

Mapping the Elephant: Illegal Drugs in South Carolina

**A study by the League of Women Voters
Of the Charleston (S.C.) Area**

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Chapter 1

Introduction and Key Findings

An ancient Indian story tells about six blind men who encountered an elephant. Feeling the elephant with their hands, the men attempted to understand the huge beast's features and dimensions. Each man discovered something different and described what he saw: the elephant's side was a wall, the waving trunk a snake, the sharp tusk a spear, the leg a tree, the ear a fan, and the tail a rope. And then the men argued vigorously about what an elephant really looks like.

Describing the dimensions of issues involved in illegal drugs is like the elephant story. A parent who fears her teenager might be tempted to experiment with drugs sees the issue differently from the teen who thinks drug use is both harmless and exciting. The law enforcement officer who fears a violent reaction while arresting a drug seller sees the situation differently from the dealer who finds selling drugs both a profitable business venture and a service to those who want or need them. For every adult who insists that using drugs is a personal right, someone employed by the government insists that it is not and calls it a crime.

To try to understand the personal dimensions of drug use, you could start with what you know about alcohol. Most of us have used alcohol and enjoy it in moderation today. But many people have a family member who has become addicted to alcohol. To be or to love an alcoholic is destructive and heart breaking. Alcoholism's damage to society measured in broken families, unemployment, homelessness, illness, and lost human potential cannot be understated. And yet the potential damage associated with illegal drug use, either casual or addictive, is far worse because of its added criminal status.

Like alcoholism, drug addiction causes great physical and mental suffering to the person afflicted, and pain to loved ones. But unlike with alcohol, even using or selling a small amount of drugs for occasional recreation risks significant consequences if the user is caught and arrested. To start, in South Carolina every drug offender's driver's license is revoked for 6 months, even if no vehicle was involved in the arrest.¹ Every offender must pay at least a "drug surcharge" of \$150 to support state drug courts. After more than one arrest, a judge has the option of sentencing the offender to a jail term and a significant monetary fine, with potential threats to job security and parental custody.²

It can be far worse for someone arrested more than twice for having, selling or manufacturing drugs, even in small quantities. This person risks years in prison and huge fines; the possible confiscation of vehicle, home and possessions; a family disrupted by the

¹ There is a resolution proposed in the South Carolina General Assembly to request during its 2010-2011 session that the state be released from this federal mandate. The federal government also requires that the governor agree to the request. Should the governor not agree, the state could opt out of the 6-month revocation, but it would lose federal transportation funds. S 1343, South Carolina Legislature. Retrieved on Aug. 5, 2010 from www.scstatehouse.gov/sess118_2009-2010/prever/1343_20100506.htm

² There is no mandatory minimum sentence for first offense possession of a small amount of any drug except ephedrine, and judges may allow probation or parole for second and third offenses that do have mandatory minimum sentences. See the "Omnibus Crime Reduction and Sentencing Reform Act of 2010." Retrieved on Aug. 5, 2010 from www.scstatehouse.gov/cgi-bin/web_bh10.exe

loss of parent and provider, with children dispersed to relatives or foster care, or even to permanent adoption by strangers; and upon release from prison, many obstacles to rebuilding a normal life.

Changes in South Carolina's drug laws in 2010: The Omnibus Crime Reduction and Sentencing Reform Act of 2010³

In June 2010 the South Carolina General Assembly passed the Omnibus Crime Reduction and Sentencing Reform Act of 2010. This new law was the outcome of a lengthy study by the state's Sentencing Reform Commission, aided by the Pew Center on the States' Public Safety Performance Project. The goals of the new law are to protect public safety, hold offenders accountable, and control the growth of corrections costs. The law is projected to save the state up to \$175 million in prison construction costs and \$66 million in operating costs over the next five years.⁴

The law covers sentencing reforms for many crimes. The law affects drug offenses as follows:⁵

- Restructures sentences for controlled substance offenses, including:
 - Provides that persons convicted for a first or second drug offense, other than trafficking offenses, are eligible for probation or a suspended sentence, parole, work release, good conduct and other credits; and that persons convicted of a third or subsequent drug offense, other than trafficking offenses, be eligible for probation, suspension, parole and credits in limited circumstances. Drug trafficking remains a violent offense with no probation or parole allowed.
- Erases the disparity in penalties for crack and powder cocaine possession.
- Clarifies the proximity to schools statute (requiring enhanced penalties for controlled substance offenses within the proximity of a school, park or playground) to require intent to commit a controlled substance offense, and intent to commit it within the proximity of a school, park or playground.
- Redefines what is considered a second or subsequent drug offense for specific drug crimes (e.g., marijuana possession is no longer counted as a second or subsequent offense if a first offense of marijuana possession occurred more than five years before the conviction; for other offenses for drug possession, the first offense must have been within 10 years to count as a prior offense).
- Requires all drug offenders to pay a controlled substance offense assessment (with a waiver for indigent defendants), and allocates the proceeds to drug court programs.

³ See the "Omnibus Crime Reduction and Sentencing Reform Act of 2010." Retrieved on Aug. 5, 2010 from www.scstatehouse.gov/cgi-bin/web_bh10.exe

⁴ "South Carolina's Public Safety Reform," June 2010, p.1, The Pew Center on the States. Retrieved on Aug. 5, 2010, from www.pewcenteronthestates.org/uploadedFiles/PSPP_South_Carolina_brief.pdf?n=5221

⁵ "South Carolina's Public Safety Reform," June 2010, pp. 6 – 7, The Pew Center on the States, Retrieved on Aug. 5, 2010 from www.pewcenteronthestates.org/uploadedFiles/PSPP_South_Carolina_brief.pdf?n=5221

- Reduces the revocation period of a drug offender's driver's license to 6 months.

Why we did this study

The purpose of the study was to educate the League of Women Voters of the Charleston Area (LWVCA) about the facts pertaining to drug issues in South Carolina. After holding a public program featuring knowledgeable advocates for and against current government policies, members of the LWVCA researched the issues and wrote the study report. Then the membership discussed the findings in another meeting, and reached consensus on positions about illegal drugs in our state. Future advocacy and legislative lobbying by the LWVCA depends on this process of arriving at positions based on an accurate understanding of the issues.⁶

Some key findings in this report

- Because of the illegality of drugs and possible criminal consequences, drug users typically keep their involvement secret. The number of people who use drugs in South Carolina is certainly higher than statistics show, and nobody knows how high. (Chapter 4)
- Drug use in South Carolina is so pervasive that every year more than 1,000 drug tests of state prison inmates are positive. The true rate of drug use in prison must be even higher, since not all inmates are tested. (Chapter 4)
- South Carolina probably has the harshest law in the nation regarding pregnant women who use illegal drugs. (Chapter 5)
- Finding and prosecuting drug offenders is rewarded beyond just upholding the law, by a system that allows state agencies to financially benefit from the personal assets that drug offenders forfeit upon arrest or conviction. (Chapter 5)
- Most South Carolina jails are non-compliant with a state law that requires them to compile and report their jail statistics to a central state agency. (Chapter 6)
- Over a decade of research shows that drug courts work better at stopping drug use than jail, prison, probation, or treatment alone. However, South Carolina drug courts have struggled annually for uncertain funding, state funding favors some courts over others, and the Aiken Juvenile Drug Court has been forced to close for lack of funds. (Chapter 5)
- In 2008 - 2009, the South Carolina Prescription Monitoring Program tracked over 18 million medical prescriptions of South Carolina residents in order to catch prescription drug abusers. (Chapter 5)
- South Carolina has ranked near the bottom in spending required to effectively prevent many teens from using the gateway drug—tobacco—and does not publicize statistics showing that tobacco is a gateway drug for many. (Chapter 8)

⁶ See the positions adopted in Appendix C in this report.

How the report is organized

While the subject of this study is illegal drugs in South Carolina, it is impossible to fully appreciate the state's situation without understanding the larger frames of reference. South Carolina's drug laws and drug supply relate to international factors, so our study begins with that picture. Because drug policy in South Carolina mostly mirrors federal policy, and because South Carolina's drug use and arrest statistics take on new significance compared with those of other states, a look at the national drug situation is warranted.

Limitations of the report

Statistics in our report are from the latest year for which they were available at the time of research, which was done in late 2009 and early 2010. The original report was released in March, 2010, and this revision was made in August, 2010 to include changes made by the South Carolina General Assembly in its 2010-2011 session.

In a report of this length, an occasional error may occur. If you notice an error, please let the League of Women Voters of the Charleston Area know by email (sharoninsc@hotmail.com). It will be checked and corrected.

We regret that because of a lack of LWVCA resources, some key related issues are not included in this report. They include the important relationship between many cases of mental illness and drug abuse; drug-related information about the four federal prisons in South Carolina; state efforts at substance use prevention for adults and youth; the total amount of money spent by arrested drug offenders for their defense, fines, loss of assets, etc.; the involvement of gangs in drugs; and the immensely important issue of illegal drug use by adolescents, with all that entails. We hope that academics or other state Leagues will take up some of these issues and build on this report.

The missing voice in this report

A key voice is not included in this report: that of the many people who occasionally use or used drugs, mainly marijuana, for recreational use, without becoming addicted, arrested, or suffering any other negative result. Information about these people is scant because what they do is illegal. U.S. Presidents Obama and Clinton used drugs in this way. It would not be farfetched to believe that even some readers of this report will relate to this situation.

Acknowledgements

The researchers and writer of this study received generous assistance from many state agencies and individuals in South Carolina, as we questioned them about issues of their expertise by phone and email. We were amazed at the willingness of so many busy people to provide us with their knowledge. There are too many sources to note here, but certain people were especially generous with their knowledge and time. We thank them for contributing to our understanding of illegal drugs in South Carolina.

Last but not least, many thanks to volunteer researchers Tim Bubenik, Sharon Fratepietro, Priscilla Quirk, Katy Simison and Michele Turner.

Chapter 2

Drugs Without Borders—The International Picture

A short history of international drug laws

The United States has promoted and signed several international treaties to pledge cooperation with other countries in opposing illegal drugs. International drug control began in Shanghai, China in 1912 at a conference arranged by the United States to oppose the opium trade. The outcome was the first international drug control treaty, the International Opium Convention.⁷ Other treaties followed over the years to deal with other drugs. When the United Nations was formed in 1945, it was charged with enforcing the treaties.

In 1961 the Single Convention on Narcotic Drugs, also promoted by the United States,⁸ consolidated all former treaties into one document and broadened the scope of drugs to be controlled. Many nations are signatories. Today this treaty aims to combat drug abuse by coordinated international action. First, it seeks to limit drugs exclusively to medical and scientific purposes. Second, it combats drug trafficking through international cooperation to deter drug traffickers.⁹

This treaty has since been supplemented by the Convention on Psychotropic Substances in 1971 to control a number of synthetic drugs,¹⁰ and the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances to strengthen provisions against money laundering, drug trafficking and the diversion of precursor chemicals.¹¹ (Drug precursors are chemical substances used to manufacture illicit drugs such as ecstasy or methamphetamine.)¹²

International enforcement

The United Nations has its own drug control program, part of the United Nations Office on Drugs and Crime (UNODC). The Commission on Narcotic Drugs is the central drug policy-making body within the United Nations system.¹³ The International Narcotics Control Board (INCB) is an independent and quasi-judicial control organ for the implementation of the United Nations drug control efforts.¹⁴

⁷ "Chapter 19, The 1912 Hague International Opium Convention," Shaffer Library of Drug Policy, Retrieved on Jan. 1, 2010 from www.druglibrary.org/schaffer/library/studies/canadasenate/vol3/chapter19_hague.htm

⁸ Judge James P. Gray, *Why Our Drug Laws Have Failed and What We Can Do About It* (Philadelphia, PA: Temple University Press, 2001) p. 27.

⁹ "Drug Related Treaties," United Nations Office on Drugs and Crime, Retrieved on Jan. 1, 2010 from www.unodc.org/unodc/en/treaties/single-convention.html?ref=menu

¹⁰ "Convention on Psychotropic Substances 1971," International Narcotics Control Board, Retrieved on Jan. 1, 2010 from www.incb.org/incb/en/convention_1971.html

¹¹ "Drug Related Treaties," United Nations Office on Drugs and Crime, Retrieved on Jan. 1, 2010 from www.unodc.org/unodc/en/treaties/single-convention.html?ref=menu

¹² "Drug precursor control," European Commission, Taxation and Customs Union, accessed on Jan. 21, 2010 from http://ec.europa.eu/taxation_customs/customs/customs_controls/drugs_precursors/index_en.htm

¹³ "Commissions," United Nations Office on Drugs and Crime, Retrieved on Jan. 21, 2010 from www.unodc.org/unodc/en/commissions/index.html?ref=menu

¹⁴ International Narcotics Control Board, Retrieved on Jan. 1, 2010 from www.incb.org/

International drug penalties

Drug enforcement varies widely among nations. Most nations, such as France and the United States impose a spectrum of sanctions ranging from probation to life imprisonment for drug offenses. Many western European countries do not prosecute the possession of small amounts of drugs for personal use, though large-scale production and trafficking may be dealt with severely in accordance with the UN Single Convention.¹⁵

However, by the end of 2000, at least thirty-four countries had laws allowing capital punishment for drug crimes, with the majority of those countries located in the Middle East, North Africa and Asian Pacific regions. In some of these countries, certain drug offenses carry a mandatory death sentence.¹⁶

The United States leads the world in the number of people incarcerated in federal and state correctional facilities. Currently more than 2 million people are in American prisons or jails, with about 25% convicted of drug offenses. The United States incarcerates more people for drug offenses than any other country. With an estimated 6.8 million Americans struggling with drug abuse or dependence, the growth of prison populations continues to be driven largely by incarceration for drug offenses.¹⁷ However, statistics released in December 2009 by the Bureau of Justice Statistics (BJS), a branch of the US Department of Justice, showed that the US prison population grew by 0.8 percent from 2007 to 2008, the slowest annual growth in eight years. Twenty states reported a decline in their prison populations, with New York, Georgia, and Michigan reporting the largest reductions.¹⁸ In South Carolina, the prison population grew 2% in 2008, but only .04% in 2009.¹⁹

Global illicit drug market

The results of a new study funded by the European Commission on the global illicit drug market were presented at the 2009 session of the Commission on Narcotic Drugs in Vienna. The study found no evidence that the global drug problem had been reduced between 1998 and 2007. For some nations, the problem declined, but for others it worsened, in some cases substantially.

