), marijuana use has risen among teens in the past three years in contrast to the previous decade. As a consequence of changing attitudes toward medical marijuana, the study found that concerns about the risks of using marijuana have plummeted. This is attributed to the discussions about medical marijuana. The study found that 1.3% of eighth graders, 3.6% of tenth graders and 6.6% of twelfth graders were daily or near daily users of marijuana. This means that 1 in 15 seniors are daily users of marijuana.[48]

Marijuana Use in South Carolina

Marijuana is also the drug of choice for most South Carolina drug users. According to the Drug Enforcement Administration (DEA) the majority of the marijuana in South Carolina enters the state from Mexico by way of I-20. I-26 and I-95 are also popular routes for traffickers targeting Charleston, Florence, Myrtle Beach and their environs. Although the majority of South Carolina's marijuana is imported, some of it is locally grown. The South Carolina Law Enforcement Division (SLED) and the South Carolina National Guard routinely destroy "pot" farms. In 2009, 3,973.5kgs. of marijuana were seized by law enforcement in South Carolina.[49]

In 2010, there were 11,164 hospital admissions where marijuana was either the primary, secondary or tertiary cause of the problem. About 34% of the marijuana admissions were to outpatient facilities and 11.5% of the admissions were to inpatient facilities.[50] (See Table 1)

Unlike other drugs, marijuana use often begins at a young age. According to SAMSHA approximately 21,000 adolescents in South Carolina used marijuana in the past month.[51] In 2010, 2,885 adolescents aged 12-17 represented 25.8% of admissions where marijuana was the primary, secondary or tertiary problem.[52]

Although marijuana is popular among both sexes, marijuana related hospital admissions among men outnumber those among women by a ratio of about two to one. Despite the fact that there are more male marijuana users than female, the number of marijuana related hospital admissions for men appears to be decreasing while the number of hospital admissions among women appears to be on the incline.[53] According to the combined statistics of 2009 and 2010, 15,749 or 69.3% marijuana admissions were for males and 6,981 or 30.7% admissions were for females.[54]

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[45] Substance Abuse and Mental Health Services Administration, *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings* (2011), http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm.
[46] *Ibid*.
[47] *Ibid*.
[48] Johnson, Lloyd D., PhD et al., *Monitoring the Future: National Results on Adolescent Drug Use* (Ann Arbor: Institute for Social Research, University of Michigan 2012).
[49] US Drug Enforcement Administration (DEA) *South Carolina 2009*, www.justice.gov/dea/pubs/state_factsheets/southcarolina.html.
[50] SC DAODAS, *Marijuana Admissions Report*, dated May 23 2011.
[51] www.inspirationsyouth.com/teen-rehab-south-carolina-asp
[52] SC DAODAS, *Marijuana Admissions Report*, dated May 23 2011.
[53] *Ibid.*
[54] *Ibid.*

Primary, Secondary or Tertiary Marijuana Hospital Admissions in South Carolina by Gender[55]

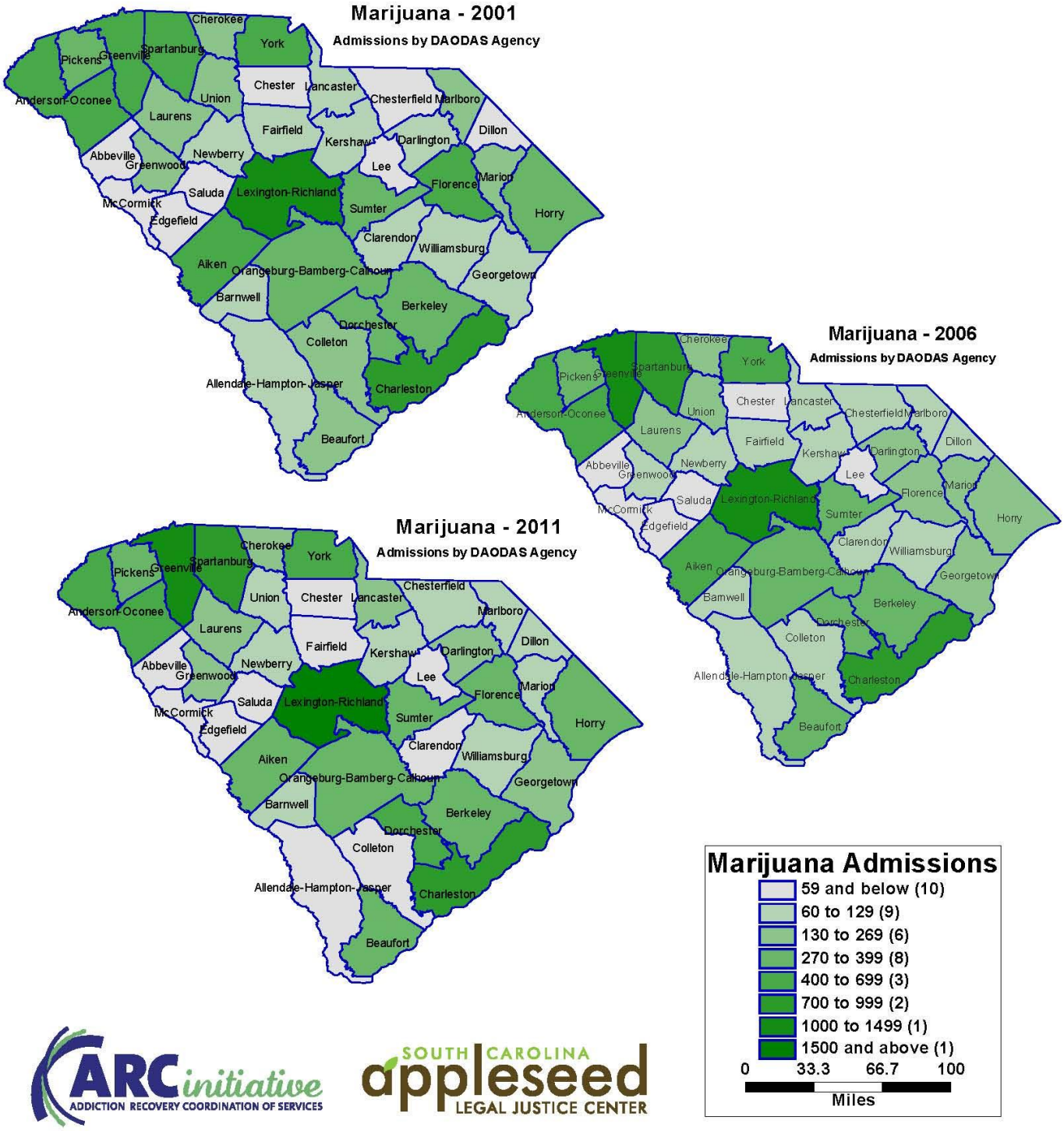
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Men	6,896 (73%)	6,120 (71.1%)	6,107 (71.6%)	6,385 (71.1%)	6,952 (70%)	7,357 (69.3%)	7,654 (68.4%)	7,808 (69.2%)	8,041 (69.4%)	7,708 (69%)
Women	2,547 (27%)	2,472 (28.7%)	2,414 (28.3%)	2,597 (28.9%)	2,936 (29.6%)	3,205 (30.2%)	3,509 (31.4%)	3,465 (30.7%)	3,534 (30.5%)	3,447 (30.9%)

Unlike other illicit drugs, marijuana is equally popular among the races. Of the total 22,749 marijuana admissions in 2009 and 2010, 13,181 or 58% were for Whites and only 8,966 or 39.4% were African-Americans.[56]

[55] *Ibid.*
[56] SC DAODAS *Marijuana Admissions Report*, dated May 23, 2011.

Table 1

Marijuana
Admissions 2001, 2006 and 2011



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Prescription Drugs

Prescription drug abuse is the fastest growing kind of drug abuse today. Prescription drug abuse refers to the taking of prescription medication in a non-prescribed manner or the taking of prescription drugs that are not prescribed to you. Abuse of prescription drugs can create numerous serious health effects, including addiction. Commonly abused classes of prescription medications include: opioids (for pain); central nervous system depressants (for anxiety and sleep disorders); and stimulants (for ADHD and narcolepsy). Opioids include drugs like hydrocodone (Vicodin) and oxycodone (OxyContin). Central nervous system depressants include barbiturates such as pentobarbital sodium (Nembutal), benzodiazepines such as diazepam (Valium), and alprazolam (Xanax). Stimulants include drugs like dextroamphetamine (Dexedrine), methylphenidate (Ritalin and Concerta), and amphetamines (Adderall). According to the DEA, OxyContin, hydrocodone products like Vicodin, and pseudoephedrine are all abused in South Carolina. They are distributed primarily through illegal sale by members of the health care profession, and doctor shopping (collecting prescriptions from a number of doctors.)[57]

While rates of prescription abuse have been relatively stable in recent years, the consequences of abuse have been rising. According to findings from the federal data system, rates of drug overdose deaths primarily caused by pain relievers increased roughly five-fold between 1990 and 2007; the proportion of SUD treatment admissions reporting any pain reliever abuse increased more than four-fold between 1998 and 2008; and emergency department visits involving the misuse or abuse of pharmaceuticals increased 98% between 2004 and 2009. In 2009 prescription drug admission admissions exceeded the number of admissions attributable to the use of illicit drugs.

Although the use of illicit drugs like cocaine has declined, prescription drug abuse has skyrocketed. According to Office of National Drug Policy (ONDP) there were an estimated 5.3 million prescription drug abusers in the United States in 2009. That is a 20% increase from the estimated 4.4 million prescription drug abusers in 2002. Nearly, one-third of people 12 and older who used drugs for the first time in 2009 began by misusing prescription drugs. Interestingly enough the same study found that over 70% of prescription drug abusers began by collecting them from friends and relatives.[58]

In 2010, 2.4 million persons aged 12 or older used prescription drugs, non-medically, for the first time. That amounts to an average of around 6,600 initiates per day. Two million people began abusing prescription drugs by abusing pain relievers. 1.2 million people began their abuse by abusing tranquilizers, 624,000 people began by abusing stimulants, and 252,000 began their prescription drug abuse by abusing sedatives.[59]

Prescription drugs were the most abused drugs by 12th graders in the prior year. Abuse of prescription drugs is highest among young adults aged 18-25 with 5.9% of them reporting non-medical use in the prior month. Among teenagers aged 12 – 17 the rate of prescription drug abuse rate in the prior month was 3%.[60]

Among 12th graders, prior nonmedical use of Vicodin decreased from 9.7 % to 8%. However, prior year nonmedical use of OxyContin increased among 10th graders over the past 5 years. Moreover, past-year nonmedical use of Adderall and over the counter cough and cold medicines among 12th graders remained at 6.5 percent and 6.6 percent, respectively. While the rate of use of sedatives and tranquilizers has decreased in the past five years, the popularity of amphetamines and opiates has increased.[61]

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[57] US Drug Enforcement Administration (DEA) *South Carolina 2*009, www.justice.gov/dea/pubs/state_factsheets/southcarolina.html

[58] Substance Abuse and Mental Health Services Administration, *Results from the 2009 National Survey on Drug Use and Health: Summary of National Findings* (2010) http://oas.samhsa.gov/NSDUH/2k9NSDUH/2k9ResultsP.pdf.

[59] Substance Abuse and Mental Health Services Administration, *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings* (2011), http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm.

[60] Substance Abuse and Mental Health Services Administration, *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings* (2011), http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm.

[61] Johnson, Lloyd D., PhD et al., *Monitoring the Future: National Results on Adolescent Drug Use* (Ann Arbor: Institute for Social Research, University of Michigan 2012).

Prescription Drug and Opiate Abuse in South Carolina

Prescription drug and opiate abuse is a problem in South Carolina. The problem is on the rise. In 2000 only 1,503 of South Carolina's 17,916 drug related hospital admissions where opiate abuse was the primary, secondary or tertiary problem. By 2009 that number had doubled. While the total substance abuse number stayed approximately the same, the percentage of opiate related admissions shot up. In 2009 there were a total of 17,838 drug related admissions of which 3,367 or 18.9% were for opiate related substance abuse. (See Table 2)[62]

Although opiate addiction affects people of all ages, it is most prevalent among young people. Between 2001 and 2010 the rate of opiate admissions for people aged 25-34 almost tripled. In 2001 there were 567 hospital admissions where opiates were the primary, secondary or tertiary problem. This amounted to 33.1% of the admissions. However, in 2010 the number increased to 1,369 or 39.5% of opiate admissions.[63]

In South Carolina, opiate admissions are equally divided between the sexes and has been consistently so for the past 10 years. Of the 1,713 hospital admissions in 2001 where opiates were the primary, secondary or tertiary problem, 971 or 56.7% of the admittees were male and 742 or 43.3% were female. In 2010 1,855 or 53.5% of the people admitted for opiate related problems were male and 1,611 or 46.5% were female.[64]

Primary, Secondary or Tertiary Opiate Hospital Admissions in South Carolina by Gender[65]

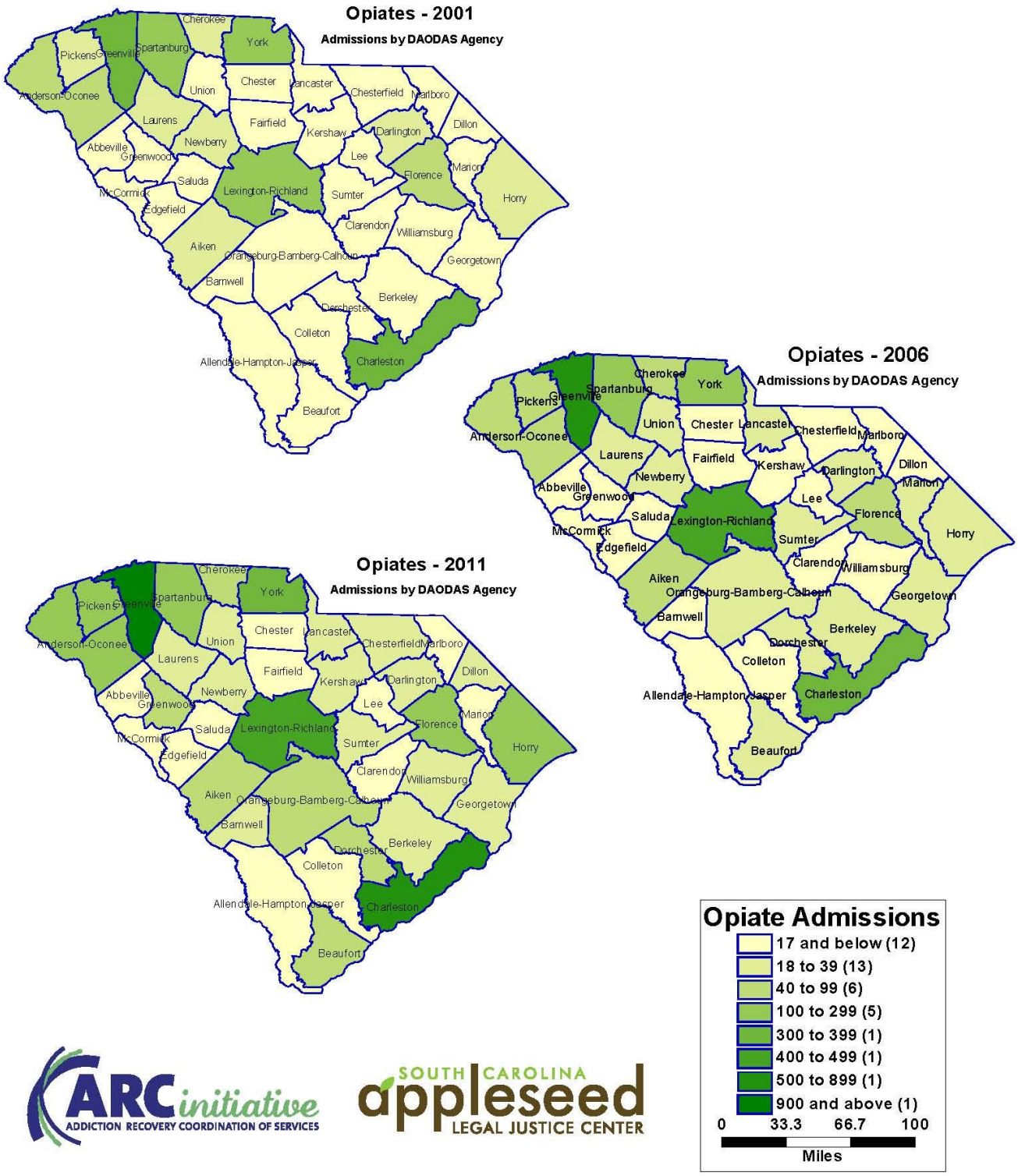
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Men	1,069 (55.6%)	1,090 (57.7%)	1,122 (57.7%)	1,111 (56.7%)	1,231 (54.4%)	1,368 (55.4%)	1,394 (53.7%)	1,595 (52.9%)	1,780 (52.9%)	1,855 (53.5%)
Women	855 (44.4%)	797 (42.2%)	818 (42.1%)	846 (43.2%)	1,029 (45.5%)	1,092 (44.2%)	1,201 (46.2%)	1,418 (47%)	1,584 (47%)	1,611 (46.5%)