A convergence of national drug policies is reported by the study, with demand reduction receiving increasing emphasis and harm reduction finding wider acceptance. Policies towards sellers and traffickers have toughened. The enforcement of drug prohibition is judged by the study to have caused substantial unintended harm, much of which could have been predicted (e.g., geographical displacement of production and trafficking).²⁰

¹⁵ European Monitoring Centre for Drugs and Drug Addiction, Retrieved on Jan. 3, 2010 from www.emcdda.europa.eu

¹⁶ *The Death Penalty for Drug Offenses*, Dec. 10, 2007, International Harm Reduction Association, Retrieved on Jan. 3, 2010 from [www.ihra.net/DeathPenalty?searchTerms\[\]=death&searchTerms\[\]=penalty](http://www.ihra.net/DeathPenalty?searchTerms[]=death&searchTerms[]=penalty)

¹⁷ "Substance Abuse Treatment and Public Safety," Justice Policy Institute, (Washington, DC: January 2008), p. 1. See Chapter 3 in this document for more on this, in the section called "The result of the drug laws—America's drug picture today."

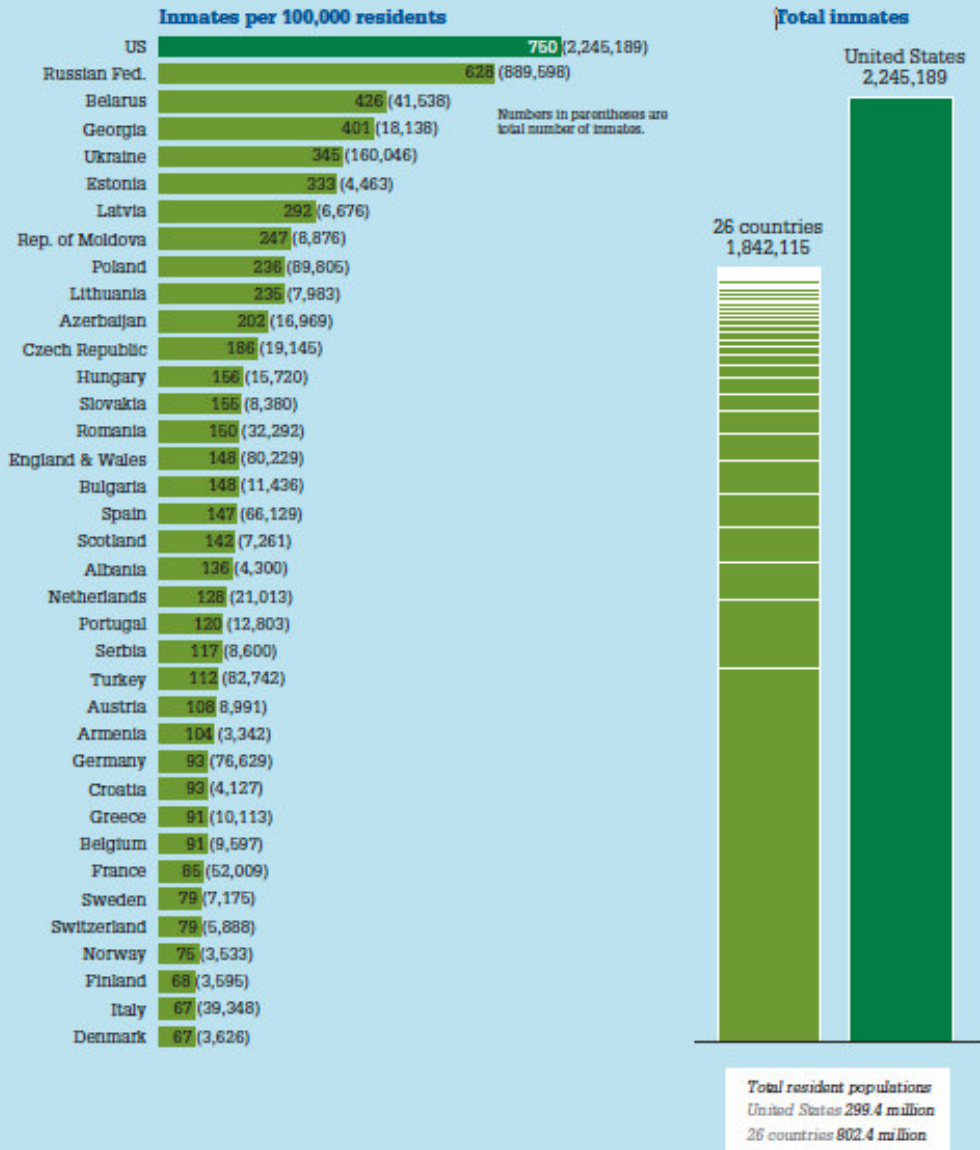
¹⁸ "United States: Cause for Hope as Prison Growth Slows," Human Rights Watch, Dec. 8, 2009. Retrieved on Jan. 3, 2010 from www.hrw.org/en/news/2009/12/08/united-states-cause-hope-prison-growth-slows

¹⁹ "South Carolina Dept. of Corrections, Average Daily Inmate Population Fiscal Year 1970 – 2009," Retrieved on Jan. 3, 2010 from www.doc.sc.gov/research/SystemOverview/AvgPop_FY1970-2009.pdf

²⁰ "Policies and Laws," *Annual Report: The State of the Drugs Problem in Europe*, 2009, The European Monitoring Centre for Drugs and Drug Addiction, Retrieved on Jan. 13, 2010 from www.emcdda.europa.eu/attachements.cfm/att_93236_EN_EMCDDA_AR2009_EN.pdf

INTERNATIONAL COMPARISONS

The U.S. inmate population compared to the 26 largest European inmate populations (years vary).



SOURCE: International Centre for Prison Studies at King's College, London, "World Prison Brief." Data downloaded January 2008.

NOTE: Rates are for total number of residents, not just adults. Figures in this chart may not align with others due to differences in counting methods.

²¹ Table A-7, "International Comparisons," *One in 100: Behind Bars in America 2008*, p. 35, The Pew Center on the States, Retrieved on Jan. 5, 2010 from www.pewcenteronthestates.org/uploadedFiles/8015PCTS_Prison08_FINAL_2-1-1_FORWEB.pdf

International drug use

As the following table shows, despite nearly 100 years of treaties and penalties, millions of people in every country persist in using illegal drugs. However, the latest report by the UN Office on Drugs and Crime suggests that the number of users in the world's biggest markets for cannabis, cocaine and opiates markets is decreasing. According to recent surveys of young people in Western Europe, North America and Oceania, cannabis use appears to be declining in these regions. Data from the world's biggest cocaine consuming region, North America, show a decrease, and the European market appears to be stabilizing. Reports from traditional opium-using countries in South-East Asia also suggest the use of this drug may be declining there. Heroin use in Western Europe appears to be stable.

In contrast, there are several indications that the global problem with amphetamine-type stimulants (ATS) is worsening. Global seizures of ATS are increasing, and ATS are being manufactured in a growing number of countries. Close to 30% of global seizures in 2007 were made in the near and Middle East, where amphetamine use may also be significant. Methamphetamine precursors are increasingly being trafficked to Central and South America to manufacture ATS for the North American market, and local use also appears to be going up.

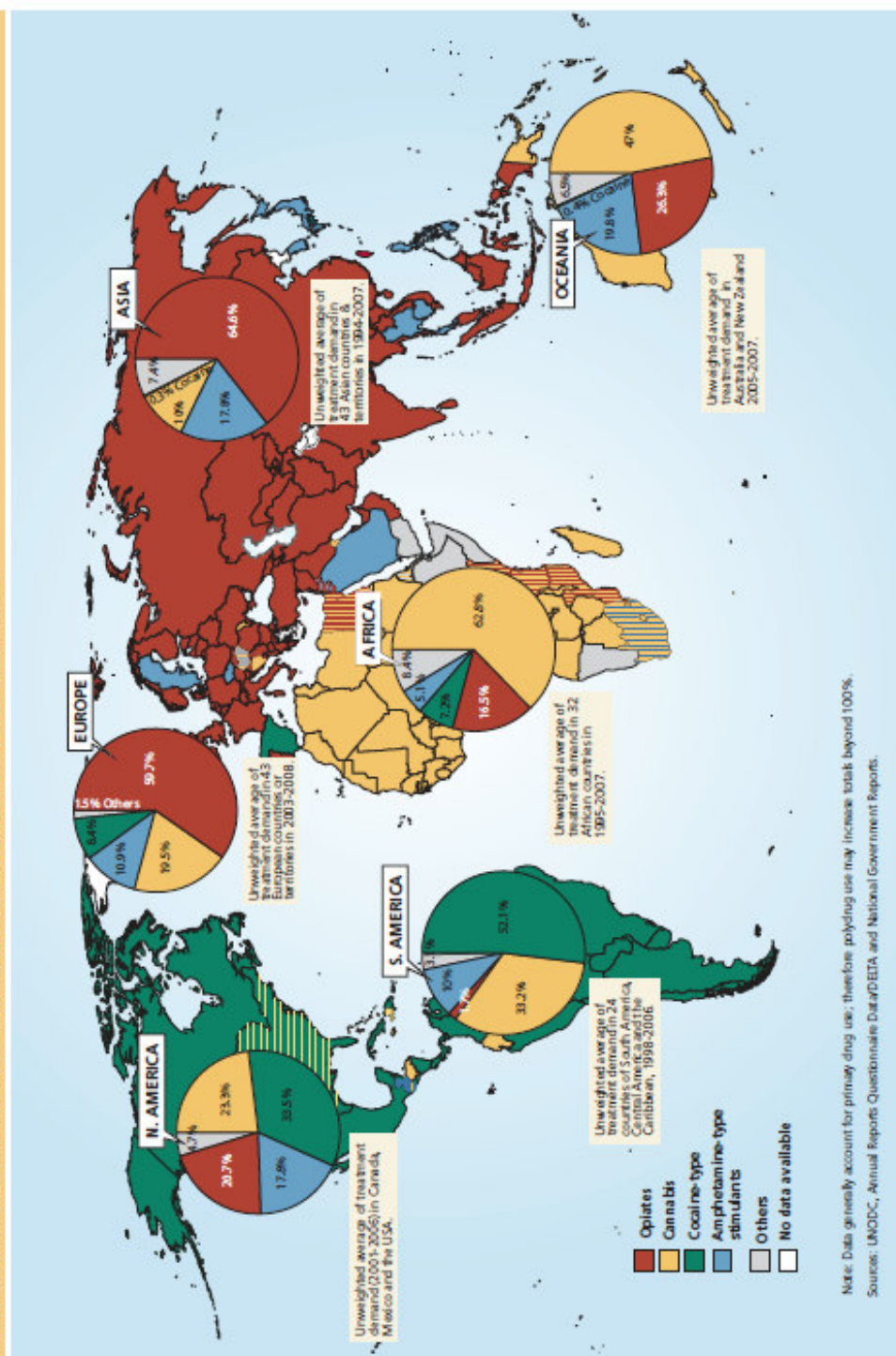
Data on ATS are particularly problematic, however, and UNODC is making a concerted effort to improve monitoring of trends in this area. The markets are clandestine, and tracking changes requires using a variety of estimation techniques. Still, data are sparse, particularly in the developing world, and the level of uncertainty in many matters is high.