Opiate addiction is not equally prevalent among the races. Among Whites, opiate abuse rates are climbing. In 2001 81.1% of opiate hospital admissions were among Whites and 17.6% were among African-Americans. According to the most recent statistics, Whites now make up 91.2% of opiate admissions. African-Americans account for only 7% of opiate admissions.[66]

[62] SC DAODAS *Marijuana Admissions Report*, (May 23, 2011) p.1.
[63] *Ibid p.1*
[64] *Ibid. p.3*
[65] *Ibid. p.4*
[66] *Ibid. p.3*

Table 2

Opiates
Admissions 2001, 2006 and 2011



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Cocaine/Crack

Cocaine is one of the oldest drugs in the world. It is a powerfully addictive stimulant which can be inhaled, smoked, injected, or ingested orally. For much of the 20th century, inhaling (or "snorting") cocaine in its powder form was the most popular way of taking cocaine. However, in the early 1980s, a potent, smokeable form of cocaine known as "crack" was developed. Crack cocaine is less expensive than the powdered form. It provides a more immediate and intense effect than inhaling powder cocaine. Crack has become one of the most commonly used forms of the drug in the United States.

Nationally, cocaine use appears to be trending downward slightly. There were 1.5 million current cocaine users aged 12 or older in 2010 and 1.6 million cocaine users in 2009. These numbers represent .6% and .7% of the U.S. population respectively.[67]

Despite our nation's best efforts, hundreds of thousands of people try cocaine for the first time each year. In 2010, an estimated 637,000 people aged 12 and older tried cocaine for the first time within the past 12 months; this averages approximately 1,700 initiates per day. Seventy-one percent of these first-time users were over 18. An estimated 617,000 people began using cocaine in 2009.[68]

Nationally, admissions to SUD treatment in which cocaine was the primary substance of abuse decreased from 1995 to 2005. The number of admissions decreased from 278,400 in 1995 (17% of all admissions) to 256,500 in 2005 (14% of all admissions).[69]

Among admissions to SUD treatment facilities in which cocaine was the primary substance of abuse, smoking was the most frequent method of administration of the drug in each year from 1995 to 2005.[70] Between 1995 and 2005 inhalation or snorting was the second most common method of taking cocaine. The proportion of individuals admitted to hospital for problems caused by inhaling cocaine increased from 14% of admissions to 22% between 1995 and 22%.[71]

Cocaine Use and Age

Crack cocaine use is most common among individuals aged between 18-25 years old. While only 2.4% - 4% of teens use crack, the percentage increases to 15% for young adults.[72] Cocaine use among high school sophomores is decreasing. NIDA reports that past-year use of crack cocaine decreased in 10th graders from 2.3% to 1.6%. Although this is an encouraging trend, some speculate that the decline in cocaine use among teenagers stems from the availability of inexpensive prescription drugs rather than a desire to forgo illicit drug use.

Cocaine Use and Race

Cocaine use is also found across all racial lines. The rate of cocaine abuse is highest among Native Americans and/or Alaskan natives. Their rate of cocaine use is about 2%. Other cocaine use rates include 1.6% for African-Americans and 0.8% for Whites and Latinos.[73]

Cocaine Use in South Carolina

Although cocaine abuse is a problem in South Carolina, prevalence rates have decreased over the past decade. In 2001, 23.9% or 7,119 of drug related hospital admissions where for cocaine. By 2010 that number was

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[67] Substance Abuse and Mental Health Services Administration, *Results from the 2009 National Survey on Drug Use and Health: Summary of National Findings* (2010) http://oas.samhsa.gov/NSDUH/2k9NSDUH/2k9ResultsP.pdf.
[68] *Ibid.*
[69] *Ibid.*
[70] Substance Abuse and Mental Health Services Administration DASIS Report, *Cocaine Route of Administration Trends: 1995-2005*; http://www.samhsa.gov/data/2k7/crackTX/crackTX.htm.
[71] *Ibid.*
[72] www.crackcocaine.us.
[73] *Ibid.*

reduced to only 4,843 or 16.9% of drug related admissions.[74] Cocaine is most prevalent among people between 25 and 44. In 2001, there were 2,405 hospital admissions where cocaine abuse was the either the primary, secondary or tertiary cause of the problem. This amounted to 33.8% of all drug related admissions. That number decreased to 1,493 cocaine related hospital admissions in 2010. That amounted to 30.8% of all drug related admissions.[75] (See Table 3)

Ten years ago cocaine was used primarily by men. In 2001, there were almost twice as many hospital admissions where cocaine was the primary, secondary or tertiary problem among men than women. 4,426 or 62.2% of the cocaine related hospital admissions were among males and only 2,693 were among females. By 2010 cocaine related hospital admissions among females almost rivaled those among males. There were 2,653 cocaine related hospital admissions among men and 2,187 were among women. That is a ratio of 54.8% male to 45.2% female.[76]

Primary, Secondary or Tertiary Cocaine Hospital Admissions in South Carolina by Gender[77]

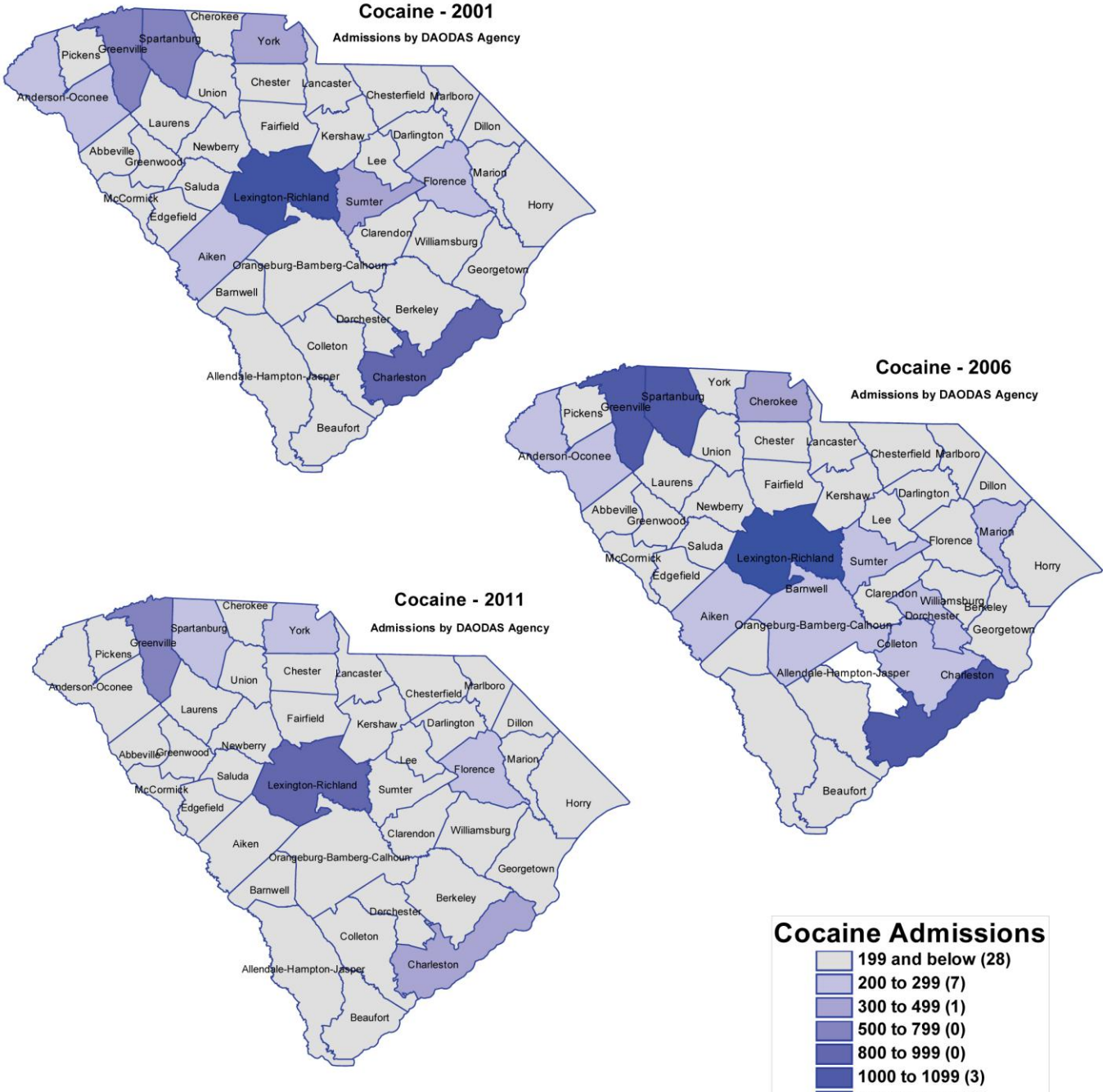
	2001	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
Men	4,426 (62.2%)	3,654 (58.6%)	3,125 (60.5%)	4,164 (51.3%)	4,767 (54.5%)	5,182 (59.9%)	4,910 (58.3%)	4,251 (55.7%)	3,382 (56.7%)	2,653 (54.8%)
Women	2,693 (37.8%)	2,579 (41.4%)	2,543 (39.4%)	2,718 (39.5%)	3,128 (39.5%)	3,448 (39.8%)	3,500 (41.6%)	3,094 (42.1%)	2,582 (43.2%)	2,187 (45.2%)

A decade ago hospital admissions where cocaine was the primary, secondary or tertiary cause of the problem were almost equally prevalent among the races. Three thousand and three or 42.2% of hospital admissions were among Whites and 4,042 or 56.8% of the admissions were among African-Americans. Ten years later that ratio flipped, 2,636 or 54.4% admissions were among White and 2,111 or 43.6% of hospital admissions were among African-Americans.[78]

[74] SC DAODAS *Cocaine Admissions Report*, (May 23, 2011) p.1
[75] *Ibid.*
[76] *Ibid. p.3*
[77] *Ibid.*
[78] *Ibid.*

Table 3

Cocaine
Admissions 2001, 2006 and 2011



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Methamphetamine

Methamphetamine (meth) is an addictive stimulant that is closely related to amphetamine. It was first synthesized by a Japanese chemist in 1919. Today's methamphetamine is much stronger than the methamphetamine made almost 100 years ago. Made frequently in small labs in rural areas, methamphetamine is long lasting and toxic to dopamine nerve terminals in the central nervous system. Methamphetamine is a white, odorless, bitter-tasting powder taken orally or by snorting or injecting. It can also come in a solid.

In 2009, 1.2 million Americans age 12 and older had abused methamphetamine at least once in the year prior to being surveyed.[79] This number is a significant increase from previous years. There were 314,000 methamphetamine users in 2008, 529,000 methamphetamine users in 2007 and 731,000 methamphetamine users in 2006.[80]

According to the Monitoring the Future Survey, the number of high school seniors to try methamphetamine has fallen in recent years. In 2009 1.6% of eighth graders reported using methamphetamine. This number is down from 2.3% in the previous year. From 2002 to 2007 past-month methamphetamine usage among 12-17 declined from .3% to .1%. [81]

Methamphetamine Use in South Carolina

According to law enforcement agencies in South Carolina, methamphetamine is a growing threat in the state. However, methamphetamine's popularity is regional. Most methamphetamine use in South Carolina centers in rural areas in the Upstate and pockets around Lexington and Charleston Counties.[82] For the past few years methamphetamine use has been trending downwards. According to SC DAODAS, methamphetamine use in South Carolina reached its peak in 2005 when methamphetamine abuse amounted to 2.8% of all drug related hospital admissions where methamphetamine was the primary cause of the problem. Since 2005, methamphetamine's percentage of overall drug related hospital admissions has declined every year until it reached 1.9% in 2010.[83] (See Table 4)

In South Carolina methamphetamine use is most prevalent among young adults aged 25-34. A review of methamphetamine related hospital admissions over the past 10 years indicates that the number of admissions has never ticked above 100 among individuals aged 12-17 and 45-65.[84] Traditionally, methamphetamine use was more prevalent among men than women. However, over the past ten years the rate of methamphetamine related hospital admissions among women has sky- rocketed. Since 2005, there have been more methamphetamine admissions among women than men. The percentage of methamphetamine related hospital admissions among women increased from 35.6% in 2001 to 53.8% in 2010.[85]

[79] Substance Abuse and Mental Health Services Administration, *Results from the 2009 National Survey on Drug Use and Health: Summary of National Findings* (2010) http://oas.samhsa.gov/NSDUH/2k9NSDUH/2k9ResultsP.pdf..

[80] Substance Abuse and Mental Health Services Administration, *Results from the 2008 National Survey on Drug Use and Health: Summary of National Findings* (2009) http://www.oas.samhsa.gov/nsduh/2k8nsduh/2k8Results.cfm**.**

[81] National Institute on Drug Abuse, *Drug Facts, Methamphetamine*, (March 2010) http://www.drugabuse.gov/publications/drugfacts/methamphetamine; Johnson, Lloyd D., PhD et al., *Monitoring the Future: National Results on Adolescent Drug Use* (Ann Arbor: Institute for Social Research, University of Michigan 2012).

[82] Sevigny, Eric L. PhD., *Methamphetamine in South Carolina: A Report on Trends and Impact*, (Columbia: Department of Criminal Justice, University of South Carolina, September 2008). p1.