For the first time, this year's *World Drug Report* is explicit about the level of uncertainty, presenting ranges rather than point estimates. UNODC estimates that between 172 and 250 million persons used illicit drugs at least once in the past year in 2007. But these large figures include many casual consumers who may have tried drugs only once in the whole year. It is important, therefore, to also have estimates of the number of people who are heavy or "problematic" drug users. Estimates made by UNODC suggest that worldwide there were between 18 and 38 million problem drug users aged 15-64 years in 2007.²²

²² *World Drug Report, 2009*, United Nations Office on Drugs and Crime, Retrieved on Jan. 6, 2010 from www.unodc.org/documents/wdr/WDR_2009/WDR2009_eng_web.pdf

Estimated number of illicit drug users in the past year aged 15-64 years, by region and subregion: 2007										
Region/ subregion	Cannabis users in the past year		Opiate users in the past year		Cocaine users in the past year		Amphetamines-group users in the past year		Ecstasy users in the past year	
	Number (lower)	Number (upper)	Number (lower)	Number (upper)	Number (lower)	Number (upper)	Number (lower)	Number (upper)	Number (lower)	Number (upper)
Africa										
North Africa	28,850,000 to 56,390,000		1,000,000 to 2,780,000		1,150,000 to 3,640,000		1,390,000 to 4,090,000		340,000 to 1,870,000	
West and Central Africa	3,670,000 to 9,320,000		120,000 to 490,000		30,000 to 50,000		240,000 to 510,000		estimate cannot be calculated	
Eastern Africa	16,110,000 to 27,080,000		550,000 to 650,000		750,000 to 1,320,000		estimate cannot be calculated		estimate cannot be calculated	
Southern Africa	4,490,000 to 9,030,000		100,000 to 1,330,000		estimate cannot be calculated		estimate cannot be calculated		estimate cannot be calculated	
	4,570,000 to 10,950,000		230,000 to 310,000		300,000 to 820,000		210,000 to 650,000		210,000 to 400,000	
Americas										
North America	41,450,000 to 42,080,000		2,190,000 to 2,320,000		9,410,000 to 9,570,000		5,650,000 to 5,780,000		3,190,000 to 3,220,000	
Central America	31,260,000 to 31,260,000		1,310,000 to 1,360,000		6,870,000 to 6,870,000		3,760,000 to 3,760,000		2,560,000 to 2,560,000	
The Caribbean	580,000 to 580,000		20,000 to 30,000		120,000 to 140,000		310,000 to 310,000		20,000 to 30,000	
South America	1,110,000 to 1,730,000		60,000 to 90,000		170,000 to 250,000		120,000 to 250,000		30,000 to 130,000	
	8,500,000 to 8,510,000		800,000 to 840,000		2,250,000 to 2,310,000		1,450,000 to 1,460,000		510,000 to 510,000	
Asia										
East	40,980,000 to 59,570,000		8,440,000 to 11,890,000		400,000 to 2,560,000		5,780,000 to 37,040,000		3,550,000 to 13,580,000	
South-East Asia	4,110,000 to 19,860,000		2,800,000 to 4,970,000		310,000 to 990,000		4,600,000 to 20,560,000		2,250,000 to 5,950,000	
South Asia	27,490,000 to 27,490,000		3,620,000 to 3,660,000		estimate cannot be calculated		estimate cannot be calculated		estimate cannot be calculated	
Central Asia	1,890,000 to 2,020,000		340,000 to 340,000		estimate cannot be calculated		estimate cannot be calculated		estimate cannot be calculated	
Near and Middle East	7,440,000 to 10,200,000		1,680,000 to 2,910,000		estimate cannot be calculated		estimate cannot be calculated		estimate cannot be calculated	
Europe										
West/ Central Europe	28,890,000 to 29,660,000		3,440,000 to 4,050,000		4,330,000 to 4,600,000		2,430,000 to 3,070,000		3,750,000 to 3,960,000	
East/South- East Europe	20,810,000 to 20,940,000		1,230,000 to 1,520,000		3,870,000 to 3,880,000		1,590,000 to 1,690,000		2,110,000 to 2,170,000	
	8,080,000 to 8,720,000		2,210,000 to 2,530,000		460,000 to 720,000		840,000 to 1,380,000		1,640,000 to 1,830,000	
Oceania	2,460,000 to 2,570,000		90,000 to 90,000		340,000 to 390,000		570,000 to 590,000		810,000 to 880,000	
GLOBAL ESTIMATE	142,580,000 to 190,270,000		15,160,000 to 21,130,000		15,630,000 to 20,760,000		15,820,000 to 50,570,000		11,580,000 to 23,510,000	

Main problem drugs (as reflected in treatment provided), 2007 (or latest year available)



²³ Ibid.

Where drugs come from

Many countries produce illegal drugs, but Colombia, Afghanistan and Mexico are major producers of particular political, economic or geographical interest to the United States.

Coca, from which powder and crack cocaine are made, largely comes from South America. For 20 years the U.S. government has been involved in the eradication of coca at the source in Peru, Bolivia and Colombia. The sale of coca has long supported a civil war in Colombia. In 2000, as part of the War on Drugs, the U.S. Congress authorized Plan Colombia, a continuing, multi-billion dollar aid program to Colombia. The money supports efforts by the Colombian military to eliminate coca by spraying it with herbicide from planes and destroying it by hand, along with help from U.S. military advisors to catch drug traffickers and processors.²⁴

The UN Office of Drug Control said the year 2008 saw some encouraging reductions in the production of cocaine and heroin. In cooperation with the affected states, UNODC conducts annual crop surveys in the countries that produce the vast bulk of these drugs. These surveys show a reduction in opium poppy cultivation in Afghanistan of 19% and a reduction in coca cultivation in Colombia of 18%.

Trends in other production countries are mixed, but not large enough to offset the declines in these two major producers. Although data are not complete enough to give a precise estimate of the global reduction in opium and coca production, there can be little doubt that it did, in fact, decrease. Production of other illicit drugs is more difficult to track.²⁵

Afghanistan produces a huge amount of opium and heroin from extensive poppy crops. Since its liberation from Taliban rule, Afghanistan's opium production has gone from 640 tons in 2001 to 8,200 tons in 2007. Afghanistan now supplies over 93% of the global opiate market. (Editor's note: Most Afghan opium and heroin go to Europe and the Middle East.) This growth has led to a well-entrenched narco-economy, strengthening the power of tribal warlords, the Taliban and al-Qaeda. In 2004, the G-8 designated Britain to lead counter-narcotics efforts in Afghanistan. Its three-year eradication policy was designed specifically not to alienate the local population, and it dictated that crop eradication be done by hand. Moreover, the British entrusted the provincial governors with the eradication process, even though Afghan provincial governors, many of whom are powerful warlords, have been engaged in the drug trade for decades. Not surprisingly, the eradication effort failed miserably.²⁶ Afghan drugs have been a major cause of government corruption, reaching up to the highest levels.²⁷

The Obama administration declared an end to U.S. efforts to eradicate poppies in 2009.²⁸

²⁴ "Background Note: Colombia," U.S. Dept. of State, Bureau of Western Hemisphere Affairs, Retrieved on Jan. 7, 2010 from www.state.gov/r/pa/ei/bgn/35754.htm

²⁵ *World Drug Report, 2009*, United Nations Office on Drugs and Crime, Retrieved on Jan. 7, 2010 from www.unodc.org/documents/wdr/WDR_2009/WDR2009_eng_web.pdf

²⁶ Rachel Ehrenfeld, "Stop the Afghan Drug Trade, Stop Terrorism," *Forbes.com*, Feb. 26, 2009, Retrieved on Jan. 7, 2010 from www.forbes.com/2009/02/26/drug-trade-afghanistan-opinions-contributors_terrorism_mycoherbicides.html

²⁷ Eugene Robinson, "A Familiar War in Afghanistan," *The Washington Post*, Eugene Robinson, Oct. 30, 2009, Retrieved on Jan. 7, 2010 from www.washingtonpost.com/wp-dyn/content/article/2009/10/29/AR2009102903924.html

²⁸ Stephen Kaufman, "U.S. Scraps Afghan Crop Eradication in Favor of Interdiction," *America.gov*, July 29, 2009, Retrieved on Jan 7, 2010 from www.america.gov/st/sca-english/2009/July/20090729184555esnamfuak0.4385187.html

Instead, the U.S. is attempting to persuade and help Afghan farmers to grow legal crops, especially wheat.

The drug situation in Mexico critically affects the United States. Besides being a major source of drugs smuggled into the United State, the drug-related violence in Mexico has escalated to extraordinary levels over the past two years. At least 6,290 people died in Mexico due to drug-related violence in 2008,¹ which is even greater than the violence that plagued Colombia in the 1980s and early 1990s, when Colombia went through a similar confrontation between its drug-trafficking organizations and the state.

Even though the majority of those killed are people involved in the drug trade, the violence has come to affect the lives of ordinary people who do not dare venture out of their houses at night (or even during the day) for fear of getting caught in the cross-fire. Elites have become targets of extortion. Kidnapping and armed robbery are markedly on the rise. The cost of violence has become cheap since the state is overwhelmed, the deterrent effect of punishment by law enforcement has declined, and social and cultural restraints on violence have been degraded. The level of drug-related violence in Ciudad Juarez, across the border from El Paso, Texas, was three times higher at the end of 2009 than in Baghdad, Iraq.²⁹

Murders and kidnapping of U.S. residents or their relatives who are caught up in the drug trade have increased dramatically. So has the kidnapping of illegal immigrants, sometimes snatched en masse from coyotes (people smugglers) and held for ransom extorted from their relatives in the United States. More and more, coyotes force illegal immigrants to carry drugs (mainly marijuana) as a payment. Because of their involvement in illegality, both groups are likely to significantly underreport abductions and kidnappings.

Increasingly, such crime is leaking from border communities deeper into the U.S. border states. The number of kidnappings in Phoenix, Arizona, for example, tripled from 48 in 2004 to 241 in 2008. Drug turf wars among the drug trafficking organizations are beginning to occur in major cities in the U.S., such as Dallas, Texas. Still, the violence and criminality on the U.S. side of the border remain relatively low, and nowhere close to their levels in Mexico.³⁰

In 2008 the U.S. government announced the Merida Initiative, a multi-year program that provides equipment and training to support law enforcement operations, and reform and oversight of security agencies in Mexico and Central America. In 2008, Congress approved over a billion dollars for Mexico.³¹

Mexico decriminalizes drugs for personal use

Mexico approved a bill early in 2009 decriminalizing possession of small amounts of narcotics for personal use, in order to free resources to fight violent drug cartels. The bill, proposed by conservative President Felipe Calderon, makes it legal to carry up to 5 grams (0.18 ounces) of marijuana, 500 milligrams (0.018 ounces) of cocaine and tiny quantities of other drugs such as heroin and methamphetamines.³²

²⁹ David Luhnow of *The Wall St. Journal*, commenting on *The News Hour*, SCETV, Dec. 23, 2009.

³⁰ Vanda Felbab-Brown, "The Violent Drug Market in Mexico and Lessons from Colombia," Brookings Institution, March, 2009, Retrieved on Jan. 6, 2010 from www.brookings.edu/papers/2009/03_mexico_drug_market_felbabbrown.aspx

³¹ "The Merida Initiative, Fact Sheet," US Dept. of State, Bureau of International Narcotics and Law Enforcement Affairs, June 23, 2009, Retrieved on Jan. 7, 2010 from www.state.gov/p/inl/rls/fs/122397.htm

³² Reuters, Mexico Senate OKs bill to legalize drug possession, April 28, 2009

Chapter 3

Drugs in the United States

Some little-known facts about the history of drug prohibition

In the 1860s opium was widely used as a painkiller for injured soldiers during the Civil War. Opiates were the first real miracle drugs because they allowed the patient to be anesthetized while the doctor performed surgery. Nevertheless, in 1869 in San Francisco and Virginia City, smoking opium was outlawed because it was a peculiarly Chinese habit and the laws were specifically directed at the Chinese. The white people feared that Chinese men were luring white women to have sex in opium dens.

In the 1870s the patent medicine industry made all sorts of concoctions that included opiates, cocaine and other drugs, and sold them with the most extravagant advertising claims. This led to a rise in addiction, which was poorly understood. Morphine and heroin were recommended as remedies for alcohol addiction. French wine made from coca, an invigorating tonic, became a popular soft drink because it contained cocaine.³³ Cocaine was an ingredient in soft drink Coca-Cola from 1886 to 1900, and Bayer Pharmaceutical Products introduced heroin in 1898 and sold it over the counter for a year.³⁴

In 1910 Dr. Hamilton Wright, considered by some the father of U.S. anti-narcotics laws, reported that U.S. contractors were giving cocaine to their black employees to get more work out of them. A few years later, stories began to proliferate about "cocaine-crazed Negroes" in the South who had run amuck. *The New York Times* published a story that alleged "most of the attacks upon white women of the South are the direct result of the 'cocaine-crazed' Negro brain." The story asserted "Negro cocaine fiends are now a known Southern menace." Some southern police departments switched to .38 caliber revolvers, because they thought cocaine made blacks impervious to .32 caliber bullets. These stories were in part motivated by a desire to persuade Southern members of Congress to support the proposed Harrison Narcotics Act, which would greatly expand the federal government's power to control drugs. This lie was also necessary because, even though drugs were widely used in America, very little crime was associated with the users.

When marijuana was popularized in the 1920s and 30s in the American jazz scene, blacks and whites sat down as equals and smoked together. The racist anti-marijuana propaganda of the time used this crumbling of racial barriers as an example of the degradation caused by marijuana. Harry Anslinger, head of the newly formed federal narcotics division, warned middle-class leaders about blacks and whites dancing together in "teahouses," using blatant prejudice to sell prohibition. During the Great Depression, the 1937 Marijuana Tax Act came into law, again using racism as its chief selling point. Mexicans vying with out of work Americans for the few agricultural jobs available, it was said, engaged in marijuana-induced violence against Americans.

³³ Robert Keel, "Drug War Timeline," University of Missouri at St. Louis, Retrieved on Jan. 5, 2010 from druglibrary.org/schaffer/history/drug_law_timeline.htm

³⁴ Judge James P. Gray, *Why Our Drug Laws Have Failed and What We Can Do About It*, (Philadelphia, PA: Temple University Press, 2001) p. 21.

In the early 1960s, nonconformist college students and 'hippies' again popularized marijuana. The growing 'counterculture' that emerged at that time questioned the value of the Vietnam War, the U.S. foreign policy and governmental authority in general. This period coincided with growing urban unrest by blacks impatient with the slow pace of implementation of civil rights legislation. The reinvigorated war on drugs declared by President Richard Nixon in 1971 targeted and effectively criminalized both groups of his staunchest critics—youth and urban minorities.³⁵

Nixon's private comments about marijuana showed he was the epitome of misinformation and prejudice. He believed marijuana led to hard drugs, despite the evidence to the contrary. He saw marijuana as tied to "radical demonstrators." He believed that "the Jews," especially "Jewish psychiatrists" were behind advocacy for legalization, asking advisor Bob Haldeman, "What the Christ is the matter with the Jews, Bob?" He made a bizarre distinction between marijuana and alcohol, saying people use marijuana "to get high" while "a person drinks to have fun." Nixon also saw marijuana as part of the culture war that was destroying the United States, and claimed that Communists were using it as a weapon. "Homosexuality, dope, immorality in general," Nixon fumed. "These are the enemies of strong societies. That's why the Communists and the left-wingers are pushing the stuff, they're trying to destroy us." His approach to drug education was just as simplistic: "Enforce the law. You've got to scare them."³⁶

Nixon's motivation to outlaw heroin also grew out of the Vietnam War. On February 25, 1971, *The New York Times* ran an article on the widespread availability of cheap and potent heroin in South Vietnam, but the story did not garner great attention until a few months later. On May 16, 1971 the front page of *The New York Times* proclaimed "G.I. Heroin Addiction Epidemic in Vietnam." Estimates of the number of soldiers addicted to heroin ranged from 10 percent to 25 percent, which meant anywhere from twenty-four thousand to over sixty thousand soldiers. The rest of the spring and summer of that year saw a flurry of reports about the "heroin epidemic" and a fear that returning soldier addicts would spread their addiction in the United States.

The GI heroin epidemic prompted Nixon to find a way to inoculate the country from returning servicemen addicted to heroin. This led to the creation of a federal methadone maintenance system, and the employment of urinalysis (used on a large scale for the first time) to screen veterans for heroin use before they returned to the United States.³⁷

A brief history of drug laws in the United States

- The earliest laws prohibiting drug use varied from state to state. In 1860, Pennsylvania enacted an anti-morphine law. In 1881, California's similar anti-opium law focused on opium smoking dens frequented by Chinese immigrants.

³⁵ "The Racial History of U.S. Drug Prohibition," Drug Policy Alliance Network, Aug. 2001, Retrieved on Jan. 4, 2010 from www.drugpolicy.org/about/position/race_paper_history.cfm

³⁶ Kevin Zeese, "Once Secret Nixon Tapes Show Why the U.S. Outlawed Pot," Kevin Zeese, AlterNet, Mar. 21, 2002, Retrieved on Jan. 4, 2010 from www.alternet.org/story/12666/

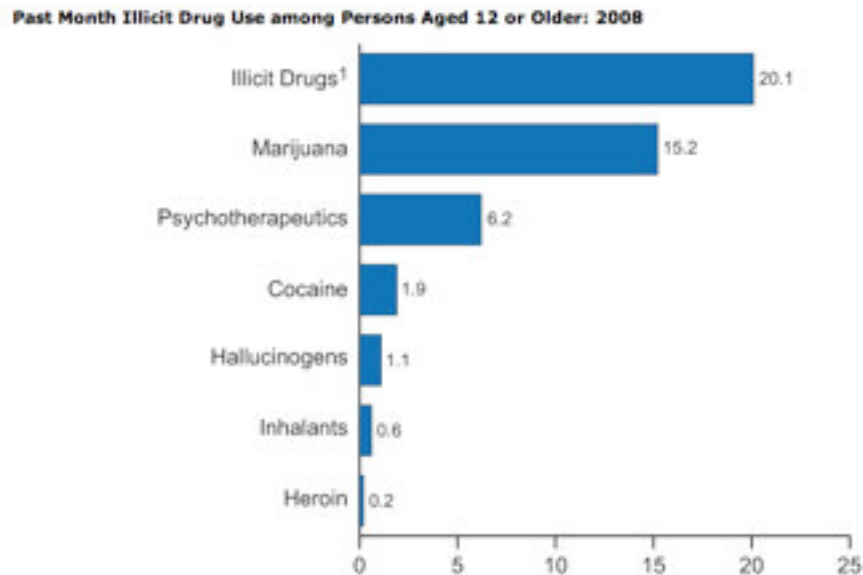
³⁷ Daniel Weimer, "Drugs-as-a-Disease: Heroin, Metaphors, and Identity in Nixon's Drug War," Northwest Vista College, Retrieved on Jan. 4, 2010 from www.janushead.org/6-2/Weimer.pdf

- Following state laws, early federal drug laws centered on “social groups using certain drugs rather than the drugs themselves.” An 1887 federal law prohibited the import of opium into the United States by any subject of China. An 1890 federal law that permitted only Americans to manufacture opium for smoking.
- The Pure Food and Drug Act of 1906, the first federal law regulating drug use, required manufacturers to list the ingredients of medicines on the label and include warnings about dangerous products. It did not prohibit any substance. Matters of public health and safety were considered the exclusive right of states.
- The Harrison Narcotics Act of 1914 made it illegal for physicians to prescribe narcotics to addicts. It was zealously enforced by the Treasury Department.
- In 1921, the 18th Amendment to the U.S. Constitution was passed prohibiting the manufacture, sale, and transport of alcohol. By this time, 39 states, including Texas, had enacted alcohol prohibition laws, while fourteen states prohibited cigarettes.
- In 1933, the 21st Amendment to the U.S. Constitution repealed the 18th Amendment, leaving regulation of alcohol sales to the states.
- On January 1, 1932, the newly established Federal Bureau of Narcotics, a unit of the Treasury Department, took over the enforcement of the federal anti-opiate and anti cocaine laws. This department encouraged states to adopt laws criminalizing the use of marijuana. The media also began to report heinous crimes committed by persons under the influence of marijuana.
- By 1937, forty-six of the forty-eight states, as well as the District of Columbia, had laws against marijuana. Under most of these state laws, marijuana was subject to the same rigorous penalties applicable to morphine, heroin, and cocaine and was often erroneously designated a narcotic.
- The Federal Marijuana Tax Act of 1937, modeled on the Harrison Narcotic Act of 1914, recognized the medicinal usefulness of the substance, although, a fee on prescribing, dispensing, growing, or importing marijuana was implemented.
- In 1970 the Comprehensive Drug Abuse Prevention Act put all drugs except alcohol and tobacco under federal control.
- Congress created the Drug Enforcement Agency (DEA) in 1972.
- The Omnibus Drug Act of 1988 placed heavier penalties on drug-related felonies and toughened the penalties for users.³⁸

³⁸ “Facts and Issues: Drug Laws and Policies in Texas,” a Study by the League of Women Voters of Texas Education Fund, 2005, Retrieved on Jan. 4, 2010 from www.lwvtexas.org/LWV_Drug%20Laws.pdf

The result of the drug laws—America’s drug picture today

In 2008, an estimated 20.1 million Americans aged 12 or older were current (past month) illicit drug users, meaning they had used an illicit drug during the month prior to the survey interview. This estimate represents 8% of the population aged 12 or older.³⁹



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Nationally, the most frequent arrests in 2008 were for **drug abuse violations (estimated at 1,702,537 arrests)**, 12.2% of the total number of all arrests.⁴¹

39 "Results from the National Survey on Drug Use and Health: National Findings," SAMHSA, Retrieved on 12/31/09 from www.oas.samhsa.gov/nsduh/2k8nsduh/2k8Results.cfm

40 FBI, Uniform Crime Reports, Crime in the United States.

41 "2008 Crime in the United States," Dept. of Justice, FBI, Retrieved on Dec. 29, 2009 from www.fbi.gov/ucr/cius2008/data/table_29.html

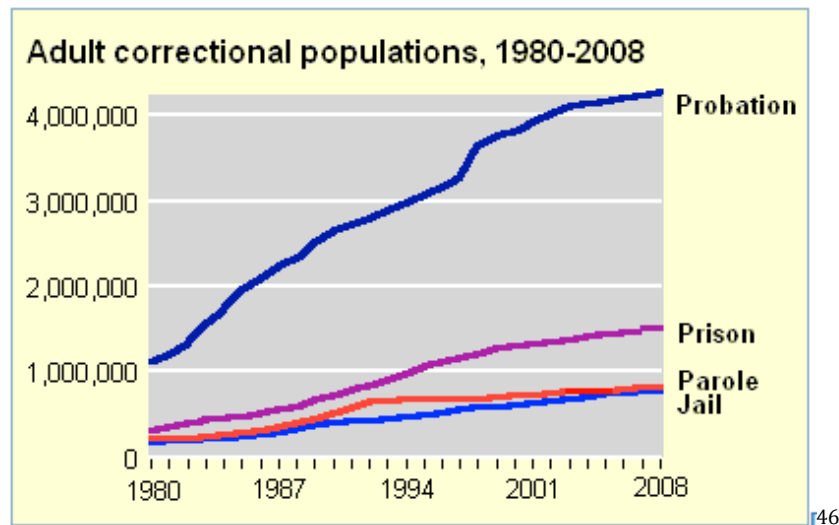
2	Estimated Number of Arrests	
3	United States, 2008	
4	Total¹	14,005,615
5	Murder and nonnegligent manslaughter	12,955
6	Forcible rape	22,584
7	Robbery	129,403
8	Aggravated assault	429,969
9	Burglary	308,479
10	Larceny-theft	1,266,706
11	Motor vehicle theft	98,035
12	Arson	14,125
13	Violent crime ²	594,911
14	Property crime ²	1,687,345
15	Other assaults	1,298,342
16	Forgery and counterfeiting	90,127
17	Fraud	234,199
18	Embezzlement	21,402
19	Stolen property; buying, receiving, possessing	111,319
20	Vandalism	285,012
21	Weapons; carrying, possessing, etc.	179,661
22	Prostitution and commercialized vice	75,004
23	Sex offenses (except forcible rape and prostitution)	79,914
24	Drug abuse violations	1,702,537
25	Gambling	9,811
26	Offenses against the family and children	118,419
27	Driving under the influence	1,483,396
28	Liquor laws	625,939
29	Drunkenness	611,069
30	Disorderly conduct	685,985
31	Vagrancy	33,852
32	All other offenses	3,835,083
33	Suspicion	1,650
34	Curfew and loitering law violations	133,063
35	Runaways	109,225

⁴²II

⁴² Ibid.

In 2008, for the first time, more than one in every 100 adults was confined in an American jail or prison.⁴³ (South Carolina ranked 9th worst in the nation for its incarceration rate of 537 per 100,000 residents.)⁴⁴

The numbers were even worse when offenders under probation, parole and in jail were taken into account. At the end of 2008, the most recent year for which figures are available, adding all probationers, parolees, prisoners and jail inmates, America now has more than 7,308,200 adults under some form of correctional control.⁴⁵



However, the Bureau of Justice Statistics reported that in 2008 the U.S. prison population grew at the slowest rate (0.8%) since 2000, reaching 1,610,446 sentenced prisoners at year-end 2008. While *growth* in imprisonment is down, the number of people in prison is still increasing, up more than 12,000 people from last year. This number continues to grow even as crime goes down.⁴⁷

For some groups, the incarceration numbers are especially startling. While one in 30 men between the ages of 20 and 34 is behind bars, for black males in that age group the figure is one in nine. Men still are roughly 10 times more likely to be in jail or prison, but the female population is growing at a far brisker pace. For black women in their mid- to late-30s, the incarceration rate also has hit the 1-in-100 mark.⁴⁸

43 *One in 100: Behind Bars in America 2008*, p. 3, The Pew Center on the States, Retrieved on Jan. 21, 2010 from www.pewcenteronthestates.org/uploadedFiles/8015PCTS_Prison08_FINAL_2-1-1_FORWEB.pdf

44 "States With the Ten Highest Incarceration Rates," *South Carolina Criminal and Juvenile Justice Trends 2009*, S.C. Dept. of Public Safety, Office of Justice Programs, Statistical Analysis Center, Editor Rob McManus, p. 100. Accessed on Jan. 21, 2010, at www.scdps.org/ojp/statistics/2009%20Crime%20Book-%20WEB%20VERSION%20v2.pdf

45 "Key Facts at a Glance, Correctional Populations," Bureau of Justice Statistics, Retrieved on Feb. 3, 2010 from <http://bjs.ojp.usdoj.gov/content/glance/tables/corr2tab.cfm>

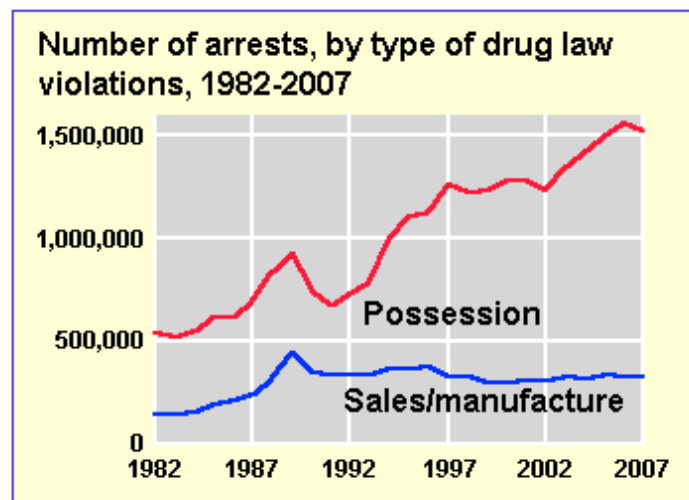
46 "Key Facts at a Glance, Bureau of Justice Statistics, Retrieved on Feb. 3, 2010 from <http://bjs.ojp.usdoj.gov/content/glance/corr2.cfm>

47 "Factsheet, DOJ Report on Prisoners in 2008," Justice Policy Institute, Retrieved on Jan. 24, 2010 from www.justicepolicy.org/images/upload/09-12_FAC_Prisoners08_PS.pdf

48 *One in 100: Behind Bars in America 2008*, The Pew Center on the States, p. 3, Retrieved on Jan. 21, 2010 from www.pewcenteronthestates.org/uploadedFiles/8015PCTS_Prison08_FINAL_2-1-1_FORWEB.pdf

While between 2000 and 2008 the number of blacks in prison declined by 18,400,⁴⁹ it is only a small reduction in the disproportion of imprisonment rates for communities of color. Black men are still 6.5 times more likely and Hispanic men 2.5 times more likely to be in prison than white men.⁵⁰ See Chapter 7 in this report for more on this disparity.

During Ronald Reagan's first term as president, 1 in every 77 adults was under the control of the correctional system in the United States. *Now 1 in 31 of all adults are under the control of the correctional system.*⁵¹



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We are indebted to The Sentencing Project for the following observations about drug offense sentencing:

"The nature of charging and plea negotiation practices imposes limitations on our understanding of the level of illegal behavior engaged in by drug offenders. Survey data show that just over a third of the offenders incarcerated for drug possession has been convicted of "possession with intent to distribute." This represents a legislative and charging decision that the volume of drugs involved exceeded a legislatively determined quantity considered greater than would be used for personal consumption, despite a lack of direct evidence that the person arrested was engaged in the illegal sale or distribution of drugs."