[83] SC DAODAS *Methamphetamine Admissions* (May 23, 2011).1

[84] *Ibid.*

[85] *Ibid.p.3*

Primary, Secondary or Tertiary Methamphetamine Hospital Admissions in South Carolina by Gender[86]

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Men	143 (64.4%)	183 (57.9%)	220 (50.9%)	350 (56.5%)	532 (58.6%)	503 (47.6%)	500 (48.8%)	431 (47.4%)	373 (44.3%)	438 (46.2%)
Women	79 (35.6%)	133 (42.1%)	211 (48.8%)	269 (43.5%)	552 (51.3%)	552 (52.2%)	521 (50.9%)	476 (52.4%)	468 (55.6%)	511 (53.8%)

Methamphetamines are far more prevalent among Whites than African-Americans in South Carolina. According to SCDAODAS, the percentage of hospital admissions where methamphetamines was the primary, secondary or tertiary cause of the problem was never lower than 94% among Whites. In 2001, 95% of meth related hospital admissions where among Whites and 4.5% were among African-Americans. The number percentage of hospital admissions among African-Americans was even smaller in 2010. 97.5% of all methamphetamine related hospital admissions were among Whites and only 1.6% were among African-Americans.[87]

Methamphetamine and Law Enforcement

According to law enforcement agencies in South Carolina, methamphetamine is a growing threat in the state. After dropping for several years, the number of clandestine labs uncovered in the state has been on a steady rise. In 2004, the first year that statistics are available, there were a total of 191 clandestine meth lab incidents including seizures of labs, dumpsites and equipment. Since bottoming out with 58 incidents in 2008, meth has made a striking comeback in the Palmetto State. In 2009 there were 99 meth incidents. The number increased to 125 and 267 incidents in 2010 and 2011 respectively.[88]

Methamphetamine Lab Incidents, 2004-2011[89]

Numbers include all meth incidents, including labs, dumpsites or chemical and glassware seizures.

Meth Seizures	2004	2005	2006	2007	2008	2009	2010	2011
	191	142	69	26	56	99	125	267

[86] *Ibid.*
[87] *Ibid.p.3*
[88] Drug Enforcement Administration, *Methamphetamine Incidents Maps 2004-2011*, http://www.justice.gov/dea/concern/map_lab_seizures.html.
[89] *Ibid.*

Causes of the Problem

Money, or lack of it, is the backdrop for many difficulties faced by individuals battling SUD in South Carolina. Whether you are talking about the government's lack of resources in waging its "war on drugs," or an individual who turns to drugs in face of poverty, it all comes down to money. However, money alone is not the cause of South Carolina's inability to adequately deal with the SUD problems of many of its citizens. South Carolina's problem falls into four basic categories: institutional barriers; criminal justice problems; age old biases and physical obstacles.

There are several institutional barriers that affect the state's ability to effectively handle its citizens' drug problems. Many institutional barriers stem from the fact that although SUD and mental illness are closely linked, they are handled by two separate state agencies with separate bureaucracies. As a result, people struggling with SUD and the people who love them are often confused about where to turn for help.

There is a misplaced reliance on incarceration over treatment as a method of dealing with SUD. Despite the fact that addiction is an illness, society still favors incarceration over treatment. Society's zeal to punish outweighs logic. Although research has proven that it is cheaper to treat SUD than to warehouse addicts in prisons, government treatment programs continue to bear the brunt of state budget cuts.

Racial and gender biases still underlie SUD treatment in South Carolina. As a result of these biases and stereotypes, addicted individuals are often unable to get the help they need because of preconceived notions about how they got into their position of need in the first place.

Fourth, physical obstacles or the isolation of South Carolina's rural counties presents difficulties for individuals battling addiction. County of residence is a huge factor in determining what services are available. If one lives in one of the state's more urban areas, there is a choice of hospitals, treatment centers, housing facilities etc. However, if one lives in a rural area you may be lucky to have just one hospital, treatment center etc., your choices are more limited.

SC DAODAS v. SC DMH: The Problem of Co-occurring Disorders

Fifty percent of people with severe mental disorders are affected by SUD and 53% of drug abusers also have at least one serious mental illness.[90] Dual diagnosis occurs when an individual has been diagnosed with co-occurring disorders -- mental illness and SUD. Research has proven that the best recovery outcomes are achieved when both problems are treated in tandem. Focusing on only one diagnosis does not ensure the other will go away. Dual diagnosis services integrate assistance for each condition, helping people recover from both in one setting, at the same time

Notwithstanding the prevalence of co-occurring disorders, the two conditions are treated by two separate state agencies. Mental illness is handled by SC DMH and substance abuse is handled by SC DAODAS thereby causing confusion. SC DMH is one of South Carolina's largest agencies and it has a wide variety of services for the treatment of mental health disorders. However, when SUD is the primary diagnosis, SC DAODAS is the lead agency. SC DAODAS is underfunded and understaffed compared to the SC DMH.

[90] National Alliance on Mental Illness, *Dual Diagnosis and Integrated Treatment of Mental Illness and Substance Abuse Disorder*, http://www.nami.org/Content/ContentGroups/Helpline1/Dual_Diagnosis_and_Integrated_Treatment_of_Mental_Illness_and_Substance_Abuse_Disorder.htm.

The South Carolina Department of Mental Health
SC DMH is one of the largest State agencies in South Carolina. It is an independent state agency which reports to the South Carolina Mental Health Commission. The mission of SCDMH is to support the recovery of adults and children affected by mental illness. SC DMH has 3,990 full time employees that serve about 102,000 South Carolinians. It operates numerous inpatient and outpatient services through 17 community mental health centers, 64 satellite clinics, one community nursing center and three nursing homes for veterans. It also operates four psychiatric hospitals including one which specializes in treating individuals with a dual diagnosis (Morris Village) and another which specializes in treating children and adolescents with dual diagnosis (William S. Hall).

In 2009, NAMI issued a report grading South Carolina's mental health service system. South Carolina was one of 21 states to receive a D. The D is more painful considering the fact that South Carolina's grade was a B in 2006. This drop was the largest in the national survey.

Budget
According to the NAMI, South Carolina leads the nation in cutting funds to its state mental health agency. In fact, SC DMH lost $86 million or 37% in State appropriations since June 30, 2008. SC DMH's current recurring state appropriation for FY1-FY12, $131 million, sends the agency back to 1987 funding levels. However, in inflation adjusted dollars, this decrease in funding is even more catastrophic. In 2011, dollars General Fund support for SC DMH was $315 million in 1987. That is a 334% reduction in state support.

The majority (58%) of SC DMH's budget comes from "other funds." Recurring state funds accounted for only 34% of SC DMH's annual budget in FY11-12. The Federal government has played a decisive role in helping SC DMH survive the recession. SC DMH has been able to leverage Medicaid dollars and receive federal grants. In January 2011, SC DMH had 40 active grants worth $34 million.

The state has drastically cut funding to SC DMH's community mental health centers. Between FY07 and FY12 the SC DMH's community mental health centers lost 36% of their state funds. Funding for SC DMH's inpatient services has also declined. Between FY06-07 and FY11-12 inpatient services lost $15million or 33% of their state funding.

Despite SC DMH's best efforts, these extensive budget cuts have resulted in the curtailment of some services as well as passing on costs to consumers. Although SC DMH recognizes that the best treatment outcomes are achieved by addressing all of the patents needs (housing, employment childcare etc.) The economic downturn in general and the state's budget cuts specifically have reduced SC DMH's efforts in this area. For example, state budget cuts have forced SC DMH to limit funding of the Department's Housing and Homeless Program. For the past 15 years this program was able to provide matching funds for those who developed housing for the mentally ill in the community. This has been discontinued in more recent budgets.

Service Gap
Although the development of a community-based system of care is a paramount objective for SC DMH, the agency has struggled to meet that goal by increasing its penetration rate. Penetration rates assess SC DMH's ability to reach people in need of mental health services. For the past several years SC DMH's adult penetration rate has been below the national average. In 2011, SC DMH's adult penetration rate was 16.9. Nationally, the penetration rate was 19.6.[91] SC DMH's decreasing penetration rate is a direct result of the budget cuts that have decimated SC DMH. In response to the cuts, SC DMH has been forced to focus on those designated as being "severely" mentally ill at the expense of people who are "just" mentally ill.

[91] South Carolina Department of Mental Health, *Accountability Report, 2011* p. 58

While SC DMH's adult penetration rate is below the national average, the children's penetration rate is above the national average. In 2011 the penetration rate for children aged 0-17 was 25.6 and the national rate was 24.2.[92] Despite the fact that SC DMH's penetration rate exceeded the national average, it declined 10% over the past decade.

South Carolina Department of Alcohol and Other Drug Services (SC DAODAS)
SC DAODAS is a cabinet level agency responsible for the treatment of adults and children struggling with alcohol and drug abuse. It is estimated that alcohol and drug abuse costs the state approximately $2.5 billion in direct and indirect costs per year.

SC DAODAS' mission is to ensure the provision of quality services to prevent or reduce the negative consequences of SUD. The Department offers a wide array of prevention, intervention and treatment services to about 50,000 South Carolinians yearly through a community based system of care. Although services are coordinated at a state level by 24 full time employees, SC DAODAS subcontracts with 33 county alcohol and drug authorities to serve people in all of the State's 46 counties.

Budget
About 50% of SC DAODAS's funding comes from federal block grants from the Substance Abuse and Mental Health Services Administration (SAMHSA). The Department receives about 30% of its budget from the state and about 20% from Medicaid and other federal grants. Like SC DMH, SC DAODAS has lost millions of dollars in state funding. Between 2008 and 2010 SC DAODAS lost half of its state funds. SC DAODAS and its county authorities received one of the largest budget cuts of any state agency. The majority of SC DAODAS' cuts were taken from the Medicaid match line. During FY10, this line was cut by 50%. For every dollar in state funds cut, there was a corresponding loss of $3 of federal Medicaid dollars from the Medicaid fund. This has resulted in a 70% reduction in community-based prevention services and a 60% reduction in the community-based treatment service budget.

Service Gap
SC DAODAS estimates that 236,000 South Carolinians struggled with substance abuse and were in need of treatment in 2011. During FY10 SC DAODAS and its provider network served only 51,664 or only 22% of South Carolinians needing treatment. This figure is basically the same as the previous year.[93]

Of the estimated 60,180 women who needed treatment in FY10 only 17, 361 or 28.8% of South Carolinians received the treatment they needed. In FY09 SC DAODAS served 16,636 women or 27.6% of the 60,180 women in need. Although SC DAODAS struggles to meet the needs of adult substance abusers in South Carolina, they do a much better meeting the needs of our children who are struggling with SUD. In FY09 SC DAODAS served 47.7% of the estimated 18,518 children battling SUD and they served 45% of the children battling SUD in FY10.

Incarceration Is Not a Cure

Contrary to the policies enacted on a state and federal level, incarceration does not cure SUD. Incarceration does not even stop drug use. The number of adults involved in the criminal justice system has soared from about 1.8 million in 1980 to 7.2 million in 2009. A 2004 Bureau of Justice Statistics (BJS) survey, revised in 2007, found that 53% of State and 45% of Federal inmates meet the standard diagnostic criteria (DSM-IV) for drug dependence or abuse.[94] Although about half of state and federal inmates have SUD, less than half of those in

[92] *Ibid. p 59*
[93] SC DAODAS Accountability Report (2011) p.2
[94] Mumola, Christopher J. and Karberg, Jennifer C, *Drug Use and Dependence, State and Federal Prisoners*, revised January 19, 2007.

need of treatment are receiving it. According to BJS, only 40% of state inmates and 49% of federal inmates battling SUD receive treatment.[95]

Left untreated, offenders with SUD can relapse and return to criminal behavior. This jeopardizes public health and public safety, leads to re-arrest and re-incarceration, and further taxes an already over-burdened criminal justice system. Accordingly, national recidivism rates are high. Among state inmates battling addiction, 53% had at least three prior sentences to prison or probation. Only 32% of other inmates had comparable recidivism rates.[96]

The South Carolina Department of Corrections (SCDC) has a zero tolerance policy about drug use in prison. It conducts random monthly drug tests to ensure that its drug policies are being followed. Those who test positive are tested more frequently. In 2005 14.7% of the inmates tested had positive drug tests.[97] The percentage of inmates with positive drug tests dropped to 6.7% in 2009.[98]

Despite the high proportion of inmates with SUD among the state's prison population, the availability SUD treatment for inmates is extremely limited. In 2006 45% or 10,451 of South Carolina's 22,871 inmates reported substance abuse problems and there were only 672 treatment beds.[99] In fact, South Carolina's failure to provide an adequate number of treatment beds for inmates with a dual diagnosis was a major fact in NAMI's decision to give a D for treatment services.

SCDC has tried to respond to the drug epidemic among its inmates by offering more drug treatment programs. Drug treatment services are available in eight of SCDC's 27 institutions. SCDC operates substance abuse treatment units and programs at the following facilities:

- **Coastal Pre-Release Center**: The Coastal Pre-Release Center is a facility located in North Charleston, SC. It offers alcohol and drug counseling to men on the verge of release. This facility also has Alcoholics Anonymous and Narcotics Anonymous groups.
- **Correctional Recovery and Straight Ahead Academies**: Located at Tuberville Correctional Institution in Tuberville SC, this is a 272-bed drug treatment unit for young male battling SUD. The program is typically 6-9 months in duration.
- **Goodman Addiction Treatment Unit**: Located at the Goodman Correctional Institution in Columbia, SC, this is a 47-bed residential program for young female offenders with SUD. The program is designed to provide offenders with 6 months of structured programming that is gender and age specific.
- **Horizon Addiction Treatment Unit**: Located at the Lee Correctional facility in Bishopsville SC, this proposed 384-bed residential SUD treatment program for males serving adult straight-time sentence. As of 2006 only 256 beds were operational.
- **Lieber Correctional Institute:** This facility is located Ridgeville. It is has a drug and alcohol program for male offenders battling SUD as well as Alcoholics Anonymous and Narcotics Anonymous groups.
- **McCormick Correctional Institution**: McCormick is a facility for men located in McCormick, SC. It offers a specialized drug treatment program for inmates battling SUD abuse as well as Alcoholics Anonymous and Narcotic Anonymous groups.
- **Woman's Recovery Academy**: Located at Leath Correctional Institution in Greenwood, SC, the Woman's Recovery Academy is a 96-bed special drug treatment unit for female inmates battling SUD.

[95] *Ibid.*
[96] Mumola, Christopher J. and Karberg, Jennifer C, Drug Use and Dependence, State and Federal Prisoners, revised January 19, 2007
[97] Mapping the Elephant: Illegal Drugs in South Carolina, A study by the League of Women Voters of the Charleston Area (August 2010) p.32
[98] *Ibid. p.32*
[99] South Carolina Department of Corrections, http://www.doc.sc.gov/programs/substance.jsp

In addition to the penal drug treatment units listed above, SCDC offers volunteer-operated Alcoholics Anonymous Narcotics Anonymous at the following institutions:

- Broad River Road Institutional, Columbia SC
- Graham (Camille Griffin) Correctional Institution, Columbia SC
- Livesay Correctional Institution, Spartanburg, SC
- Manning Correctional Institution, Manning SC
- McDougall Correctional Institution, Ridgeville, SC
- Palmer Pre-Release Center, Florence SC
- Perry Correctional Institution, Pelzer SC
- Ridgeland Correctional Institution, Ridgeland SC
- Stephenson Correctional Institution, Columbia, SC
- Tyger River Correctional Institution, Enoree SC
- Walden Correctional Institution, Columbia, SC

The following 9 institutions do not have any programs or services to treat SUD.