"Unfortunately, the sub-category of possession with intent to distribute is not effective in conveying with any degree of precision the seriousness of the charge. Charging and plea negotiation practices also result in cases in which persons convicted of drug possession may have originally been charged with drug trafficking, but subsequently agreed to a plea bargain for a possession conviction."

⁴⁹ "Prisoners in 2008," U.S. Dept of Justice, Bureau of Justice Statistics, December 8, 2009, Retrieved on Jan. 1, 2010 from <http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=1763>

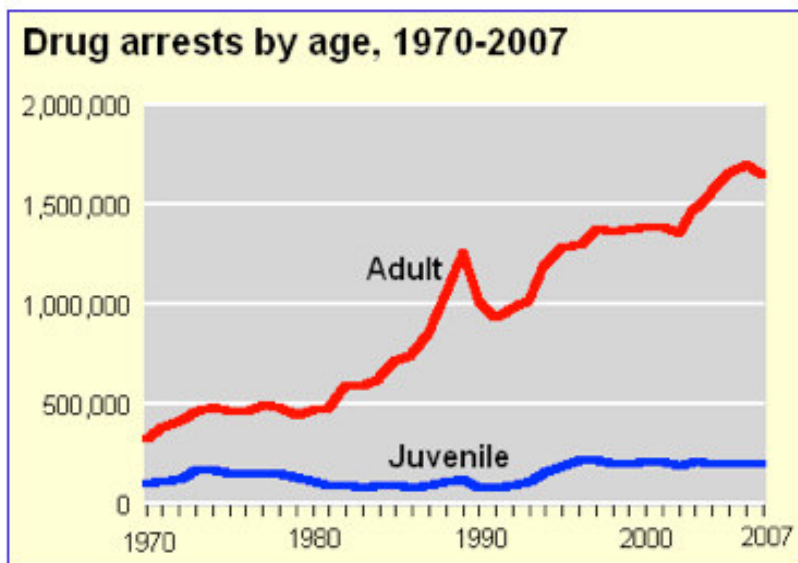
⁵⁰ "Factsheet, DOJ Report on Prisoners in 2008," Justice Policy Institute, Retrieved on Jan. 24, 2010 from www.justicepolicy.org/images/upload/09-12_FAC_Prisoners08_PS.pdf

⁵¹ "1 in 31 U.S. Adults are Behind Bars, on Parole or Probation," The Pew Center on the States, Retrieved on Jan. 1, 2010 from www.pewcenteronthestates.org/news_room_detail.aspx?id=49398

⁵² *Crime in the United States*, FBI, Uniform Crime Reports, Retrieved on Jan. 2, 2010 from <http://bjs.ojp.usdoj.gov/content/dcf/enforce.cfm#salespos>

“To the extent these court dynamics are at work, though, it is still unlikely that the group of possession convictions on the whole was engaged in the drug trade at a significant level. Few prosecutors would agree to a plea bargain to possession for a defendant whom they believed and could prove was responsible for importing, manufacturing, or distributing significant quantities of illegal drugs.”

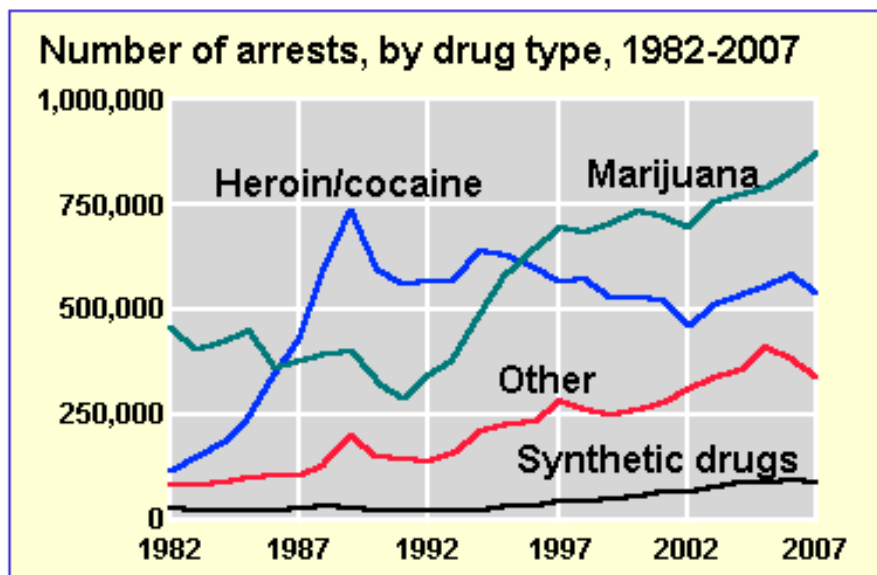
“Similarly, the category of drug trafficking, comprising a majority (54.5%) of all drug offenders, incorporates a broad range of drug offender behavior. Within this category would fall both a drug “kingpin” responsible for a multi-million dollar operation and a young woman selling \$10 “rocks” of crack on a street corner to support her drug habit. While both behaviors are clearly illegal, the implications of imprisonment, both on the offender and the drug trade, are distinctly different. It is plausible that the imprisonment of the kingpin would disrupt the drug operation at least temporarily, but there is little evidence that incarceration of lower level sellers produces any significant street impact.”⁵³



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⁵³ Ryan S. King and Marc Mauer, *The Sentencing Project, Distorted Priorities: Drug Offenders in State Prisons*, Sept. 2002, p. 6, Retrieved on Jan. 2, 2010 from www.sentencingproject.org/doc/publications/dp_distortedpriorities.pdf

⁵⁴ *Crime in the United States*, FBI, Uniform Crime Reports, Retrieved on Jan. 2, 2010 from <http://bjs.ojp.usdoj.gov/content/dcf/enforce.cfm#salespos>



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Nationally, in 2008 an estimated 1,702,537 arrests were for drug abuse violations, the single largest category of arrests. Half of those arrests were for marijuana, mostly for possession.

Year	Total arrests	Total drug arrests	Total marijuana arrests	Marijuana possession arrests	Marijuana trafficking/sale arrests
2008	14,005,615	1,702,537	847,863	754,224	98,640

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⁵⁵ Ibid.

⁵⁶ Get the Facts, DrugWarFacts.org, Retrieved on Feb. 27, 2010 from www.drugwarfacts.org/cms/node/53

Drugs and crime

Percent of prison and jail inmates who committed offense to get money for drugs

Offense	<u>Local jail inmates</u> 2002	<u>State prisoners</u> 2004	<u>Federal prisoners</u> 2004
Total	16.4%	16.6%	18.4%
Violent	8.0	9.8	14.8
Property	26.9	30.3	10.6
Drugs	24.8	26.4	25.3
Public-order	5.2	6.9	6.8

Source: BJS, *Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002*, NCJ 209588, July 2005 and *Drug Use and Dependence, State and Federal Prisoners, 2004*, NCJ 213530, October 2006.

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The Uniform Crime Reporting Program (UCR) of the Federal Bureau of Investigation (FBI) reported that in 2007, 3.9% of the 14,831 homicides in which circumstances were known, were narcotics related. Murders that occurred specifically during a narcotics felony, such as drug trafficking or manufacturing, are considered narcotics related.⁵⁸

Drug violence

Trafficking in illicit drugs tends to be associated with the commission of violent crimes. Reasons for the relationship between drug trafficking and violence include the following:

- Competition for drug markets and customers.
- Disputes and rip-offs among individuals involved in the illegal drug market.
- The tendency toward violence of individuals who participate in drug trafficking.
- Locations in which street drug markets proliferate tend to be disadvantaged economically and socially; legal and social controls against violence in such areas tend to be ineffective.
- The proliferation of lethal weapons in recent years has also made drug violence more deadly.

The evidence indicates that drug users are more likely than nonusers to commit crimes, that arrestees frequently were under the influence of a drug at the time they committed their offense, and that drugs generate violence. However, the Office on National Drug Control also issues this caution: Assessing the nature and extent of the influence of drugs on crime requires that reliable information about the offense and the offender be available, and that definitions be consistent. In the face of problematic evidence, it is impossible to say quantitatively how much drugs influence the occurrence of crime.⁵⁹

⁵⁷"Prisoners in 2008," U.S. Dept. of Justice, Bureau of Justice, Drugs and Crime Facts, Dec. 8, 2009, Retrieved on Jan. 3, 2010 from <http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=1763>

⁵⁸ Ibid.

⁵⁹ "Drug Related Crime, 2000," Office of National Drug Control Policy, accessed on Jan. 21, 2010 from www.whitehousedrugpolicy.gov/publications/factsht/crime/index.html#drugsgenerate

Chapter 4

Drugs in South Carolina

Where our drugs come from

South Carolina, once considered a “consumer state,” is now considered a “source state” for illegal drugs. It is increasingly documented as a transshipment corridor for all manners of illicit drugs and drug proceeds. South Carolina is strategically located midway between Miami and New York City, where I-20, I-26, and I-77 intersect with I-95 and I-85. This location is ideal for transshipping contraband throughout the Eastern Seaboard. From Mexico and the southwest border states, traffickers travel on I-20 and I-85 to supply northeastern states with cocaine, marijuana, methamphetamine, and heroin. Containerized cargo through the Port of Charleston is also a popular transshipment method for cocaine.⁶⁰

Major Domestic Drug Smuggling Corridors Targeted by the HIDTA Domestic Highway Enforcement (DHE) Initiative



⁶⁰“South Carolina 2009.” U.S. Drug Enforcement Administration (DEA), Retrieved on Jan. 2, 2010, from www.justice.gov/dea/pubs/state_factsheets/southcarolina.html

Drug use and drug offenses in South Carolina

Although marijuana is used most often, the U.S. Drug Enforcement Administration (DEA) says that cocaine hydrochloride (HCl), crack cocaine, and methamphetamine are the major illegal drug threats in South Carolina. Cocaine HCl and crack cocaine have long been South Carolina's major drug threat; however, methamphetamine poses a slow but steadily increasing threat in the northern regions of the state. Methamphetamine seizures in the last year have increased.⁶¹

Spinoff crimes are different for each drug. Meth users and meth cooks want to feed their own habits. They usually commit unarmed property crimes, stealing money or something else to sell quickly. Cocaine dealers often are in business for the money, not the high. Armed dealers rob each other, creating violent dealer-on-dealer crime. When word gets out that a dealer has a sizable amount of drugs—or has just sold a large amount—it's like advertising for a robbery. Unfortunately, bystanders, neighbors and youngsters can be in the wrong place at the wrong time.⁶²

From 2005- 2006, among South Carolinians 12 years of age and older, 7.3% of those surveyed said they had used illegal drugs in the previous month. The chart below shows the drugs South Carolinians preferred, and the next chart shows that South Carolina is slightly below the national average of estimated drug users.

ILLEGAL DRUG USE ESTIMATES SOUTH CAROLINA 2005 - 2006

Drug use	Annual Users	Estimated Percent
Cocaine past year	80,247	2.2%
Illegal drugs past month	262,067	7.3%
Marijuana past month	196,279	5.4%
Marijuana past year	318,818	8.8%
Non-medical use of pain relievers past year	175,675	4.9%

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⁶¹ Ibid.

⁶² Adam Beam and John Monk, "The State's yearlong look at illegal drugs finds S.C. at a crossroads," *The State*, Nov. 4, 2007, Retrieved on Feb. 15, 2010 from www.thestate.com/drugs/story/219805.html

⁶³ Rob McManus, Editor, *Altered States in the Palmetto State: Statistical Indicators of Illegal Drug Use*, p. 96, June 2008, South Carolina Dept. of Public Safety, Retrieved on Jan. 29, 2010, from www.scdps.org/ojp/statistics/Altered%20States%20in%20SC.pdf

State or jurisdiction	Annual Average for 2003–2004		Annual Average for 2004–2005		Annual Average for 2005–2006	
	Estimated number of users (thousands)	Percent who are current users	Estimated number of users (thousands)	Percent who are current users	Estimated number of users (thousands)	Percent who are current users
Alabama	258	6.94	275	7.33	279	7.36
Alaska	60	11.79	63	12.16	58	11.10
Arizona	377	8.29	345	7.33	395	8.07
Arkansas	170	7.54	173	7.63	192	8.35
California	2,571	8.92	2,575	8.85	2,675	9.09
Colorado	379	10.18	375	9.94	384	9.99
Connecticut	247	8.54	262	9.02	268	9.18
Delaware	58	8.56	58	8.33	57	8.07
District of Columbia	45	9.56	44	9.51	53	11.05
Florida	1,110	7.77	1,216	8.30	1,218	8.13
Georgia	560	8.00	539	7.52	578	7.80
Hawaii	81	7.96	86	8.38	83	8.03
Idaho	77	6.94	80	6.98	84	7.19
Illinois	788	7.62	780	7.49	772	7.36
Indiana	377	7.41	378	7.37	417	8.08
Iowa	161	6.52	146	5.88	157	6.32
Kansas	148	6.66	161	7.19	177	7.88
Kentucky	294	8.63	288	8.39	242	6.98
Louisiana	278	7.66	299	8.18	299	8.37
Maine	104	9.31	107	9.45	113	9.99
Maryland	317	7.03	301	6.57	287	6.22
Massachusetts	547	10.16	503	9.37	537	9.96
Michigan	750	9.00	730	8.72	734	8.76
Minnesota	313	7.41	349	8.17	349	8.15
Mississippi	135	5.79	157	6.65	177	7.49
Missouri	384	8.13	366	7.66	385	8.00
Montana	75	9.70	77	9.79	84	10.65
Nebraska	98	6.86	93	6.47	102	7.05
Nevada	161	8.68	161	8.31	188	9.39
New Hampshire	108	9.87	98	8.88	98	8.85
New Jersey	490	6.86	517	7.21	537	7.44
New Mexico	173	11.25	139	8.87	132	8.34
New York	1,451	9.10	1,478	9.24	1,508	9.38
North Carolina	497	7.23	511	7.31	549	7.69
North Dakota	39	7.47	33	6.16	30	5.66
Ohio	745	7.88	743	7.82	754	7.93
Oklahoma	241	8.44	233	8.07	244	8.43
Oregon	283	9.47	291	9.63	295	9.58
Pennsylvania	808	7.80	823	7.91	798	7.65
Rhode Island	98	10.84	97	10.67	101	11.21
South Carolina	261	7.65	253	7.32	255	7.25
South Dakota	44	6.96	41	6.50	44	6.89
Tennessee	331	6.80	394	7.99	442	8.89
Texas	1,226	6.96	1,213	6.76	1,247	6.78
Utah	126	6.88	142	7.55	133	6.83
Vermont	56	10.44	57	10.66	59	11.01
Virginia	434	7.25	411	6.76	448	7.26
Washington	434	8.52	438	8.45	528	10.03
West Virginia	113	7.36	119	7.70	123	7.95
Wisconsin	356	7.77	346	7.48	333	7.17
Wyoming	33	7.87	32	7.62	37	8.67
United States	19,272	8.06	19,397	8.02	20,040	8.19

Note: "Any illicit drug" includes marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or any prescription-type psychotherapeutic used nonmedically.