- Allendale Correctional Institution, Fairfax SC
- Campbell Correctional Institution, Columbia SC
- Catawba Correctional Institution, Bennettsville SC
- Evans Correctional Institution, Rock Hill SC
- Kirkland Correctional Institution, Columbia SC
- Kershaw Correctional Institution, Kershaw SC
- Lower Savannah Correctional Institution, Aiken SC
- Trenton Correctional Institution, Trenton SC
- Wateree Correctional Institution, Rembert SC

Like all other state agencies, SCDC has been the recipient of significant budget cuts over the past few years. It has been operating on a budget deficit in recent years. As a consequence of the overall financial precariousness of the agency, substance abuse programs have lost funding. In 1998 SCDC received 75% of its funding for substance abuse treatment from a federal grant. Over the years federal funding ended and as of 2009 South Carolina funds 100% of drug treatment units in state penal institutions. Due to recent economic down turns and a shift in priorities, SCDC's treatment programs have faced closure. One substance abuse unit was closed for nine months in 2008.[100]

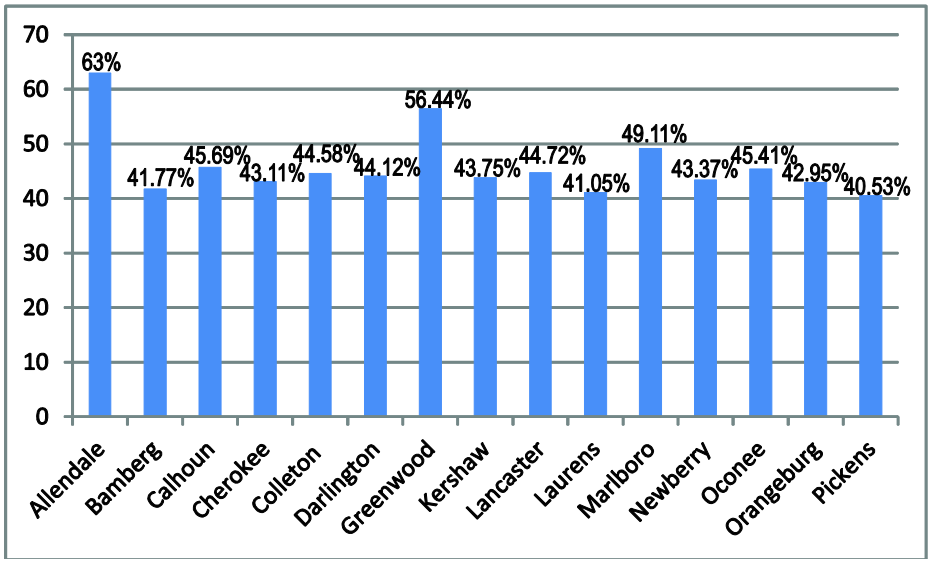
If South Carolina has trouble ensuring that its inmates do not abuse drugs during their terms of incarceration, it is understandably difficult to keep the state's probationers and parolees from abusing. The South Carolina Department of Probation Pardon and Parole Services (PPP) oversees probationers and parolees reentry into the

[100] Mapping the Elephant: Illegal Drugs in South Carolina, A study by the League of Women Voters of the Charleston Area (August 2010) p.76

community. Drug tests are routinely a condition of continued release and PPP has the authority to drug test at will.

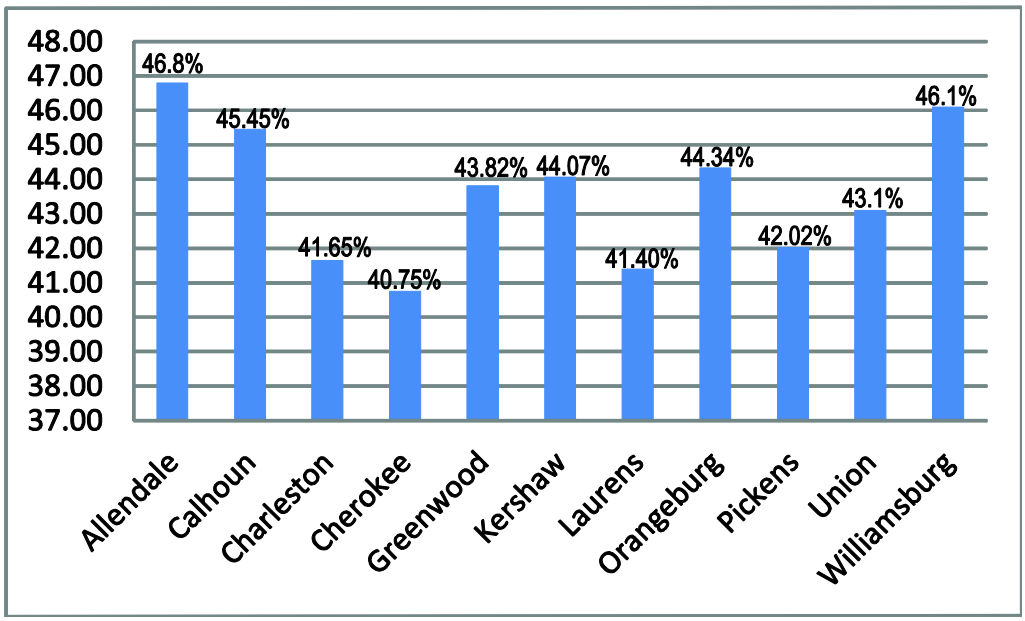
SUD is rife among South Carolina's probationers and parolees. Of the 18,291 offenders drug tested in 2011, 6,472 or 35% of the tests came back positive. Allendale County led the way with 63.55 % of probationers and parolees testing positive for illicit drug use.

Probation Pardon and Parole Offender Drug Testing Chart
2011[101]



The numbers in FY2010 were strikingly similar. PPP drug tested 14,548 probationers and parolees and found that 36.35% or 7,841 of the tests were positive. The majority of offenders tested positive for continued drug use in Lancaster (64.71%), Lee (51.01%) and Marlboro (50.52%) counties. Positive drug test rates exceeded 40% in another 11 counties.

Probation Pardon and Parole Offender Drug Testing Chart
2010[102]



[101] Drug Offender Testing, Probation Pardon Parole Services 2010 Statistical Annual Report p. 61
[102] Drug Offender Testing, Probation Pardon Parole Services 2011 Statistical Annual Report p. 61

Although over one-third of the probationers and parolees tested for drugs test positive for drug use, the number has been decreasing in recent years. In 2008 40.10% of offenders tested positive from illicit drugs.[103] The percentage of positive drug tests was 39.27% and 40.46% in 2006 and 2007 respectively.[104]

PPP does have the ability to offer treatment to those testing positive. Unlike SCDC, PPP does not have an in-house department to handle the needs of individuals who have tested positive for drug use. Although 4,921 of the 6,472 offenders were referred for drug treatment in 2011, re-incarceration is still the most common solution for drug abusing individuals within PPP's orbit.[105]

Like its sister state agencies, PPP has been hit hard by budget cuts. This has resulted in a cut in services, despite the agency's best efforts. PPP has been forced to cut back on drug testing. Prior to the economic down turn PPP's budget was $51,923,234 in FY08-09.[106] Since that time the budget has fallen every year until it reached $38,002,421in FY10-FY11.[107] That represents a budget cut of about 28%. The budget cuts have also necessitated staff reductions. From 2008 to 2010 PPP's staff has been reduced from 779 to 589 full time employees.[108]

Prevention is not a Priority

It is recognized that prevention and treatment works, yet more money is spent warehousing sick people in jails and prisons. SUD places a heavy toll on society. Left untreated, addiction causes or contributes to a myriad of other expensive diseases like cancer and heart and liver disease. Moreover, SUD can contribute to mental illness, child abuse and neglect, and violent crime. Despite overwhelming evidence that SUD is both treatable and preventable, our policy makers neglect to tackle the problem head on while SUD overwhelms our judicial and social service systems causing illness, injury and death among our citizens.

The federal government spends billions of dollars each year dealing with all of the problems that surround people battling addiction. In 2005, the federal government spent a total of $238.2 billion in the "Drug War" to tackle problems that emanate from substance abuse. That represents 9.6% of the entire federal budget.[109] In 2005, the federal government spent approximately $527.5 billion on healthcare. That represents 21.4% of the entire federal budget. Thirty-two percent or $170 billion of the government's healthcare spending was for drug-related treatment and services. $157.8 billion was spent on SUD related problems via the Medicaid program and the Veterans Administration spent $9.2 billion to operate their SUD programs.[110] State governments spent a total of $135 billion on SUD in 2005. That figure represented 15.7% of all state spending. An astronomical 94% of state SUD related expenditures were to deal with the consequences of abuse (e.g. the criminal justice system and health care costs). Only 2.4% of state drug-related spending was for treatment and prevention.[111]

In 2005 alone, state and federal governments spent an astounding $207.2 billion on SUD related healthcare costs and another $47 billion on drug offenders in the justice system.[112] While the government dedicates billions of dollars to dealing with the consequences of SUD, very little money is spent on prevention or treatment. In 2005, only 2.4% or $8.8 billion was for treatment and prevention. For every dollar the government spent to treat

[103] Population Characteristics, Probation Pardon Parole Services 2009 Statistical Annual Report p. 53
[104] South Carolina Department of Probation, Parole and Pardon Services, presentation to the Sentencing Reform Commission on February 26, 2009.
[105] Probation Parole and Pardon Services Accountability Report 2011, p.4
[106] Probation Parole and Pardon Services Accountability Report 2010, p.8
[107] Probation Parole and Pardon Services Accountability Report 2011, p.9
[108] Probation Parole and Pardon Services Accountability Report 2010, p.7
[109] The National Center on Addiction and Substance Abuse at Columbia University, Shovel Up: Impact of Substance Abuse on Federal, State and Local Budgets, May 2009 p.4
[110] *Ibid. p.16*
[111] *Ibid.*
[112] *Ibid. p.3*

or prevent SUD, it spend $59.83 on programs up clean up the consequences of addiction.[113] According to the National Institute on Drug Abuse, the return on investing in treatment may be in excess of 12:1. Every dollar spent on treatment can reduce on future costs by $12 plus more in reductions in drug-related crime and criminal justice and health care costs.[114]

Prevention programs in South Carolina

According to the National Center on Addiction and Substance Abuse, state governments spent an average of 14.8% of their budgets funding programs that deal with the problems of addiction in 2005. These programs included: the criminal justice system; healthcare; public assistance; and mental health services. South Carolina's funding was well below the national average. South Carolina devoted only 8.5% of its budget to the problems resulting from SUD. This level of expenditure ranked South Carolina 46th nationally monies spent on the consequences of SUD and dead last for per capita expenditures on items related to the consequences of SUD.[115]

State spending on drug treatment and prevention varies. On average, states spent .37% of their budgets on drug treatment and prevention programs in 2005. South Carolina fared much worse spending less than half a percent of its state budget on treatment and prevention programs. The state ranked 50th for this type of expenditure. South Carolina also finished last in per capita spending for SUD treatment and prevention programs.[116]

Re-Entry Barriers

South Carolina displays very little compassion for people convicted of drug crimes. Although most people consider rape and murder more serious crimes, drug offenses are often treated more severely because they often carry additional collateral penalties that target drug abusers specifically. According to a study by the Center for Cognitive Liberty and Ethics, South Carolina has some of the most severe collateral punishments for marijuana or drug offenders who have already served their time in the nation.[117] As a result of these collateral penalties, individuals battling SUD can find themselves barred from becoming a foster parent, living in public housing, receiving food stamps years after they have served their sentences.

Financial Aid for Higher Education

The Higher Education Act (HEA) was signed into law in 1965 by President Lyndon Johnson to open the door to higher education to many students. It established federal financial aid programs such as Perkins Loans, Pell Grants, Supplemental Educational Opportunity Grants, PLUS Loans, and Work-Study Programs. In 1998, Congress amended the Act to deny loans and grants, to people with drug convictions. No other type of conviction was covered by the Act. The Act was scaled back again in 2006. The prohibition is limited to people who drug offenses committed while enrolled in college and receiving federal Title IV aid.[118] To obtain a South Carolina tuition grant, a student must wait one year after receiving two drug offenses.[119]

Public Housing

Due to the high correlation between addiction and poverty, access to public housing is important to many addicted individuals in recovery. It is difficult to focus on overcoming addiction when you have no place to live. Both the state and federal governments restrict people who have been convicted of drug offenses from obtaining

[113] The National Center on Addiction and Substance Abuse at Columbia University, Shovel Up: Impact of Substance Abuse on Federal, State and Local Budgets, May 2009 p.46
[114] The National Center on Addiction and Substance Abuse at Columbia University, *Shovel Up: Impact of Substance Abuse on Federal, State and Local Budgets*, May 2009p.4
[115] *Ibid. p.40.*
[116] *Ibid.p.52.*
[117] Bloire, Richard Glen,JD, *Life Sentences: Collateral Sanctions Associated with Marijuana Offences*, (ver.1 published July 2, 2007.)
[118] Drug Convictions - How They Affect Your Financial Aid - StateUniversity.com; http://www.stateuniversity.com/blog/permalink/Drug-Convictions-How-They-Affect-Your-Financial-Aid.html#ixzz1s2uYOP1Y
[119] www.sctuitiongrants.com/public_forms

public housing. In South Carolina, felony drug offenders are barred from public housing for a period of 3 to 5 years from conviction.[120]

There is no similar restriction on drug related misdemeanors. Under the United States Housing Act, public housing leases must contain a clause prohibiting drug activity by the tenant or by their guests. A violation of this clause results in eviction. The United States Supreme Court went even further. It ruled that a tenant can be held responsible for the drug activity of guests on their property even if they did not know anything about the conduct.[121]

The Supplemental Nutrition Assistance Program (SNAP)
Formally known as the food stamp program, SNAP is a governmental program that provides food assistance to people in need. Instead of assisting limited resource addicts get back on their feet, South Carolina continues to punish them by banning them from being eligible for SNAP forever. This restriction extends to households that include someone with a drug felony conviction.[122]

South Carolina Department of Social Services (Public Assistance)
S.C. Code Ann § 43-5-1190 (2006) prohibits individuals with a substance abuse conviction from receiving public assistance unless they agree to participating in a South Carolina Department of Social Service approved drug treatment program and submit to random drug testing. This law makes no distinction between misdemeanor and felony convictions. Additionally, this law prohibits people who have been "identified" as needing drug treatment from receiving public assistance unless they agree to participate in a drug treatment program and submit to random drug testing. The law does not define the guidelines for determining how a person is identified as needing treatment.

Eligibility to Become a Foster Parent
Despite a scarcity of good foster homes for needy children in South Carolina, state law prohibits convicted drug felons' from becoming foster parents. The law does not allow authorities to consider what the former offender has done with his or her life after serving their time. Moreover, the law does not allow authorities to consider how much time has passed since the drug offense was committed or the offender's age at the time of the offense.[123]

The collateral sanctions listed often present significant roadblocks to the road to recovery for many people battling SUD. Limiting access to social safety net resources disproportionately harms low income families**.** It hurts only those with the most need. People fighting SUD from well-to-do backgrounds do not have to worry about losing food stamps or being kicked off of public assistance. They are able to purchase the food and housing they need. Moreover, they are often able to afford the legal representation necessary to avoid a drug conviction in the first place.

Racial Disparities and SUD

Issues of race and class have a huge impact on the likelihood of involvement with the criminal justice system and treatment within the system. People from limited resource communities are overrepresented at every stage of the criminal justice system and a disproportionate number of people of color are poor. According to the US Department of Health and Human Services (DHHS), African-Americans represented about 12% of the general population yet 14% of American drug users in 2006. Yet, African-Americans represented 35% of the drug

[120] Bloire, Richard Glen,JD, *Life Sentences: Collateral Sanctions Associated with Marijuana Offences*, (ver.1 published July 2, 2007.)
[121] *Department of Housing and Urban Development v. Rucker*, 535 US 125[122 SCt 1230] (2002)
[122] League of Women Voters, *Mapping the Elephant: Illegal Drugs in South Carolina, A Study by the League of Women Voters of Charleston*, August 2010.
[123] S.C. Code Ann. § 20-7-1642 (2006).

arrests and 53% of drug convictions in the same year.[124] The Sentencing Project found similar numbers. In 2007 Whites were incarcerated at a rate of 412 per 100,000 while African-Americans were incarcerated at a rate of 2,290 per 100,000.[125]

The "War on Drugs" has impacted on both the number of and the composition of the people incarcerated for a drug offense. Although African-Americans are only about 12 % of the US population, they make up more than 60% of people in prison. African-American youths represent 17% of their age group in the general population but 46% of the juvenile arrests, 31% of referrals to juvenile court and 41% of the waivers to adult court.[126] According to the Sentencing Project, African-Americans to White imprisonment ratio is 5.6:1.[127] If current trends continue, one in three African-American males born today will be incarcerated during his lifetime.[128]

Prior criminal records are other factors which contribute racial disparities among the incarceration rate of African-Americans. The more serious the previous offence the more likely you are to serve time for the new offense. Location is another factor which contributes to disparities. Places that have a higher reporting of crime have a greater police presence and areas with a greater police presence usually have arrests and those places are usually minority neighborhoods. According to a study cited in *Changing Racial Dynamics of the War on Drugs*, found that disparities in arrest and incarceration rates between Whites and African-Americans existed even if the rates were adjusted for criminal history.[129]

In addition to impacting law enforcement practices, it also affected sentencing policies. Although the federal government equalized sentences for crack and cocaine, mandatory minimum sentences for drug offences are still flooding our jails and prisons. In fact, as of September 30, 2010, 75,579 or 39.4% of the 191,757 offenders in prison were subject to a mandatory minimum penalty at sentencing.[130] Hispanic offenders accounted for 38.3% of offenders convicted of an offense carrying a mandatory minimum penalty. African-Americans were next at 31.5% and White offenders were at 27.4%.[131]

Although the prevalence of arrest and imprisonment for women is less than men, many of the same racial disparities exist. African-American women are more likely to be incarcerated than their White and Hispanic counterparts. In 2009, 1 in 703 African-American women was confined in a federal prison compared to about 1 in 1,987 White females and 1 in 1,356 Hispanic females.[132] Although African-American women are 6.4% of the population in the United States they are 29.1% of the federal prison population.[133]

Racial Disparities in South Carolina

Justice is not color blind in South Carolina. Racial disparities pervade all elements of the judicial system. According to statistics compiled by BlackDemographics.com, African-American males comprised 13.1% of the general population in South Carolina.[134] Yet African-American males are arrested and incarcerated at much higher rates than their White counterparts. Of the 36,030 drug-related arrests in 2005 16, 511 or 45.8% were African-American males. Only 12,734 or 35.3% of White males were arrested in that year. 2006's numbers

[124] Sabol, W.J. Couture H. and Harrison, P. *Prisoners in 2006 Washington DC*, Bureau of Justice Statistics. (2007)
[125] Marc Mauer and Ryan S. King, *Uneven Justice: State Rates of Incarceration by Race and Ethnicity*, the Sentencing Project, July 2007.
[126] Snyder, H., Juvenile *Arrests 2004 OJJDP Bulletin: Washington DC National Disproportionate Minority Contact Databook*.(2006)
[127] www.sentencingproject.com
[128] Marc Mauer and Ryan S. King, *Uneven Justice: State Rates of Incarceration by Race and Ethnicity*, (the Sentencing Project July 2007)
[129] Marc Mauer, *the Changing Racial Dynamics of the War on Drugs*, (The Sentencing Project April 2009)
[130] Executive Summary: Report to Congress: Mandatory Minimum Penalties in the Federal Criminal Justice System, United States Sentencing Commission (Washington, DC: October 2011), xxix.
[131] *Ibid. p. xxviii*.
[132] West, Heather C.;Sabol,, William J, and Greenman, Sara J., *Prisoners in 2009 Bureau of Justice Statistics* (Washington DC: US Department of Justice, December 2010) NCJ 231675, Appendix Table 12, p.27.
[133] McKinnon, Jesse D., Bennett, Claudette E., *We the People: Black in the United States*, (US Census Bureau, August 2005); West, Heather C.;Sabol,, William J, and Greenman, Sara J., *Prisoners in 2009 Bureau of Justice Statistics* (Washington DC: US Department of Justice, December 2010) NCJ 231675,Appendix Table 12, p.27.
[134] Data Set:2009 American Community Survey1-Year Estimates, www.blackdemographics.com

were very similar. Of the 38,035 arrests, 17,585 or 46.2% were African-American males and 12,768 or 33.5% were White males.[135]

According to the Sentencing Project, African-American males in South Carolina are incarcerated at a Black/White ratio of 4.5 to 1. The rate of incarceration is higher than that of both Mississippi and Alabama.[136] As of June 2011, 14,427 or 66% of South Carolina's prison population is made up of African-American males.[137] African-American males also represented 40.5% of new prison admissions in 2011. White males were only 23.3% of new prison admissions.[138] Racial disparity is less stark for serious drug offenses. In fact, serious drug offenses are the most common serious offenses in South Carolina state prisons. 3,256 or 22.2% of serious drug offenses were committed by African-American males and 715 or 10.2% were committed by White men.[139]

Racial disparities for women exist in South Carolina as well. African-American women are 14.7% of the population in South Carolina and 28.7% of all females. However, they represented 24,549 or 44.35% of all female arrests in 2006.[140] African-American women also represented 2,548 or 36.7% of all of the women arrested for drug related offenses in 2006.[141] Of the 1,482 women incarcerated in South Carolina prisons 637 or 43% are African-American, while 821 or 55% of the female prison population is White.[142]

Special Problems Facing Women with SUD

Drug use is more prevalent in men than women. In 2009, as in prior years, the national rate of current illicit drug use among persons aged 12 or older was higher for men than for women, 10.8% vs. 6.6% percent, respectively. Men were more likely than women to be current users of marijuana (8.6% to 4.8%), psychotherapeutic drugs for recreational purposes (3.1% to 2.4%), and cocaine (.9% vs. .4%). However, methamphetamine is popular among both sexes with a .2% rate of prevalence.[143] Although the rate of illicit drug use among males 12 and older increased from 9.9% in 2008 to 10.8% in 2009. Correspondingly, the illicit drug use rate for females 12 and older went from 6.3% in 2008 and 6.6% in 2009.[144]

Gender Differences in Drug Use

Scientists have become increasingly aware of the important differences between the way substance abuse affects men and women. Accordingly, they are recognizing that these differences have an impact on treatment. When women's specific needs are addressed at the beginning of treatment outcomes are more successful. Women initiate drug use for a variety of reasons including: biology and physiology, relationships, and self-medication.

Biology and Physiology

Women have different physical responses to drugs and typically get addicted faster than men. Factors that either influence or compound the physiological effects of drugs include: ethnicity; health disparity, socioeconomic status; developmental issues; aging, and co-occurring conditions. Although the physiological effects of illicit drugs have not been as well studied, research has shown that abuse of substances such as stimulants, opioids, and some prescription (e.g., anxiolytics, narcotic analgesics) and over-the-counter (e.g., laxatives, diuretics, diet

[135] Budget and Control Board Statistical Abstract, http://abstract.sc.gov
[136] Interactive Map, The Sentencing Project, www.sentencingproject.com
[137] Profile of Inmates in Institutional Count as of June 30, 2011, SC Department of Corrections
[138] South Carolina Department of Corrections, *Admissions to SCDC Base Population FY11*, (SC Department of Corrections 2011)
[139] Most Serious Offense Distribution of SCDC Total Inmate Population FY11, SC Department of Corrections
[140] Budget and Control Board, *Total South Carolina Arrests by Age, Race, Sex and Charge* (2006)
[141] *Ibid.*
[142] Profile of Inmates in Institutional Count as of June 30, 2011, SC Department of Corrections
[143] Substance Abuse and Mental Health Services Administration. (2010). "*Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings (*Office of Applied Studies," NSDUH Series H-38A, HHS Publication No. SMA 10-4586 Findings). Rockville, MD., p 21.
[144] *Ibid.*

pills) drugs cause adverse effects on women's menstrual cycles and gastrointestinal, neuromuscular, and cardiac systems.[145]

Relationships

From a sociological perspective, women (more than men) tend to define themselves in terms of their relationships with others. Women are mother, wives, daughters, etc. More than men, women are significantly influenced by relationships and the effects of a partner's substance abuse. Female addicts are more likely to have partners who are addicts. Unfortunately, some women believe that shared substance abuse is the only way of maintaining a relationship with their substance abusing partner. Additionally, women are at a greater risk of contracting HIV/AIDS and hepatitis by sharing needles or having sexual relationships with men who inject drugs.

Relationship status also influences the potential development of SUD. Marriage can be protective for some women.[146] Separated, never married, and divorced women are at greater risk for use and the development of SUD. Women who are victims of domestic violence and sexual trauma are also at a greater risk for developing substance abuse disorders. The importance of a relationship does not end when treatment begins. Women achieve better outcomes when they are not forced to go through their treatment program in a vacuum.

Self-medication

Women also take illicit drugs to self-medicate. Drug usage turns to abuse as a way of treating other problems like depression, anxiety, posttraumatic stress syndrome and eating disorders. A history of trauma, including interpersonal and childhood sexual abuse, are factors which contribute to substance abuse among women.

African-American Women and Drugs

According to the United States Census, there are approximately 18 million African-American females in the United States, approximately 6.4% of the general population.[147] African-American women represent 673,853 or 14.7% of the population in South Carolina.[148] Among African-American women, poverty is more prevalent than in the general population.[149] Among African-American single mothers, approximately 35% live in poverty compared to 19% of non-Hispanic single White mothers. In South Carolina, 47.6% of African-American single mother headed households with children under 18 live below the poverty level.[150]

Although genetics accounts for some differentials about some diseases among African-Americans, biology does not explain a lot about the disparities in health status between African-Americans and Whites. Overall, African-Americans have disproportionately higher rates of disease and illness, a wider variety of undetected diseases, more chronic health conditions, and shorter life expectancies than Whites. African-American women experience higher morbidity and mortality rates than White women for many health conditions.[151]

Coupled with the direct and indirect effects of racism and racial stereotypes, African-American women disproportionately experience negative health and social consequences of drug use. Accordingly, African-American women are more likely to have their children legally removed from their custody, in part, as a result

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[145] Center for Substance Abuse Treatment. Substance Abuse Treatment: Addressing the Specific Needs of Women. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2009. (Treatment Improvement Protocol (TIP) Series, No. 51.) Executive Summary

[146] Center for Substance Abuse Treatment. *Substance Abuse Treatment: Addressing the Specific Needs of Women*. (Rockville MD: Substance Abuse and Mental Health Services Administration 2009). Treatment Improvement Protocol (TIP) Series, No. 51, Executive Summary.

[147] McKinnon, Jesse D. and Bennett, Claudette E., *We the People: Black in the United States*, (US Census Bureau, August 2005.)

[148] www.blackdemographics.com

[149] Littlefield, Gray M., Black *"Women and Addiction"* Straussner SLA, Brown S., editors. *The Handbook of Addiction Treatment for Women: Theory and Practice.* (San Francisco: Jossey-Bass; 2002) pp. 301–322.

[150] www.blackdemographics.com

[151] Minino AM, Arias E, Kochanek KD, Murphy SL, Smith BL. *National Vital Statistics Reports* (Hyattsville, MD: National Center for Health Statistics; 2002)

of societal bias and discrimination.[152] Additionally African-American women are 10 times more likely than White women to have positive drug screens. Yet, this difference may be directly related to a disproportionate percentage of testing among African-American women.[153] The threat of losing custody of your children or legal sanctions for drug use during pregnancy may prevent African-American women from obtaining prenatal care or seeking SUD treatment. Nonetheless, once treatment is initiated, issues surrounding pregnancy, child care, parenting, and custody need to be addressed in a nonthreatening but constructive manner— showing support and guidance in promoting and nourishing a healthy parent–child relationship.[154]

For African-American women battling SUD, treatment needs to extend beyond the general parameters of gender oriented treatment. It needs to be culturally sensitive as well. Spiritual components and Afrocentric perspectives should be incorporated into treatment to ensure a holistic approach and to assist African-American women in recovery.[155]

Rural Women

SUD is a major health concern in rural South Carolina. While drug use varies little across most age groups in urban and rural settings, drug use among rural youth has been trending upward. Although rural and urban areas have similar rates of SUD, the consequences are more serious in rural areas because of limited access to health care and substance abuse treatment. For example, only 10.7% of hospitals in rural areas offer SUD treatment services compared to 26.5% of urban or suburban hospitals.[156] None of the hospitals in rural South Carolina have specialized drug treatment units.

Risk factors for SUD among women living in rural areas are significant. Many rural families are impoverished, and women often experience stress associated with poverty. As a result of the dearth of services in rural areas, rural women often feel compelled to self-medicate as a result.[157]

Pregnancy and Childcare

Pregnancy is a major concern in treating females with SUD and of childbearing age. Nationally, among pregnant women aged 15 to 44, 5% reported using illicit drugs in the past month, based on combined 2006 and 2007 NSDUH data. This rate is significantly lower than the 10% rate among women aged 15 to 44 who were not pregnant.[158]

Some women who are abusing do not realize that they are pregnant. In fact, some women confuse the early signs of pregnancy with symptoms related to their abuse. Frequently pregnant addicts do not begin prenatal care until well into their pregnancies. Unfortunately, some of the most negative effects of SUD on the developing embryo can occur early in the first trimester. Adequate prenatal care often defines the difference between a routine and a high-risk pregnancy. Nationally, timely prenatal care remains a problem among all women and it is an even bigger problem among women battling SUD. Sadly, only 14% of SUD treatment programs offer

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[152]Wallace, B.C., *Crack Cocaine Smokers as Adult Children of Alcoholics: The Dysfunctional Family Link.* (Journal of Substance Abuse Treatment 1990) p.89–100.