¹Estimates are based on a survey-weighted hierarchical Bayes estimation approach.

Source: Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies, Office of Applied Studies (2005–2007). *State Estimates of Substance Use from the National Surveys on Drug Use and Health (formerly National Household Survey on Drug Abuse) for 2003–2006*. Rockville, MD: U.S. Department of Health and Human Services. Available at <http://www.oas.samhsa.gov/nsduh.htm> (accessed on June 30, 2008).

From 1996 – 2006, the median age of South Carolinians arrested for drug offenses was 25 years.

DRUG ARRESTS BY AGE **1996 – 2006**

Age Group	Number	Percent	Rate	
Juvenile	18,126	5.7%	17.3	
9 & younger	21	<0.1%	<0.1	
10 - 14	4,615	1.5%	14.6	
15 - 16	13,490	4.3%	104.4	
Adult	297,501	94.3%	87.1	
17 - 24	138,688	43.9%	269.0	
25 - 34	81,753	25.9%	130.8	
35 - 44	52,973	16.8%	78.2	
45 - 54	20,339	6.4%	33.1	
55 & older	3,748	1.2%	3.8	
Total	315,627	100.0%	70.7	64

As charts on the following page show, arrestees were far more likely to be male than female, and somewhat more likely to be black. Just 28.5% of the population in South Carolina is black.⁶⁵ See Chapter 7 in this document for more information about the racial disparities.

⁶⁴ Rob McManus, Editor, *Altered States in the Palmetto State: Statistical Indicators of Illegal Drug Use*, p. 24, June 2008, South Carolina Dept. of Public Safety, Retrieved on Jan. 29, 2010, from www.scdps.org/ojp/statistics/Altered%20States%20in%20SC.pdf (By South Carolina statute, 17 is generally the age of adult criminal responsibility. Three hundred sixteen arrestees were missing age data. The sum of the percents for the age groups does not equal the overall juvenile and adult percents due to rounding.)

⁶⁵ "State and County QuickFacts," U.S. Census Bureau, Nov. 17, 2009. Retrieved on Jan. 28, 2010 from <http://quickfacts.census.gov/qfd/states/45000.html>

DRUG ARRESTS BY RACE 1996 – 2006

Race	Number	Percent
Asian	562	0.2%
Black	167,586	53.1%
Native American	548	0.2%
White	146,964	46.6%
Total	315,660	100.0%

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DRUG ARRESTS BY SEX 1996 – 2006

Sex	Number	Percent	Rate
Female	51,114	16.2%	22.3
Male	264,825	83.8%	122.1
Total	315,939	100.0%	70.7

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⁶⁶ Rob McManus, Editor, *Altered States in the Palmetto State: Statistical Indicators of Illegal Drug Use*, p. 28, June 2008, South Carolina Dept. of Public Safety, Retrieved on Jan. 29, 2010, from www.scdps.org/ojp/statistics/Altered%20States%20in%20SC.pdf

⁶⁷ Ibid., p. 26.

Most drug arrests in South Carolina were for marijuana, as shown in the following chart.

DRUG ARRESTS BY SUBSTANCE **1996 - 2006**

Substance	Number	Percent
Cannabis	190,438	64.3%
Hashish	180	0.1%
Marijuana	190,258	64.2%
Cocaine	86,744	29.3%
Crack	68,228	23.1%
Powder	18,516	6.2%
Depressants	936	0.3%
Barbiturates	194	0.1%
Other Depressants	742	0.3%
Hallucinogens	1,189	0.4%
LSD	292	0.1%
Other Hallucinogens	865	0.3%
PCP	32	<0.1%
Opiates	5,267	1.8%
Heroin	1,826	0.6%
Morphine	147	<0.1%
Opium	44	<0.1%
Other narcotics	3,250	1.1%
Other/Unknown	5,842	2.0%
Stimulants	5,903	2.0%
Meth & Amphetamine	5,372	1.8%
Other Stimulants	531	0.2%
Total	296,319	100.0%

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Drug trafficking (55.8%) was the major offense presented in General Sessions Court. (Cases involving juveniles are usually heard in Family Court and less serious offenses involving adults may be heard in Magistrate Court.) The first chart below refers only to cases heard in General Sessions Court, where most cases were for cocaine (64.6%) and

⁶⁸ Ibid., p. 22. (19,620 drug equipment only offenses...are excluded. Total percent does not add up to 100 due to rounding.)

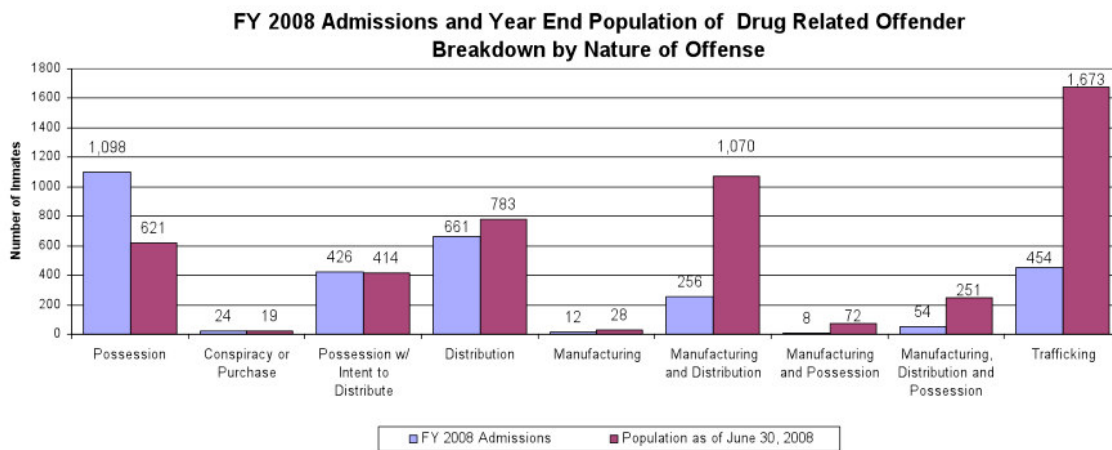
marijuana (33.5%). The second chart shows the type of offense admissions to South Carolina state prisons.

NOTE: Solicitors often adjust charges down from trafficking or other offenses to possession, in the course of making plea bargains with defendants.

GENERAL SESSIONS COURT CASES FILED BY TYPE OF DRUG OFFENSES FY 01 – FY 07

Type of Offense	Number	Percent
Other	16,621	7.7%
Possession	79,007	36.5%
Trafficking	120,795	55.8%
Total	216,423	100.0%

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Charleston County had the highest number of drug arrests, and the highest rate of arrest in 2006 (shown per 10,000 of population).⁷¹

⁶⁹ Ibid., p. 42.

⁷⁰ Presentation to the South Carolina Sentencing Reform Commission, Jon Ozmint, Director, S.C. Dept. of Corrections, Feb. 26, 2009, Retrieved on Jan. 1, 2010 from www.scstatehouse.gov/citizensinterestpage/SentencingReformCommission/SentencingReform.html

⁷¹ Rob McManus, Editor, *Altered States in the Palmetto State: Statistical Indicators of Illegal Drug Use*, p. 34, June 2008, South Carolina Dept. of Public Safety, Retrieved on Jan. 29, 2010, from www.scdps.org/ojp/statistics/Altered%20States%20in%20SC.pdf

DRUG ARRESTS BY COUNTY **2006**

County	Number	Rate	County	Number	Rate
Abbeville	112	43.2	Greenwood	601	88.1
Aiken	1,257	82.8	Hampton	104	48.8
Allendale	53	49.5	Horry	2,878	120.7
Anderson	1,015	57.0	Jasper	262	120.2
Bamberg	97	61.8	Kershaw	371	64.5
Barnwell	208	89.3	Lancaster	621	97.6
Beaufort	968	68.2	Laurens	394	56.0
Berkeley	1,153	75.7	Lee	122	59.2
Calhoun	88	58.7	Lexington	1,851	77.1
Charleston	4,869	146.7	McCormick	26	25.5
Cherokee	560	103.9	Marion	183	52.7
Chester	396	120.4	Marlboro	368	126.0
Chesterfield	599	138.7	Newberry	467	123.5
Clarendon	286	85.9	Oconee	386	54.7
Colleton	287	72.7	Orangeburg	562	61.9
Darlington	859	127.1	Pickens	502	43.9
Dillon	323	104.2	Richland	3,227	92.7
Dorchester	1,066	89.6	Saluda	111	58.1
Edgefield	176	69.6	Spartanburg	1,699	62.7
Fairfield	241	101.3	Sumter	681	65.2
Florence	1,732	131.9	Union	387	136.7
Georgetown	515	84.6	Williamsburg	144	39.9
Greenville	4,079	97.8	York	2,004	100.7

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In 2006, 38,211 South Carolinians were arrested for drug offenses.⁷³ As the next chart shows, drug offenses account for the largest category of inmates in South Carolina state prisons. (It does not include inmates arrested for other crimes while using drugs.) From 2005 – 2009, that category declined. For possible explanations, see Chapter 7 in this report.

⁷² Ibid., p. 10.

⁷³ Ibid., p. 34. (Within the South Carolina Incident Based Reporting System (SCIBRS) data, illegal drug activity was defined as an arrest for either drug/narcotic law violations or drug/narcotic equipment violations. SCIBRS captures up to three offenses per arrest. Any arrest that included a drug offense among the arrest offense was defined as drug related, regardless of which offense was the most serious.)

**MOST SERIOUS OFFENSE DISTRIBUTION OF SCDJ TOTAL INMATE POPULATION
AS OF JUNE 30, FISCAL YEARS 2005-2009**

OFFENSE CLASSIFICATION	FY 2005		FY 2006		FY 2007		FY 2008		FY 2009	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
DANGEROUS DRUGS	5,194	22.0%	4,809	20.6%	4,740	19.8%	4,934	19.7%	4,729	19.0%
BURGLARY	3,469	14.7%	3,631	15.5%	3,697	15.5%	3,905	15.4%	3,882	15.6%
HOMICIDE	2,995	12.7%	3,050	13.0%	3,126	13.1%	3,212	12.8%	3,340	13.4%
ROBBERY	2,938	12.4%	2,873	12.3%	2,899	12.1%	3,042	12.1%	3,107	12.5%
ASSAULT	1,948	8.2%	2,128	9.1%	2,177	9.1%	2,196	8.8%	2,245	9.0%
SEXUAL ASSAULT	1,240	5.2%	1,473	6.3%	1,516	6.3%	1,526	6.1%	1,537	6.2%
KIDNAPPING	513	2.2%	816	3.5%	885	3.7%	962	3.8%	1,030	4.1%
LARCENY	1,040	4.4%	583	2.5%	663	2.8%	758	3.0%	774	3.1%
TRAFFIC OFFENSE	746	3.2%	577	2.5%	604	2.5%	686	2.7%	677	2.7%
FAMILY OFFENSE	382	1.6%	475	2.0%	509	2.1%	408	1.6%	559	2.2%
SEX OFFENSES	74	0.3%	124	0.5%	127	0.5%	165	0.7%	526	2.1%
FRAUDULENT ACTIVITY	657	2.8%	439	1.9%	462	1.9%	490	2.0%	455	1.8%
STOLEN VEHICLE	951	4.0%	761	3.3%	770	3.2%	807	3.2%	394	1.6%
FORGERY/COUNTERFEITING	512	2.2%	377	1.6%	374	1.6%	378	1.5%	330	1.3%
WEAPON OFFENSE	215	0.9%	341	1.5%	324	1.4%	336	1.3%	328	1.3%
OBSTRUCTING POLICE	84	0.4%	266	1.1%	258	1.1%	264	1.1%	242	1.0%
ACCESSORY TO FELONY	0	0.0%	0	0.0%	0	0.0%	109	0.4%	163	0.7%
ARSON	129	0.5%	139	0.6%	130	0.5%	138	0.6%	117	0.5%
STOLEN PROPERTY	117	0.5%	71	0.3%	105	0.4%	117	0.5%	115	0.5%
FLIGHT/ESCAPE	25	0.1%	114	0.5%	90	0.4%	95	0.4%	85	0.3%
DAMAGED PROPERTY	92	0.4%	59	0.3%	52	0.2%	233	0.9%	77	0.3%
CRIMINAL CONSPIRACY	0	0.0%	0	0.0%	0	0.0%	43	0.2%	61	0.2%
SMUGGLING	3	0.0%	14	0.1%	21	0.1%	19	0.1%	19	0.1%
INVASION OF PRIVACY	13	0.1%	7	0.0%	4	0.0%	8	0.0%	17	0.1%
POSSESSION OF TOOLS	0	0.0%	0	0.0%	0	0.0%	17	0.1%	16	0.1%
COMMERCIALIZED SEX	4	0.0%	6	0.0%	7	0.0%	12	0.0%	13	0.1%
CRIME AGAINST PERSON	0	0.0%	0	0.0%	0	0.0%	0	0.0%	12	0.0%
MISPRISON TO FELONY	0	0.0%	0	0.0%	0	0.0%	6	0.0%	7	0.0%
OBSTRUCTING JUSTICE	11	0.0%	5	0.0%	2	0.0%	10	0.0%	5	0.0%
CONSERVATION	4	0.0%	3	0.0%	6	0.0%	6	0.0%	5	0.0%
PUBLIC PEACE	10	0.0%	13	0.1%	6	0.0%	7	0.0%	4	0.0%
MISCONDUCT IN OFFICE	0	0.0%	0	0.0%	0	0.0%	4	0.0%	3	0.0%
MISCELLANEOUS	199	0.8%	170	0.7%	188	0.8%	34	0.1%	2	0.0%
EMBEZZLEMENT	26	0.1%	30	0.1%	28	0.1%	33	0.1%	2	0.0%
OBSCENE MATERIALS	5	0.0%	1	0.0%	1	0.0%	2	0.0%	2	0.0%
TAX REVENUE	3	0.0%	1	0.0%	1	0.0%	1	0.0%	1	0.0%
DRUNKENNESS	2	0.0%	0	0.0%	0	0.0%	1	0.0%	1	0.0%
COMPUTER CRIMES*	1	0.0%	0	0.0%	81	0.3%	64	0.3%	1	0.0%
GAMBLING	9	0.0%	0	0.0%	2	0.0%	0	0.0%	0	0.0%
HABITUAL OFFENDER	3	0.0%	0	0.0%	0	0.0%	3	0.0%	0	0.0%
EXTORTION	2	0.0%	3	0.0%	0	0.0%	0	0.0%	0	0.0%
BRIBERY	2	0.0%	1	0.0%	1	0.0%	0	0.0%	0	0.0%
LICENSE VIOLATION	1	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
HEALTH & SAFETY	1	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
LIQUOR	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
VAGRANCY	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
PROPERTY CRIME	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
MULTIPLE OFFENSE*	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Non-Jurisdictional Inmates*	37	0.2%	30	0.1%	31	0.1%	35	0.1%	0	0.0%
TOTAL	23,657	100.0%	23,390	100.0%	23,837	100.0%	25,066	100.0%	24,383	100.0%