[153] Neuspiel DR, *Racism and Perinatal Addiction*. Ethnicity and Disease. (1996; 6(1–2) p.47–55..

[154] Center for Substance Abuse Treatment. *Substance Abuse Treatment: Addressing the Specific Needs of Women*. (Rockville MD: Substance Abuse and Mental Health Services Administration US); 2009. Treatment Improvement Protocol (TIP) Series, No. 51. Chapter 6: Substance Abuse Among Specific Population Groups and Settings.

[155] Center for Substance Abuse Treatment. Substance Abuse Treatment: Addressing the Specific Needs of Women.(Rockville MD: Substance Abuse and Mental Health Services Administration US) 2009). Treatment Improvement Protocol (TIP) Series, No. 51.) Chapter 6: Substance Abuse Among Specific Population Groups and Settings.

[156] Dempsey P., Bird DC, Hartley D, "*Rural Mental Health and Substance Abuse"* In: Ricketts TC, editor. *Rural Health in the United States* (New York: Oxford University Press 1999) pp. 159–178.

[157] Boyd MR, Mackey MC. *Alienation from Self and Others: The Psychosocial Problem of Rural Alcoholic Women.* Archives of Psychiatric Nursing. 2000a; 14(3):134–141.

[158] Past-Month Substance Use, Based on Combined 2006 and 2007 Data: National Survey on Drug Use and Health (NSDUH), 2007 (SAMHSA 2008).

special programs for pregnant women.[159] Parenting and childcare are other factors which effect drug consumption among women. They increase the likelihood of a woman entering and completing treatment. For many women, drug use significantly decreases after becoming aware of their pregnancies.[160] However, it is not uncommon for women who abstained from drug use during pregnancy to return to using after childbirth. Thus, pregnancy can be a double-edged sword in treatment planning. On the one hand, pregnancy may represent a "teachable moment" where motivation to protect the fetus high. On the other hand, progress toward recovery made by pregnant women may be transient if this progress is primarily in response to the pregnancy itself.

Women are also much more likely than men to enter treatment because it affects child custody.[161] If they are able to have their children in treatment, women are more likely to enter treatment, participate and stay in the program, and maintain abstinence.[162] Likewise, women with children in treatment have better treatment outcomes in major life areas in comparison to women who are without their children in treatment.[163] Women in recovery see the support of their children as an essential ingredient for their recovery.[164]

For the past 20 years, South Carolina has led the nation in prosecuting, pregnant women with SUD. The state has taken the lead in using child neglect and homicide statutes to punish women who are pregnant and engage in a behavior that might endanger a viable fetus. In a 3 to 2 decision in *Whitner v. State,* the South Carolina State Supreme Court held that the word "child" in the state's criminal child endangerment statute includes viable fetuses.[165] The case arose after Cornelia Whitner was charged with child abuse after she gave birth to a healthy baby that tested positive for cocaine. Ms. Whiner pled guilty thinking she would get the treatment she needed. Instead of getting treatment, Ms. Whitner was sentenced to eight years in prison. The court declared that fetuses were children and that a pregnant illicit drug user could be prosecuted as a child abuser and sentenced to up to ten years in prison. It should be noted that in the years following *Whitner* decision, South Carolina's infant mortality rate increased for the first time after a decade of steady decline.[166]

Although South Carolina prosecutes pregnant drug abusers, the state has not put resources toward providing pregnant offenders with specialized drug treatment programs which meet their needs. Currently, there are only a few programs specializing in drug treatment for pregnant women. South Carolina leads the nation in arresting pregnant women suffering with SUD and 50th in the amount of dollars spent on drug treatment.[167]

Obstacles to Treatment for Women

Various factors present obstacles to women battling SUD. According to a 2004-2006 SAMHSA survey of females with SUD aged 18-49 about why they were not seeking treatment, 36.1% of them responded that they did not want to stop taking drugs. Another 34% of the women surveyed said that they did not seek treatment for

[159] Substance Abuse and Mental Health Services Administration. *Results from the 2006 National Survey on Drug Use and Health: National Findings*. (Rockville, MD: Office of Applied Studies; 2007).

[160] Tough S, Tofflemire K, Clarke M, Newburn-Cook C. *Do Women Change their Drinking Behaviors while Trying to Conceive? An Opportunity for Preconception Counseling.* Clinical Medicine and Research. (2006) 4 (2):97–105.

[161] Grella CE, Joshi V., *Gender Differences in Drug Treatment Careers among Clients in the National Drug Abuse Treatment Outcome Study* American Journal of Drug and Alcohol Abuse. 1999;25 (3):385–406.

[162]Brady TM, Ashley OS., *Women In Substance Abuse Treatment: Results from the Alcohol and Drug Services Study (ADSS)*. (HHS Publication No. SMA 04-3968, Analytic Series A-26).

[163] Stevens SJ, Patton T., "*Residential Treatment for Drug Addicted Women and their Children: Effective Treatment Strategies"* In: Stevens SJ, Wexler HK, editors. *Women and Substance Abuse: Gender Transparency*. (New York: Haworth Press; 1998a). pp. 235–249.

[164] Tracy EM, Martin TC., Children's Roles in the *Social Networks of Women in Substance Abuse Treatment*. Journal of Substance Abuse Treatment. 2007; 32(1):81–88.

[165] Whitner v. State , 492 S.E.2d 777 (S.C. 1997), *cert. denied*, 118 S. Ct. 1857 (1998).

[166]*See Infant Mortality on Rise in '97*, Post & Courier (Charleston, S.C.), Feb. 19, 1999, at B1; See The Annie E. Casey Foundation, Kids Count Data Book 160 (2001), http://www.aecf.org/kidscount/kc2001, (reporting that infant mortality decreased from 11.7 in 1990 to 8.4 in 1996, but increased to 9.6 for 1997 and 1998, the two years following the Whitner decision).

[167] The National Center on Addiction and Substance Abuse at Columbia University, *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets*, (New York, May 2009).

SUD because of concerns about cost or insurance coverage. 28.9% said that they did not want treatment for SUD because of the "social stigma" and 15.5% of the respondents said that they did not need help to quit.[168]

Fears of not being able to use drugs to cope with stress or to reduce weight or to deal with mental illness often serve as significant obstacles to treatment. Women going into treatment sometimes face other barriers like feelings of failure in regards to previous treatment efforts, feelings of guilt regarding the behavior associated with SUD, the fear of losing custody of children because of the abuse and feelings of helplessness in face of the enormity of SUD.[169]

Other health issues can serve as a powerful roadblock for women. Depending on the medical diagnosis, women may encounter difficulties in accessing treatment, securing appropriate services, and coordinating medical and SUD treatment needs. Many women neglect their health while they are actively abusing, hence treatment may be delayed or difficult to coordinate due to the additional burden imposed by health issues like HIV/AIDS, other infectious diseases, mental disorders, and gynecological and obstetric needs. Thus, poor physical health may hinder entry into treatment.[170] Treatment is also difficult for many women because they are usually the primary caregivers of children or other family members and they are often unable or not encouraged to enter and remain in treatment. A woman's family or friends may also be substance abusers and they may not see a benefit in encouraging the woman to become drug free.[171]

Women are also more stigmatized by drug use than men. Female with SUD are often characterized as morally lax, sexually promiscuous, or as helpless victims while males with SUD appear cool and hip. In addition, women with SUD children fear that admitting to a substance use problem will cause them to lose custody of their children. They worry that they will be viewed as irresponsible, bad mothers. These fears put additional pressure on the woman with SUD and often interfere with her decision to get help.[172]

Treatment Gaps in Services for Women

According to NSDUH's most recent survey of SUD treatment gaps among women, 6.2% of women aged 12 and older were classified with substance dependence or abuse in 2004, but only 0.9 percent received treatment. A SAMHSA survey found that 87% of these programs accepted women as clients, but only 41% provided special programs or groups for women.[173] Another survey found that only 17% of treatment facilities offered groups or programs for pregnant or postpartum women.[174] Being responsible for the care of dependent children is one of the biggest barriers to women seeking treatment for SUD.[175] Women without access to a treatment program that includes child care or cannot arrange childcare must make a choice between their children and their own wellbeing.

Many SUD treatment providers do not fully understand the needs and the types of interventions most conducive to assisting women in recovery. Even among the competent professionals of the drug treatment community, notions of gender bias and sexist stereotypes persist. Treatment providers are a part of the community at large

[168] Center for Substance Abuse Treatment. *Substance Abuse Treatment: Addressing the Specific Needs of Women*. (Rockville MD, 2009). Treatment Improvement Protocol (TIP) Series, No. 51, Appendix A: Bibliography.

[169] Center for Substance Abuse Treatment, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (Rockville MD, 2009). Treatment Improvement Protocol (TIP) Series, No. 51. Chapter 5: Treatment Engagement, Placement, and Planning; Greenfield SF. Women and substance use disorders. In: Jensvold MF, Halbreich U, editors. Psychopharmacology and Women: Sex, Gender, and Hormones. Washington, DC: American Psychiatric Press; 1996. pp. 299–321.

[170] Center for Substance Abuse Treatment, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (Rockville MD, 2009); Treatment Improvement Protocol (TIP) Series, No. 51.) Chapter 5: Treatment Engagement, Placement, and Planning; Jessup, M., Humphreys. J., Brindis, C., Lee, K., "*Extrinsic Barriers to Substance Abuse Treatment among Pregnant Drug Dependent Women"* Journal of Drug Issues. 2003;23(2):285–304.

[171] Center for Substance Abuse Treatment., *Substance Abuse Treatment: Addressing the Specific Needs of Women* (Rockville MD, 2009) Treatment Improvement Protocol (TIP) Series, No. 51. Chapter 5: Treatment Engagement, Placement, and Planning.

[172] *Ibid*.

[173] Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *The National Survey of Substance Abuse Treatment Services: 2003. The DASIS Report (March 11, 2005)* (Rockville MD, 2005a.).

[174] Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *National Survey of Substance Abuse Treatment Services (N-SSATS): 2005. Data on Substance Abuse Treatment Facilities*, (Rockville MD 2006.).

[175] Wilsnack SC., *Barriers to Treatment for Alcoholic Women*. Addiction and Recovery. 1991;11(4):10–12.

and it is often hard for them to divorce themselves from age old stereotypes and myths. In addition, some programs lack cultural competence in addressing treatment issues for women from different cultural or language backgrounds. Thus, many ethnic women are reluctant to seek treatment if the staff or the programs feel foreign, judgmental, hostile, or indifferent.[176]

Even women who are highly motivated for treatment face additional program barriers that may produce significant challenges. These barriers include waiting lists, delayed admission, limited service availability, and preadmission requirements (e.g., paperwork requirements, detoxification). Other barriers that are particularly significant in South Carolina include: program location; limited funding sources, and lack of transportation. Since there is often a correlation between poverty and substance abuse, access to transportation is tantamount to access treatment. Despite the recognized importance of offering drug treatment programs for woman, many counties in South Carolina do not have those specialized programs. The following counties do not have specialized programs for women.

- Allendale
- Beaufort
- Berkeley
- Chesterfield
- Fairfield
- Hampton
- Jasper
- Kershaw
- Laurens
- Lee
- Newberry
- Union

Treatment resources for pregnant women with SUD are even more limited. Few programs combine prenatal care with drug treatment and childcare services.[177] Pregnant women with SUD face a variety of obstacles and treatment providers are often afraid of treating them. In addition to routine SUD treatment services, facilities that have special programs for pregnant drug abusers must also be able to handle the medical issues arising from the pregnancy. Thus, many facilities fear increased liability as well as having staff with expertise in both pregnancy and SUD.

Geography

Drugs in South Carolina

Once considered solely a "consumer state" for illegal drugs, South Carolina has transformed into a source state. Conveniently located about halfway between New York City and Miami, South Carolina has increasingly morphed into becoming part of the transshipment corridor for all types of illicit drugs. The presence of I-95, I-20, I-26, I-77, and I-85 have made South Carolina a hot spot for transporting drugs to different sections of the eastern seaboard. I-20 and I-85 have become major thoroughfares in the importation of cocaine, marijuana,

[176] Center for Substance Abuse Treatment, *Substance Abuse Treatment: Addressing the Specific Needs of Women*, (Rockville MD 2009). Treatment Improvement Protocol (TIP) Series, No. 51. Chapter 6: Substance Abuse Among Specific Population Groups and Settings.
[177] Amaro H, Hardy-Fanta C., *Gender Relations in Addiction and Recovery*, Journal of Psychoactive Drugs. 1995; 27(4):325–337.

methamphetamines and heroine from Mexico and the Southwest to the East. Containerized cargo through the Port of Charleston has become another popular way of transporting cargo through the state.[178]

All Counties are not Treated Equally

Geography plays a leading role in any study about access to treatment services. Although there is a stereotype that drug prevalence is a big city problem, rural people are not immune to SUD. Methamphetamine use is more commonly associated with rural communities than urban. Although both rural and urban areas are home to people combating SUD, consequences of abuse are greater in rural areas because of limited access to SUD treatment services. According to the 2010 NSDUH, the rate of illicit substance use and abuse varied by geographic area. The rate of SUD in nonmetropolitan counties was 7.6%, compared to 8.9% in small metropolitan counties and 8.9% in large metropolitan counties.[179] Despite similar rates of misuse, across the nation only 10.7% of hospitals in rural areas offer SUD treatment services compared to 26.5% of metropolitan hospitals.[180]

If you are drug dependent and live in a city like Charleston or Greenville or a resort area like Hilton Head or Myrtle Beach, you have access to a wide array of services. Teaching hospitals, in and outpatient treatment facilities, community service agencies, shelters, transitional housing, and public transportation are all available locally.

Access to treatment in rural South Carolina is completely different. Most rural counties have only one small community hospital with limited services and a bare bones treatment center with few, if any, specialty services. Housing options are also limited. There are fewer shelters and transitional housing is almost non-existent. If you have SUD in rural South Carolina, you must have a car or access to one. There is no public transportation system.

Charleston and Allendale: A Case Study Comparison

To gain a better understanding of the all of the obstacles faced by the residents of rural South Carolina we compared one of South Carolina's poorest counties, Allendale, to one with significant resources, Charleston. Located adjacent to the Savannah River approximately two hours from Charleston and two from Columbia, Allendale County is one the most geographically remote counties in the State. As illustrated below, Allendale and Charleston Counties are on opposite ends of the spectrum of whatever factor that you are evaluating.

	Allendale	**Charleston**
Population (2010)[181]	10,419	350,209
Population percent change between 2000-2010	-7.1%	+13%
Number of members in the SC Senate	1	7
Number of members in the SC House of Representatives	1	14
Percent African-American	73.6%	29.8%
Percent White	23.7%	64.2%
Percent with a college degree	13.2%	37.5%
Median Household income 2006-2010	$20.081	$48,433

[178] US Drug Enforcement Administration (DEA) *South Carolina 2009,* www.justice.gov/dea/pubs/state_factsheets/southcarolina.html.
[179] SAMHSA, National Survey on Drug Use: Summary of National Findings (2010), www.samhsa.gov.
[180] Dempsey, P. Bird, D.C. and Hartley, D., *Rural Mental Health and Substance Abuse*. In: Ricketts, T.C., ed. *Rural Health in the United States*. (New York, NY: Oxford University Press, 1999) 159-178.
[181] All statistics excluding the unemployment rate are from the US Census; www.quickfcts.census.gov

Percentage of residents below the poverty line	42.4%	16.5%
Unemployment rate February 2012[182]	17.7% (2nd highest among the counties)	7.5% (3rd lowest among the counties)
Percentage of uninsured	25%	19%
Ratio of primary care physicians	621:1	457:1

Because of its tiny population and isolated location, Allendale has few services to offer people with SUD. Charleston residents battling SUD have a variety of local treatment options. Public options include two well-funded centers, Charleston Center and Charleston Dorchester Mental Health Center. Private treatment options include: South Carolina STRONG; Clinical Solutions of Charleston; the Liberty Hill Academy and Palmetto Low Country Behavioral Health. Charleston also has six hospitals including the internationally renowned Medical University of South Carolina (MUSC). MUSC operates specialized inpatient and outpatient services for individuals battling SUD. Charleston also has four free clinics, four food pantries, nine homeless shelters, and seven transitional housing facilities. Narcotics Anonymous and Alcoholics Anonymous operate several groups in in the Charleston area.

Local service options are very different for Allendale County residents. Publicly funded treatment options in Allendale include: the Allendale Mental Health Clinic and the New Life Center. There is no private drug treatment program in Allendale. Due to budget constraints, neither the New Life Center nor the Allendale Mental Health Center is able to offer the same array of services as their Charleston counterparts. Allendale Community Hospital does not have a specialized drug treatment unit or a free health clinic. A single non-profit organization, the Christ Central Mission, operates a food pantry and provides emergency housing to Allendale residents. Although Alcoholics Anonymous has a group in Allendale, Narcotics Anonymous does not.

The geographic conundrum of rural South Carolina is that the population is too small and too isolated to attract the attention of large teaching hospitals, state of the art drug treatment centers or even large non-profits. Economies of scale are impossible to achieve in rural counties with high unemployment and populations below 10,000. The small population means that these counties have few elected officials and little political power. The problem is compounded by the fact that small rural county governments do not have resources to hire grant writers and other professionals who can help them apply for funds for treatment programs.

The State of South Carolina received a total of $77,790,340 in competitive grants from the federal government to address SUD in 2010.[183] The grants were given to state and local governments, schools, and law enforcement to combat drug use and its harmful side effects. Unfortunately, little of that money went directly to rural South Carolina. Not a single dollar of direct support went to Allendale, Bamberg Barnwell, Chester, Colleton, Darlington, Dillon Hampton, Jasper, Laurens or Newberry Counties.

[182] Employers Association of South Carolina; http://eascinc.com/employment_rate.html.
[183] Office of National Drug Policy, *South Carolina Drug Control Update*, http://www.whitehouse.gov/sites/default/files/docs/state_profile_-_south_carolina.pdf.

Recommendations

Since 1971 the United States spent at least $1 trillion on the "War on Drugs." In 2009 alone, American taxpayers spent at least $51 billion combating drugs on a state and federal level. That is $169 for every man, woman and child in America.[184] Yet, despite the enormous expenditure, despite the fact that hundreds of thousands of people have lost their lives to overdose and drug-related disease and despite the fact that millions have been incarcerated for low-level drug offences, America still has one of the highest rates of SUD in the world. With one of the most rigorous drug policies and the most punitive drug laws in the world, the United States has the highest levels of lifetime illegal cocaine and marijuana use among 17 of the world's largest countries.[185] The time has come reevaluate state and federal drug policy and put more effective policies in place. The ARC Initiative makes the following recommendations:

Criminal Justice

- Increase the number of diversion programs for people battling SUD
- Increase the availability of SUD treatment services in prisons and jails
- Eliminate barriers to expungement for drug related crimes.

Treatment and Prevention

- Increase funding for SUD treatment programs
- Improve treatment for individuals with co-occurring disorders
- Increase the number of SUD treatment programs for women
- Increase the number of prevention programs

Supportive Solutions

- Increase affordable housing stock
- Develop new public transportation systems and improve existing ones
- Amend laws that treat former drug offenders differently from other offenders
- Implement SUD and mental health related provisions of the Affordable Care Act
- Increase the number of job training programs for individuals battling SUD.

Criminal Justice Solutions

Increase the Number of Diversion Programs for People Battling SUD

Understanding that the disease of addiction is the root cause of much of the criminal behavior that fills South Carolina's prisons and jails to overflowing, drug court was established to serve as an alternative to incarceration for non-violent drug offenders. With the weight of the judicial system behind them, participation in drug court offers qualified participants a combination of treatment combined with incentives and sanctions.

[184] www.drugpolicy.org

[185] Degenhardt L., Chiu, W-T, Sampson N., Kessler, RC, Anthony, JC, et al. *Toward a Global View of Alcohol, Tobacco, Cannabis, and Cocaine Use: Findings from the WHO World Mental Health Surveys* (2008) PloS Med 5(7): e141. Doi:10.1371/journal.pmed.0050141.

Drug courts operate using a carrot and stick approach. On the carrot side there is an extensive course of treatment at little expense with the opportunity to receive an expungement upon successful completion of the program. The stick includes mandatory drug tests and varying degrees of court imposed sanctions. These sanctions range from essay writing to confinement in a correctional or mental health institution. Drug courts connect the court, law enforcement and treatment communities with other providers through a comprehensive case management system that provides holistic, comprehensive treatment by addressing all of the participants needs. In addition to counseling, drug court participants receive help with job training, housing, transportation and school. Drug courts help participants recover from SUD and assist in preventing future criminal activity by reducing the need to of repeatedly prosecuting the same non-violent, low level offenders for the same crime. As of February 2011, there were 1,829 American drug courts that had been operating for more than two years and 364 recently implemented, bringing the total operating drug courts to 2,193. There are 208 currently being planned.[186]

In their approximately 20 years of existence, drug courts have had a tangible positive effect on criminal recidivism. A recent study by the United States Department of Justice found that 84% of drug court graduates were not rearrested within a year of graduating from drug court. The same study found that 72.5% of drug court graduates had not been rearrested for a period of two years after graduation.[187]

The Urban Institute conducted a study on the cost effectiveness of drug courts. The study found that drug courts provided $2.21 in benefits to the criminal justice system for every dollar invested. When the program was expanded to accept all at- risk arrestees, the rate of return on investment increased to $3.36 for every dollar spent.[188] Another cost-benefit evaluation of drug courts estimated the average investment per program participant was $5,928. The study found $2,329 in savings from avoided criminal justice system costs and another savings of $1,301 in avoided victimization costs over a 30 month period.[189]

Drug Courts in South Carolina

Drug courts have been operating in South Carolina for about 20 years. Currently, there are 30 drug courts that operate in 26 counties. In most judicial circuits drug courts are operated by the solicitor's office. Charleston County's drug court is the exception and is operated by the probate court. Drug court is open to solicitor referred non-violent offenders whose crimes are the result of SUD. The program provides participants with intensive treatment and other services for a period of one to two years. The court subjects program participants to frequent random and non-random drug testing and requires them to make regular appearances in court. To encourage compliance participants are rewarded for good behavior. Rewards include anything from Wal-Mart gift cards to candy.

Although drug court is typically operated by the judicial system, team members are from a variety of disciplines. Drug courts have team members from: drug treatment centers, law enforcement, state agencies like the Department of Juvenile Justice, non-profit organizations and educational institutions. Participation of team members from a variety of disciplines allows drug court to offer a holistic approach toward treatment. Drug court participants get access to housing assistance, life skills and parenting classes, job training and other services that could help produce better outcomes.

Unlike traditional courts, drug courts recognize that program participants suffer from a disease and that lapses are a part of the sickness. Drug courts treat lapses as part of the healing process and not as an additional act of criminality. Accordingly, drug court participants who are perceived as sincerely trying to succeed are given

[186] BJA Drug Court Clearinghouse Project, *Summary of Drug Court Activity by State and County*, (Washington, DC: American University, Justice Programs Office, February 2, 2011), p. 120.
[187] Office of National Control Policy, Fact Sheet Drug Courts: *A Smart Approach to Criminal Justice May 2011*; http://www.whitehouse.gov/sites/default/files/ondcp/Fact_Sheets/drug_courts_fact_sheet_5-31-11.pdf.
[188] Ibid.
[189] National Institute of Justice, *Drug Courts: The Second Decade* (June 2006); https://www.ncjrs.gov/pdffiles1/nij/211081.pdf.

multiple opportunities to get their lives back on track. Failure is a part of the process. Although a simple lapse is not viewed as a cause for program expulsion, it does warrant sanctions.

Drug courts have been effective in dealing with SUD among juveniles and adults. South Carolina has eight juvenile drug courts which serve individuals between the ages of 13-18. Juvenile drug court operates in a manner similar to the adult program. The major difference revolves around the role of the parents or guardians. Since juvenile participants are minors, participation of parents or guardians is a mandatory part of the program. Parents are legally obligated to make court appearances with their children and they are sometimes required to attend drug treatment sessions. Additionally, parents are required to monitor their children's behavior at home and report any illegal or inappropriate behavior to the court.

Increase the Number of Drug Treatment Options for Individuals in Prison or Jail
More resources should be allocated to treating addicted individuals within the criminal justice system. Drug treatment can help many drug abusing offenders change their attitudes about drug use, avoid relapse, and in some cases remove themselves from a life of addiction and crime. Although legal pressure may play a significant role in getting a person into treatment, unmotivated people may change once they become engaged in a treatment process. Successful SUD treatment in the criminal justice system can help reduce crime as well as the spread of HIV/AIDS, hepatitis, and other infectious diseases.

Treatment Solutions

Increase Funding for SUD Treatment Programs
Just like any other illness, SUD can be effectively treated. Investing in treatment is both necessary and valuable. Drug treatment can cut drug abuse in half, reduce criminal activity up to 80%, and reduce all arrests up to 64%.[190] According to several conservative estimates, every $1 invested in substance use treatment programs yields a return of between $4 and $7 in reduced drug-related crime, criminal justice costs, and theft. When savings related to healthcare are included, total savings can exceed costs by a ratio of 12 to 1.[191] Increasing access to SUD treatment programs:

- Cuts medical costs;[192]
- Improves productivity;[193]
- Reduces child abuse and foster care rates;[194] and
- Decreases homelessness.[195]

Improve Treatment for Individuals with Co-occurring Disorders
Despite the correlation between SUD and mental illness, substance abuse and mental healthcare professionals struggle to accurately diagnose individuals battling both problems. It is difficult to determine which problem is primary. SUD can imitate, mask, or aggravate mental illness. Conversely, mental illness can contribute to SUD,

[190] Center for Substance Abuse Treatment. *The National Treatment Improvement Evaluation Study (NTIES)* (Substance Abuse and Mental Health Services Publication No. SMA-97-3156. 1997).
[191] National Institute on Drug Abuse, *Principles of Drug Addiction Treatment: A Research Based Guide.* Second Edition; http://www.nida.nih.gov/PDF/PODAT/PODAT.pdf, p. 13.
[192] Druss, B.G., Rosenheck, R.A.. *Patterns of Health Care Costs Associated with Depression and Substance Abuse in a National Sample.* Psychiatric Services website: http://psychservices.psychiatryonline.org/cgi/content/full/50/2/214.
[193] *Issue Brief #4: What You Need to Know About Mental and Substance Use Health Conditions.* HHS Publication No. SMA 10-4609; http://www.samhsa.gov/Financing/file.axd?file=2010/12/MentalandSubstanceUseDisorders-wpb4.pdf, pp. 1, 2.
[194] Child Welfare League of America, *Fact Sheet: The Child Protection/Alcohol and Drug Partnership Act Will Help Keep Children Safe and in Permanent Families;* http://www.cwla.org/advocacy/aodfactsheet.htm.
[195] Zerger, S., *Substance Abuse Treatment: What Works for Homeless People? A Review of the Literature*. National Health Care for the Homeless Council; http://www.nhchc.org/Publications/SubstanceAbuseTreatmentLitReview.pdf, p. 25.

making it difficult to identify and effectively treat individuals with a dual diagnosis. Many SUD treatment professionals believe that mental illness is just a symptom of substance abuse; while many mental health treatment professionals believe that substance abuse is a symptom of mental illness. There is a lack of willingness to work together in the best interest of the patient. The situation in South Carolina is exacerbated as substance abuse and mental illness are treated by two separate state agencies.

The National Institute of Mental Health, National Institute of Drug Abuse and National Institute on Alcohol Abuse and Alcoholism have recommended the integration of treatment for mental illness and SUD.[196] By standardizing the definition of dual diagnosis, dually diagnosed individuals will be identified universally rather than by personal opinion.

Increase the Number of SUD Treatment Programs for Women

South Carolina needs more SUD treatment programs for women. Gender impacts the physical effects of drug use and specific issues related to SUD. To offer the best chance for recovery, SUD treatment programs for women must incorporate all aspects of women's lives: a woman's social and economic environment; her relationships with family; and her support network. Access to safe affordable childcare is another important factor to a successful recovery for many women.

Women battling SUD respond better to supportive therapies rather than the traditional confrontational approach used in many treatment centers. Women need treatment in an environment that is supportive, safe, and nurturing and the therapeutic relationship should be one of mutual respect, empathy, and compassion. Studies have shown that women achieve better outcomes in female only treatment groups.[197]

South Carolina also needs more SUD treatment programs that target the needs of pregnant women. Special programs are needed that combine prenatal care with drug abuse treatment.

Increase the number of Prevention Programs

Prevention is the foundation of any public health initiative and South Carolina needs to devote more resources to preventing SUD. Preventing drug use is the most effective way to prevent SUD. Research has shown that people who reach the age of 21 without abusing drugs are unlikely to ever abuse drugs.[198]

For every dollar spent to prevent and treat SUD, the government spends more than $50 on public programs aimed at addressing the effects of SUD.[199] Preventing SUD before it begins is the most cost-effective, common-sense approach to promoting safe and healthy communities. Prevention of SUD results in fewer car accidents due to drugged driving, and more productive workplaces due to lower absenteeism. It decreases healthcare costs and lowers HIV-transmission rates from injected drug use. For teens and young adults, preventing SUD can result in improved academic performance.[200]

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[196] Hyrb,,Kathyrn, MSW, Kirkhart,,Rob, PhD, PA-C, Talbert, Rebecca, "*Call for Standardized Definition of Dual Diagnosis*," Psychiatry MMC September 2007.

[197] Center for Substance Abuse Treatment, *Substance Abuse Treatment: Addressing the Specific Needs of Women*. (Rockville MD, 2009) Treatment Improvement Protocol (TIP) Series, No. 51., Chapter 7: Substance Abuse Treatment for Women.

[198] The National Center on Addiction and Substance Abuse at Columbia University, *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets*, (New York: Columbia University, 2009) p.60.

[199] Ibid. p.4.

[200] The federal government funds the following prevention programs: ACOER/CORA Coalition (Greenwood), All on Board Coalition (Rock Hill), Chesterfield Coordinating Council, Community Roundtable of Irmo, Dutch Fork, and Chapin, Florence County Coalition for Alcohol and Other Drug Abuse Prevention, Greenville Safe Communities Drug Alliance, Lexington One Community Coalition, RCSC Coalition (Columbia), Richland One Community Coalition, Spartanburg Youth Council and The Rise Above It: Lexington Two Community Coalition.