Drug use in South Carolina prisons

Going to prison does not always mean an inmate stops using drugs. Given the large number of inmates who go to prison for drug offenses, and the many who are addicted, the attempted use of drugs in prison is not surprising. Some inmates succeed.

Between 2005 and 2009, South Carolina Dept. of Corrections statistics show that 12,152 inmate drug tests were positive, declining steadily up to the present time.⁷⁴

INMATE DRUG TESTING, FYS 2005-2009*					
	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
TOTAL NUMBER OF TESTS ADMINISTERED	21,969	20,581	22,971	21,613	20,765
NUMBER OF POSITIVE DRUG TESTS	3,245	2,719	2,854	1,925	1,409
NUMBER OF INMATES TESTING POSITIVE	1,141	973	997	702	520
THC POSITIVE	92.0%	85.3%	87.6%	86.1%	88.0%
COCAINE POSITIVE	10.9%	16.9%	11.1%	11.7%	5.8%
MORPHINE POSITIVE	0.0%	0.4%	0.6%	1.3%	2.4%
AMPHETAMINE POSITIVE	0.4%	0.2%	0.8%	0.4%	1.1%
BARBITUATE POSITIVE	0.0%	0.3%	0.5%	1.0%	0.9%
BENZO POSITIVE	1.8%	2.0%	3.0%	3.4%	4.8%
PCP POSITIVE	0.4%	0.3%	0.5%	0.7%	1.7%
* All locations, all test reasons					
Note: Inmates may be tested more than once during the fiscal year, and each testing occasion may yield a positive screen for more than one drug during the test.					

Drugs, of course, are contraband in prison and when found have been illegally smuggled inside. The most prevalent methods are simply throwing them over prison fences, stuffed inside footballs, duffel bags and taped packages. Sometimes they are smuggled in by prison staff, typically in return for some form of financial reward. (An employee caught smuggling drugs is charged with the appropriate criminal charges and terminated.)⁷⁵

While drug use within prisons is not confined to South Carolina, statistics on this issue are surprisingly hard to find. The Bureau of Justice Statistics Dept., a branch of the U.S. Dept. of Justice and the most likely source of this information, does not collect it. Googling for this information provides few references.⁷⁶ In 2002 a survey of 44 prisons in the United States

⁷⁴ Chart provided by the South Carolina Dept. of Corrections in an email on Jan. 28, 2010

⁷⁵ This and the following information were emailed by Josh Gelinas of the S.C. Dept. of Corrections, Dec. 23, 2009 and Jan. 6, 2010

⁷⁶ Among the few references is the following: Roughly 1,000 "drug incidents" are reported annually at California prisons —

showed that the average percent of positive drug tests was 3.07%; however, drug testing policies differed among institutions, making an apples with apples comparison difficult.⁷⁷

The South Carolina Dept. of Corrections has a strict policy and detailed, specific procedures to follow on drug use in prison: “The South Carolina Dept. of Corrections is committed to a zero tolerance of drug use or possession by inmates. To further this commitment, the Agency will maintain a controlled substance abuse testing, sanctioning, and intervention program designed to identify, prevent, and/or treat inmate drug abuse. All inmates under the jurisdiction of the SCDC will be subject to drug testing at any time, regardless of their gender, national origin, race or religion. Drug testing will not be conducted for the purposes of harassing any inmate(s).”

Each month the SCDC randomly tests from 4.5% - 7.5% of SCDC inmates, selected via computer. Those who test positive are named members of a Target Group, and subject to more frequent testing. Those in the Addiction Treatment Units (see Chapter 6 in this document) also are tested more frequently, as are inmates in Work Release/Pre-Release programs, outside labor crews, and anyone involved in a workplace accident. Other incentives to test particular inmates include reasonable suspicion, focus testing at a particular prison, and a general authorized category called “Other,” which might include a parole clearance check, for example.

The SCDC policy also mandates that inmates convicted of the use or possession of narcotics, marijuana, or unauthorized drugs, including prescription drugs, will be subject to disciplinary detention, loss of “good time,” and suspended privileges. Further, the policy states that inmates who test positive will be referred to the substance abuse treatment program for screening and possible placement in the program.

seizures of marijuana, heroin and other drugs. Between 2006 and 2008, 44 inmates in the state died of drug overdose deaths. Florida has implemented anti-contraband strategies that its legislative watchdog office says match or exceed those in other states — including drug-detecting dog teams, metal detector searches of staff and visitors at all prisons, and even random pat-down searches of staff, rarely done in other states. Despite these efforts, 1,132 random drug tests of inmates in 2008-09 were positive — the same positive rate of 1.6 percent as 10 years earlier. Even more striking, officers seized 2,832 grams of marijuana and 92 grams of cocaine at the prisons during the year, by far the highest figures of the past decade. Retrieved on Jan. 21, 2010 from http://news.yahoo.com/s/ap/20100118/ap_on_re_us/us_drugs_behind_bars

⁷⁷ Cece Hill, “Survey Summary: Drug Testing,” *Corrections Compendium Journal*, April 2003.

Drug use among South Carolina probationers and parolees

Top Offenses Offenders under PPP supervision by frequency	
Offense	# of Active PPP Offenders
Assault and battery of a high and aggravated nature - ABHAN	2,719
Possession of less than one gram of meth. Or cocaine base, 1st offense	1,959
Burglary (non-violent (After 6/20/85) – second degree	1,849
Manufacture, possession of other substance in schedule I, II, III – 1st offense	1,344
Manufacture, possession with intent to distribute narcotic drugs in schedule 1b, 1c, LSD, cocaine – 1st offense	1,229
Forgery, value less than \$5,000	1,171

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As might be expected, illegal drugs comprise the largest category of offenses among South Carolinians on probation and parole. Post-prison-release drug testing of inmates convicted of drug offenses continues for probationers and parolees through the Dept. of Probation, Parole and Pardon Services.

	Total Active Offenders	Total Tests Conducted	Offenders Tested	Total Positive Tests	% of Offenders Testing Positive
2009 To date	32,148	2,236	540	259	37.41%
2008 12/08	32,127	101,095	14,746	9,622	39.00%
2007 12/07	32,739	106,287	15,884	10,612	39.27%
2006 12/06	32,009	108,707	17,527	12,254	40.46%

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Testing is at the PPP officer's discretion. In 2009, drug tests for marijuana were 48% positive; for cocaine 29% positive; and for other drugs 23% positive. The penalty for one violation might be a public service assignment, or a requirement for more visits to the PPP officer. For two or three violations probation may be revoked and the offender sent back to prison.⁸⁰

⁷⁸ South Carolina Dept. of Probation, Parole and Pardon Services, presentation to the South Carolina Sentencing Reform Commission on Feb. 26, 2009.

⁷⁹ Ibid.

⁸⁰ Phone conversation with Peter O'Boyle, South Carolina Dept. of Probation, Parole and Pardon Services, Jan. 5, 2010.

What it costs to incarcerate South Carolina drug offenders



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South Carolina spent \$14,545 in 2009 to incarcerate each prison inmate. But based on all state, federal and special revenues, the annual cost came to \$16,312 per inmate.⁸² In 2007, the state spent \$0.49 on corrections for every dollar the state spent on higher education.⁸³

We are indebted to statistician and editor Rob Mc Manus, from the South Carolina Department of Public Safety, Office of Justice Programs, not only for many of the charts in this chapter, but also for the following insights and summary about drugs in South Carolina. His book-length statistics about illegal drug use in South Carolina (as well as several other books of statistics on other subjects) include vast amounts of interesting and important data.⁸⁴

Summary

“Perhaps the most salient finding was the sheer volume of numbers involved in illegal drug use, regardless of the specific measure used. The number of drug arrests in a single year ranged from a low of more than 21,000 to a high of more than 38,000. The total numbers for court cases, prison admissions and admissions to community correctional supervision were equally impressive. Drug testing of offenders under community corrections supervision numbered in the tens of thousands year after year. The volume of inpatient and emergency room services was equally impressive as was the associated costs. *The magnitude of estimated use was perhaps the most impressive measure, with estimated illegal drug users in South Carolina numbering in the hundreds of thousands.* (Italics added.)

⁸¹ “South Carolina 2009”, U.S. Drug Enforcement Administration (DEA), Retrieved on Jan. 2, 2010 from www.justice.gov/dea/pubs/state_factsheets/southcarolina.html

⁸² “Cost Per Inmate Fiscal Years 1988-2009,” S.C. Dept. of Corrections, Retrieved on Feb. 4, 2010 from www.doc.sc.gov/research/BudgetAndExpenditures/PerInmateCost1988-2009.pdf

⁸³ “Making Decisions Where to Spend,” *One in 100: Behind Bars in America 2008*, The Pew Center on the States, P. 16, Retrieved on Jan. 2, 2010 from www.pewcenteronthestates.org/uploadedFiles/8015PCTS_Prison08_FINAL_2-1-1_FORWEB.pdf

⁸⁴ Rob McManus, Editor, *Altered States in the Palmetto State: Statistical Indicators of Illegal Drug Use*, pp. 222-223, June 2008, South Carolina Dept. of Public Safety, Retrieved on Jan. 29, 2010, from www.scdps.org/ojp/statistics/Altered%20States%20in%20SC.pdf

Finally, it is important to discuss the risk of apprehension. Despite the large volume of drug arrests, comparing arrest rates to NSDUH⁸⁵ user estimates, it is apparent that the risk of detection for illegal drug use is low. (In 2007) NSDUH estimated that an average of 318,818 South Carolinians over 12 used marijuana in the previous year and 80,247 used cocaine in the previous year. During that same time period (2005 – 2006), an average of 21,039 marijuana arrests and 10,232 cocaine arrests were made. Using these findings to construct an indicator of risk, the ratio of arrests to users was 1 to 15.2 for marijuana and 1 to 7.8 for cocaine. Applying the percent of arrests for personal use activities (marijuana, 90.7%; cocaine, 64.7%) during that time period, the ratio of arrests to users is 1 to 16.7 for personal use of marijuana and 1 to 12.1 for personal use of cocaine. These are probably high-end risk estimates, since they do not account for frequency of use, individuals being arrested more than once and other factors. *In any case, such low risk levels do not seem likely to provide a credible deterrence to illegal drug use.*⁸⁶ (Italics added by this study editor.)

⁸⁵The National Survey on Drug Use and Health by the U.S. Dept. of Health and Human Services, SAMHSA

⁸⁶Rob McManus, Editor, *Altered States in the Palmetto State: Statistical Indicators of Illegal Drug Use*, pp. 222-223, June 2008, South Carolina Dept. of Public Safety, Retrieved on Jan. 29, 2010, from www.scdps.org/ojp/statistics/Altered%20States%20in%20SC.pdf

Chapter 5

The Criminality of Drug Use in South Carolina

Criminal penalties as deterrents

In 2008 in South Carolina, law enforcement made 34,474 drug arrests.⁸⁷ (This was down 8.3% from 2007.)

Drug offenses are most visible at a local level. For example, in 2008, North Charleston, the state's third largest city, made 14,951 arrests, of which 2,072 were for drug offenses (over half of them for marijuana).⁸⁸

In 2009, 4,729 South Carolinians are in state prisons for drug offenses (19% of the total prison population, and more than for any other offense).⁸⁹

Other South Carolinians are currently serving time for drug offenses in the state's four federal prisons and 49 jails.

Still more are awaiting trial for drug offenses in jails or their communities.

These are just the men, women and youth specifically charged with drug offenses. Other jail and prison inmates were using drugs while committing other crimes, particularly thefts to pay for drugs.