Supportive Solutions

Increase Affordable Housing Stock

There is a need for more affordable housing options in South Carolina. Homelessness and addiction often go hand in hand. Addicts might have lost their home as a consequence of incarceration or because they were unable to pay their mortgage or rent because of their addiction. Many people battling SUD are kicked out by their families and some are forced to leave their neighborhoods because they are rife with people and places that trigger continued drug use. Affordable housing is an important factor in recovery for individuals battling SUD. It is hard to focus on recovery in an unstable housing situation. SUD treatment programs need to offer additional services to assist their clients to obtain housing.

Due to the high correlation between poverty and SUD, access to public housing for low income individuals is also an important factor in successful recovery. Instead of frustrating recoveries by prohibiting drug offenders from obtaining public housing, state and federal regulations should allow former offenders to access public housing. If murderers and kidnappers are allowed to reside in public housing, individuals battling SUD should be permitted to reside in public housing as well.

Develop New Public Transportation Systems and Improve Existing Ones

The availability of reliable transportation is a mandatory part of any successful SUD treatment program. It does not matter how wonderful the SUD treatment program is if the patient cannot get to the program. Many people with SUD do not have private transportation or access to it. Individuals with SUD routinely lose their drivers' licenses as a result of legal penalties stemming from their illness. As a consequence, access to reliable, public transportation can be the difference between relapse and recovery.

South Carolina does not have a comprehensive public transportation system. Although all of the urban areas have bus systems, bus routes cover a limited service area and do not run frequently. With one-way fares between $1.25 and $1.75 the cost of a roundtrip ride to treatment three times a week may be too expensive for some individuals with SUD.[201] Public transportation is even more limited in rural South Carolina. In many places buses do not have regular schedules and do not operate daily. Seven counties do not have any public transportation at all.[202] To aid addiction recoveries, South Carolina needs a more comprehensive public transportation system or drug treatment centers need to be able to provide transportation for their clients.

Amend Laws that Treat Former Drug Offenders Differently from Other Offenders

State and federal public benefit laws should not treat SUD offenders differently from other offenders. Although drug offenses are considered less of an affront to society than violent crimes like rape and murder, drug offenders are subjected to many collateral sanctions that a person convicted of rape or murder does not have to face. Drug-related misdemeanor and felony convictions can trigger prohibitions on financial aid for higher education, serving as a foster parent, revocation or suspension of occupational licenses, and the suspension of one's driver's license.

Implement SUD Treatment Provisions of the Affordable Care Act

The Affordable Care Act (ACA) is a comprehensive series of health insurance reforms that will make health insurance available to millions of people at a lower cost. The ACA contains special reforms to help individuals battling drug addiction. Special programs focusing on drug prevention, early intervention, and the treatment of drug abuse as an integral part of improving and maintaining overall health. When fully implemented, the ACA will provide access to coverage for an estimated 32 million Americans who are now uninsured.

[201] The cost of a one-way bus fare$1.75 in Charleston and $1.50 in Columbia and Greenville.

[202] The following counties do not have public transportation Abbeville, Cherokee, Greenwood, Lancaster, Laurens, Saluda and Union.

Increase the Number of Job Training Programs for Individuals Battling SUD

Job training is another important of component of comprehensive drug treatment services. Outcomes improve when patients are gainfully are employed. Not only does employment afford the addicted individual the ability to be financially self-sufficient, it also provides them with the opportunity to stay busy and avoid activities that may have triggered previous drug use. Job training programs are also important because many drug abusers have lost their professional licenses as a result of their SUD.

APPENDIX I

	Services Available	Services Unavailable	Services are being Planned
Adult Drug Court	Anderson, Allendale, Beaufort, Berkeley, Charleston, Chesterfield, Clarendon, Colleton, Dorchester, Edgefield, Georgetown, Greenville, Hampton, Horry, Jasper, Kershaw, Lancaster, Lee, Lexington, Marlboro, Pickens, Richland, Spartanburg, Sumter, Williamsburg and York.	Abbeville, Bamberg, Barnwell, Calhoun, Cherokee, Chester, Darlington, Dillon, Fairfield, Greenwood, Laurens, Marion, Newberry, Oconee, Orangeburg, Union	Aiken, Florence, McCormick, Saluda
Food Pantries[203]	Abbeville, Aiken, Anderson, Beaufort, Berkeley, Calhoun, Charleston, Cherokee, Chesterfield, Clarendon, Darlington, Dillon, Dorchester, Fairfield, Florence, Georgetown, Greenville, Horry, Kershaw, Lancaster, Laurens, Lee, Lexington, Marion, Marlboro, Newberry, Oconee, Pickens, Richland, Saluda, Spartanburg, Sumter, and York.	Allendale, Bamberg, Barnwell, Colleton, Edgefield, Hampton, Jasper, McCormick, Union, Williamsburg	
Free Health Clinics	Anderson, Beaufort, Berkeley, Charleston, Chester, Chesterfield, Darlington, Dillon, Dorchester, Edgefield, Florence, Greenville, Greenwood, Horry, Kershaw, Laurens, Lexington, Marion, Newberry, Oconee, Pickens, Richland, Saluda, Spartanburg, Sumter, and York.	Abbeville, Aiken, Allendale, Bamberg, Barnwell, Calhoun (Calhoun County residents can use the free clinic in Orangeburg), Cherokee, Clarendon, Colleton, Dillon, Fairfield (Fairfield County residents can use the free clinic in Chester), Georgetown, Hampton, Jasper (Jasper County residents can use the free clinic in Beaufort), Lancaster, Lee, Marlboro, McCormick, Saluda, Sumter, Union and Williamsburg.	
Homeless Shelters	Aiken, Anderson, Beaufort, Berkeley, Charleston, Dorchester, Florence, Greenville, Horry, Lee, Lexington, Oconee, Orangeburg, Pickens, Richland, Spartanburg, Sumter, and York.	Abbeville, Allendale (one shelter operated by a church), Bamberg, Barnwell, Calhoun, Chesterfield, Clarendon, Colleton, Darlington, Dillon, Edgefield, Fairfield, Georgetown, Hampton, Jasper (one shelter operated by a church), Kershaw, Lancaster, Laurens, Lee, Marion, Marlboro, McCormick,	

[203] Many local churches also provide food to those in need.

		Newberry, Saluda, Union and Williamsburg.	
Inpatient Substance Abuse Treatment Facilities[204]	Abbeville, Aiken, Anderson, Berkeley, Charleston Clarendon, Fairfield, Florence, Georgetown, Greenville, Horry, Kershaw, Lee, Lexington, Marion, Marlboro, Newberry, Pickens, Richland, Saluda, Spartanburg, Sumter, and York.	Allendale, Anderson, Bamberg, Barnwell, Beaufort, Calhoun, Cherokee, Chester, Chesterfield, Clarendon, Darlington Dillon, Edgefield, Fairfield, Georgetown, Hampton, Jasper, Lancaster, Laurens, Lee, Marion, Marlboro, McCormick, Oconee, Orangeburg, Pickens, Saluda, Union and Williamsburg	
Juvenile Drug Court	Anderson, Beaufort, Berkeley, Charleston, Chesterfield, Clarendon, Dorchester, Fairfield, Florence, Georgetown, Greenville, Horry, Kershaw, Lancaster, Lee, Lexington, Marion, Marlboro, Newberry, Oconee, Pickens, Richland, Saluda, Spartanburg, Sumter, and York.	Abbeville, Aiken, Allendale, Bamberg, Barnwell, Calhoun, Cherokee, Chester, Colleton, Darlington, Dillon, Edgefield, Fairfield, Greenwood, Hampton, Jasper, Lancaster, Laurens, Marlboro, Marion, McCormick, Newberry, Saluda, Spartanburg and Union	Beaufort
Narcotics Anonymous	Abbeville, Aiken, Anderson, Bamberg, Barnwell, Beaufort, Berkeley, Charleston, Cherokee, Chester Chesterfield, Clarendon, Colleton, Darlington, Dorchester, Edgefield, Fairfield, Florence, Georgetown, Greenville, Greenwood, Hampton, Horry, Kershaw, Lancaster, Laurens, Lee, Lexington, Marlboro, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Sumter, Williamsburg and York.	Allendale, Calhoun, Dillon, Jasper, Lee Marion, Marlboro, McCormick, Newberry and Union	
Public Transportation	Aiken, Allendale, Anderson, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Chester Chesterfield, Clarendon, Colleton, Darlington, Dillon Dorchester, Edgefield, Fairfield, Florence, Georgetown, Greenville, Hampton, Horry, Jasper, Kershaw, Lee, Lexington, Marion, Marlboro, McCormick, Oconee, Orangeburg, Pickens, Richland, Spartanburg, Sumter, Williamsburg and York.	Abbeville, Cherokee, Greenwood, Lancaster, Laurens, Saluda and Union	
Transitional Housing	Aiken, Anderson, Berkeley, Charleston, Chester Chesterfield, Clarendon,	Abbeville, Allendale (one transitional housing facility operated by a church),	

[204] Several facilities including the Medical University of South Carolina and Morris Village serve the entire state.

	Colleton, Darlington, Dillon Dorchester, Edgefield, Fairfield, Florence, Georgetown, Greenville, Hampton, Horry, Jasper, Kershaw, Laurens, Lee, Lexington, Marion, Marlboro, McCormick, Oconee, Orangeburg, Pickens, Richland, Spartanburg, Sumter, Williamsburg and York.	Barnwell, Bamberg, Beaufort, Berkeley, Calhoun, Chester, Chesterfield, Clarendon, Darlington, Dillon, Dorchester, Edgefield, Fairfield, Hampton, Jasper, Laurens, Lee, Marion, Marlboro, McCormick, Newberry, Saluda, Union and Williamsburg.	

APPENDIX II

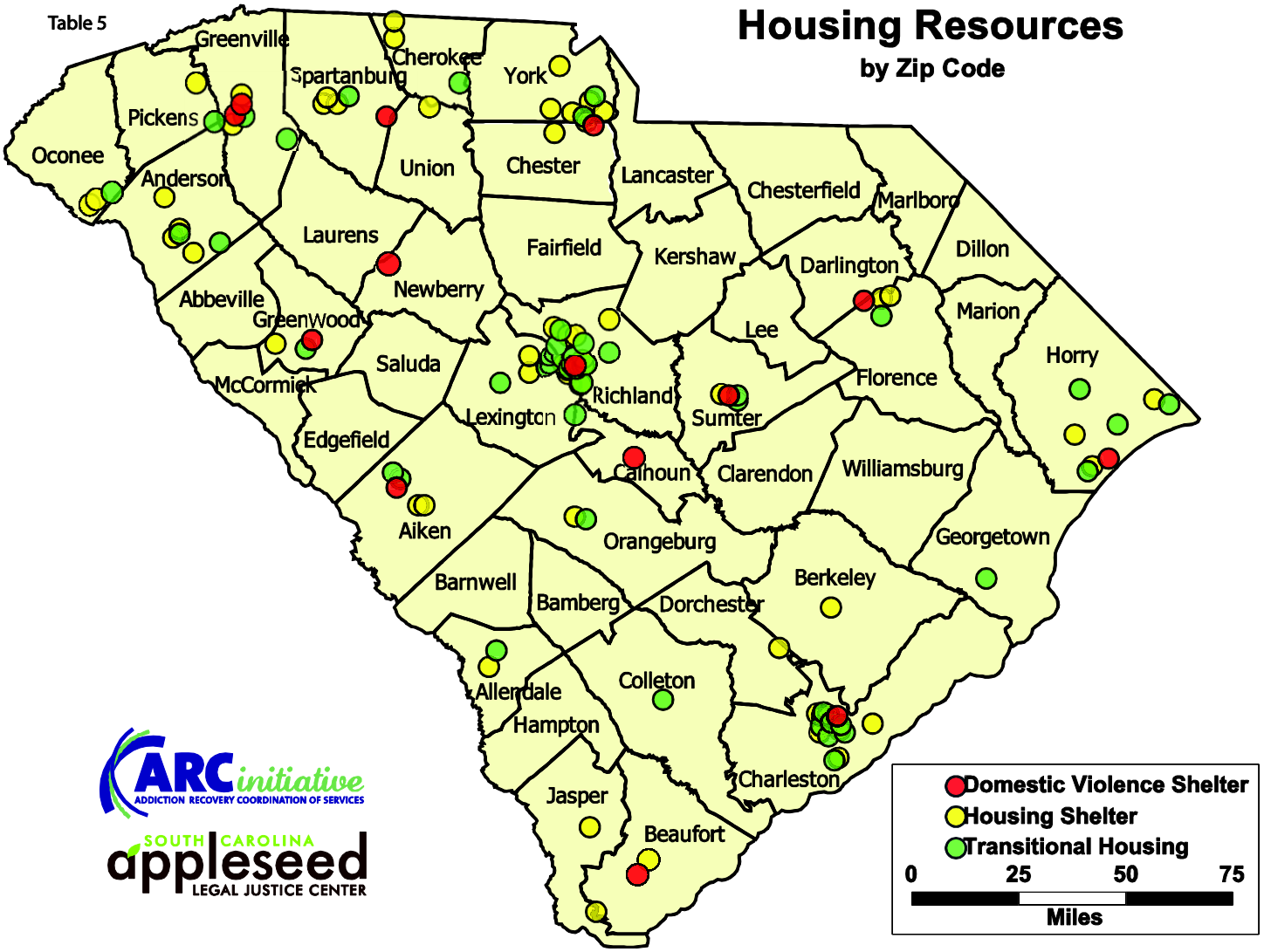
Table 5
Housing Resources
by Zip Code
Greenville
Spartanburg
Cherokee
York
Pickens
Oconee
Anderson
Union
Chester
Lancaster
Chesterfield
Marlboro
Laurens
Fairfield
Kershaw
Darlington
Dillon
Abbeville
Newberry
Greenwood
Lee
Marion
Horry
Saluda
McCormick
Richland
Sumter
Florence
Edgefield
Lexington
Calhoun
Clarendon
Williamsburg
Aiken
Orangeburg
Georgetown
Barnwell
Bamberg
Dorchester
Berkeley
Allendale
Colleton
Hampton
Charleston
Jasper
Beaufort
ARC initiative
ADDICTION RECOVERY COORDINATION OF SERVICES
SOUTH CAROLINA
appleseed
LEGAL JUSTICE CENTER
Domestic Violence Shelter
Housing Shelter
Transitional Housing
0
25
50
75
Miles

APPENDIX III

Governmental and non-profit agencies cited in this report.

1. Drug Enforcement Administration (DEA)
2. National Alliance on Mental Illness (NAMI)
3. National Institute of Drug Abuse (NIDA)
4. National Institute on Mental Illness (NIMI)
5. National Survey on Drug Use and Health (NSDUH)
6. South Carolina Law Enforcement Division (SLED)
7. South Carolina Department of Alcohol and Substance Abuse Services (SC DAODAS)
8. South Carolina Department of Corrections (SCDC)
9. South Carolina Department of Mental Health (SC DMH)
10. South Carolina Department of Probation Pardon and Parole Services (PPP)
11. Substance Abuse and Mental Health Services Administration (SAMSHA)