Worst of all, violent and often deadly drug-related crimes occur daily across the state, as drug dealers, many just teenagers, protect turf, rob rivals, or avenge drug deals gone wrong. The very illegality of drugs makes them so profitable to sell on the black market that the death or incarceration of any drug dealer simply creates a job opportunity for another person to break into the lucrative business.

As Justice William E. Hunt of the Montana Supreme Court said, "From the appeals I see involving drugs, I can only conclude that the (drug) war is a failure because so many people are willing to risk so much to be able to sell the drugs. The people who come before our courts are often those who have been there before and received sentences that served no purpose at all so far as deterring them from future sales."⁹⁰

⁸⁷ *South Carolina Criminal and Juvenile Justice Trends 2009*, edited by Rob McManus, S.C. Dept. of Public Safety, Office of Justice Programs, Statistical Analysis Center, p. 62. Retrieved on Jan. 21, 2010 from www.scdps.org/ojp/statistics/2009%20%20Crime%20Book-%20WEB%20VERSION%20v2.pdf

⁸⁸ Statistics provided by the North Charleston Police Dept.

⁸⁹ "Most serious offense distribution of SCDC total inmate population as of June 30, fiscal years 2005-2009," S.C. Dept. of Corrections, Retrieved on Jan. 21, 2010 from www.doc.sc.gov/research/InmatePopulationStatsTrend/ASOFTrendMSOFY05-09.pdf

⁹⁰ Judge James P. Gray, *Why Our Drug Laws Have Failed and What We Can Do About It*, (Philadelphia, PA: Temple University Press, 2001) p. 57.

South Carolina drug laws

South Carolina's drug laws mirror federal laws to a great extent. However, states do have some leeway to adjust those laws, though sometimes under protest by the federal government. (A good example of this is the current legalization of marijuana for medical purposes by 14 states and the District of Columbia, though not South Carolina. See Chapter 8 in this report for more on this topic.)

In 1971 South Carolina passed an Omnibus Controlled Substances Act that specifies state laws on illegal drugs.⁹¹ These laws were revised by passage of the Omnibus Crime and Sentencing Reform Act of 2010. (See Chapter 1 in this report for specific changes.)⁹²

South Carolina's strict drug laws include penalties ranging from misdemeanor fines and the threat of jail or prison for first time drug users, up to felony trafficking offenses that imprison men, women and young adults for decades. Anyone charged with any drug offense must immediately surrender his or her driver's license for 6 months, regardless of where the drug offense occurred, and even if it had nothing to do with driving. Similarly, anyone convicted of any drug offense must pay a "drug surcharge" of \$150 to support the state's drug courts, on top of any other fine imposed by the court.

For many years, throughout the country, as well as in South Carolina, penalties for using and selling crack cocaine have been much greater than those for powder cocaine. (Crack is the street name given to the form of cocaine that has been processed to make a rock crystal that can be heated and smoked.)⁹³

Crack is cheaper than powder cocaine and more likely to be used by economically disadvantaged African-Americans. (See Chapter 7 in this report for more.) The sentencing disparity between crack and powder cocaine has contributed to the imprisonment of African Americans at six times the rate of whites, and led to the United States' position as the world's leader in incarceration.⁹⁴ After nearly 20 years of this policy, in 2005 the South Carolina General Assembly made an attempt to equalize most of the state's penalties for crack and cocaine offenses.

In 2010 the crack/powder penalties were changed at both federal and South Carolina levels. **In South Carolina, all penalties for the two drugs are equal.** Under federal law, it now takes 18 times as much powder cocaine as crack to trigger the same mandatory minimum sentence for a drug offense (it used to be 100 to 1).⁹⁵

⁹¹ "Poisons, Drugs and Other Controlled Substances," South Carolina Code of Laws, Section 44-53, Retrieved on Jan. 22, 2010 from www.scstatehouse.gov/code/t44c053.htm.

⁹² See the "Omnibus Crime Reduction and Sentencing Reform Act of 2010." Retrieved on Aug. 5, 2010 from www.scstatehouse.gov/cgi-bin/web_bh10.exe

⁹³ "Crack Vs. Powder Cocaine: A Gulf in Penalties," *U.S. News and World Report*, Oct. 1, 2007, Retrieved on Jan. 22, 2010 from www.usnews.com/news/national/articles/2007/10/01/crack-vs-powder-cocaine-a-gulf-in-penalties.html.

⁹⁴ Carrie Johnson, "Bill Targets Sentencing Rules for Crack and Powder Cocaine," *The Washington Post*, Oct. 16, 2009, Retrieved on Jan. 22, 2010 from www.washingtonpost.com/wp-dyn/content/article/2009/10/15/AR2009101501992.html.

⁹⁵ Historic Reform: Congress Lowers Penalties for Crack Cocaine," *The Sentencing Project*, July 28, 2010. Retrieved on Aug. 8, 2010 from www.sentencingproject.org/detail/news.cfm?news_id=966&id=167

Typical drug arrest scenarios⁹⁶

For a simple possession of marijuana, first offense (one ounce or less), the police arrest the offender and the case is handled in magistrate's or municipal court. The misdemeanor offense carries a penalty of 0 – 30 days or \$100 - \$200, plus a \$150 drug surcharge (to support the state's drug courts), and suspension of the offender's driver's license for 6 months. If the judge grants the offender a conditional discharge, various conditions may be set by the court, such as drug treatment, drug education, or community service. If the conditions are successfully completed without further offense, the charges are dismissed.

For all other simple drug possession charges, the case goes to a local solicitor, who has absolute discretion on how to charge. The solicitor negotiates with the offender to reach what the solicitor considers a fair disposition in the case.

If the offender does not have a significant criminal history, the offender may be diverted from the court system. The solicitor may offer the offender the opportunity to participate in the Pre-trial Intervention program (PTI) run by the Solicitor's Office. The PTI program provides counseling, treatment if indicated, an obligation for the offender to do public service, etc. When the program is completed the charges are dismissed with no court or criminal record involved, and the offender does not lose his driver's license at any point in the process. However, a \$150 drug surcharge must be paid by the offender.

If the offender has a more significant criminal history, the case is prosecuted by the solicitor in state court. Depending on the facts of each case and the, the judge may sentence the offender to probation or prison. If the offender successfully completes the conditions of probation, without any further arrests, no prison time is served.

Many offenders charged with drug possession have significant addiction problems and are sent to drug court. If these individuals respond positively to intensive drug treatment, their charges are dismissed.

If the offender has a pattern of low-level drug arrests, the judge may sentence the offender to a more severe prison sentence, but may suspend the sentence and commit the offender to drug court for a set period of time. If the offender violates the drug court terms, he goes to prison. If the offender completes drug court successfully, he does not go to prison.

The solicitor might recommend that the judge sentence a young defendant as a Youthful Offender. This designation is entirely discretionary on the state sentencing court's part.⁹⁷ The Youthful Offender Act (YOA) applies to people between the ages of 17 and 25 who are not also charged with a violent crime, and it provides alternatives to adult sentencing. Youthful offenders are housed in a special section of the S.C. Dept. of Corrections, separate from adults, with the goal of rehabilitation, not just punishment. A Youthful Offender typically receives a sentence not to exceed 6 years at a YOA facility—the defendant would serve 10 months of the sentence and then be released on parole for 1 year, and if there is no violation the sentence is over after that year. Shock incarceration (boot camp) is also an

⁹⁶ We are indebted to 9th Circuit Solicitor Burns Wetmore for his help in educating us about this section during phone conversations on Dec. 21, 2009 and by email on Aug. 9, 2010.

⁹⁷ "Correction and Treatment of Youthful Offenders," South Carolina Code of Laws Section 24-29-10, Retrieved on Dec. 29, 2009, from www.scstatehouse.gov/code/t24c019.htm.

alternative for those who qualify. Although the shock incarceration program is 90 days long, after which the defendant is released on parole, there is typically a 2-3 month wait before the program begins, which means the defendant will be gone for 5-6 months before being released. The law provides for the expungement of a conviction as a Youthful Offender after 5 years have passed, if he or she has had no subsequent convictions.⁹⁸

The disposition of charges of Distribution, and Possession with Intent to Distribute, are also largely based on the amount of drugs involved and the prior drug convictions of the offender. The solicitor considers the facts of each case in reaching a disposition. The sentencing ranges for these offenses offer a lot of leeway, but can include years of prison and large fines.

Drug trafficking, a charge also based on the amount of drugs involved, is considered part of the drug problem, and such offenders are not offered PTI or probation or drug court. Offenders can be sentenced up to 30 years in prison.

In all these cases the solicitor has absolute discretion. He or she typically considers the recommendation of the police. Usually defendants are formally charged by Grand Jury indictment. The solicitor can reduce or dismiss charges based on several factors (factual or legal problems with the case, the defendant's cooperation with police, the defendant's forfeiture of assets, etc).

When any drug offender is arrested, on the very first day the police typically ask the offender to inform on other people involved in drug offenses, especially someone higher up the drug distribution chain. Naming someone more minor usually does not result in a lower charge or a dismissal. (In federal court, there is a specific step in the process called downward departure, where the defendant has a similar opportunity to cooperate with law enforcement.)

Asset forfeiture—A significant source of income for state agencies⁹⁹

Assets are things of value that either belong to a drug offender or appear to belong to him (like a leased car), and which the law considers to have been acquired through profits gained by drug or alcohol offenses.¹⁰⁰ Assets can include a wide variety of items: pocket money, bank accounts, cars, boats, securities, land, homes, businesses and much more. The law allows the assets of drug offenders to be confiscated by law enforcement and solicitors. Assets are sought and controlled by the solicitor's office or a designated substitute (like a city attorney) in each jurisdiction.

Typically, the drug offender is eager to hand over assets to the police as a way to improve his situation when arrested. The offender is given a copy of a police form stating he or she has agreed to relinquish the assets. If the offender does not agree to do this, the solicitor or

⁹⁸ "Expungement of Criminal Records," South Carolina Code of Laws Section 22-5-910, Retrieved on Dec. 29, 2009 from www.scstatehouse.gov/code/t22c005.htm.

⁹⁹ "Forfeitures," South Carolina Code of Laws 44-53-520 (to 590), specifies the details of when and how assets can be seized. Retrieved on Dec. 30, 2009 from www.scstatehouse.gov/code/t44c053.htm.

¹⁰⁰ Alcohol profits through moonshining. So, for example, murder with a kitchen knife would not be vulnerable to confiscation of the house.

designee can initiate a court procedure to try to get control of the assets, and the offender must prove the assets were not tied to illegal drug activity.

Once seized, the burden of proof is upon the offender or an innocent co-owner to sue to get assets back, again by showing the assets were not gained through drug activity. Many assets truly are derived from drug profits, but not all are. If a defendant is arrested with a specific amount of drugs in his car, the car may be seized, even if it is the family car that an innocent spouse needs to drive their children to school and herself to work. If a house in which one spouse manufactures or sells drugs is confiscated, the other innocent spouse must go to court to prove her right to keep the house, and so on.

The court may return any seized item to the owner if the owner demonstrates to the court by a preponderance of the evidence that: (1) in the case of an innocent owner, the person or entity was not a consenting party to, or privy to, or did not have knowledge of the use of the property that made it subject to seizure and forfeiture; (2) in the case of a manager or an owner of a licensed rental agency, a common carrier, or a carrier of goods for hire, that any agent, servant, or employee of the rental agency or of the common carrier or carrier of goods for hire was not a party to, or privy to, or did not have knowledge of the use of the property which made it subject to seizure and forfeiture.

The law specifies the minimum amount of drugs that can trigger an asset seizure. While that minimum must be at least one pound or more of marijuana or hashish, the minimum amount of other controlled substances is extremely small. Keep in mind that one gram of cocaine or heroin is about the amount found in a restaurant sugar packet, and one gram equals about 15 grains. An asset can be seized for more than four grains of opium, more than two grains of heroin, more than four grains of morphine, more than ten grains of cocaine, more than fifty micrograms of lysergic acid diethylamide (LSD) or its compounds, more than ten grains of crack, or more than one gram of ice or crank (meth).

The law also requires that all assets seized must be documented, and that the assets must be sold for cash, for the most part. The money derived must go to the following:

- 75% percent to the law enforcement agency or agencies involved in the arrest, to use only for drug enforcement activities
- 20% to the prosecuting agency (solicitor) for matters relating to the prosecution of drug offenses and litigation of drug-related matters
- 5% to the state treasurer for the state's general fund.

Based on this formula, in the last fiscal year (July 1, 2008 – June 30, 2009) the South Carolina Treasurer's Office received \$167,743.¹⁰¹ This means the total value of all forfeited assets gained by state law enforcement agencies for that year was \$3,354,860.

The item for Asset Forfeiture in the 2007 Charleston County Sheriff's Dept. budget gives an example of the use of asset seizure money by that law enforcement agency. That year the department gained \$396,145 from the proceeds of seized assets.¹⁰² Offsetting expenditures

¹⁰¹ Phone conversation with Scott Malyerck, S.C. Deputy State Treasurer, on Jan. 27, 2010.

¹⁰² Mostly from Charleston County, although sometimes from other sources through participation in federal or multijurisdictional law cases, according to Dana Valentine, by phone on Jan. 4, 2010. Total revenue shown on the FY 2009 Charleston County Organizational Report, Sheriff's Asset Forfeiture budget, Run Date 06/24/08, Retrieved on Jan. 29, 2010 from www.charlestoncounty.org/departments/Budget/budgetpdfs/Detail2009.pdf.

included aviation related items; K9 (dog) expenses; electricity, gas and telephone charges; maintenance of buildings and grounds; fleet fuel; the “police confidential fund” and more.¹⁰³ In contrast, for 2009 just \$55,231 was expected, with significantly fewer offsetting expenses due to the smaller amount, and the intention of adhering closely to the law that restricts how those funds may be spent.¹⁰⁴

Asset forfeiture funds must not be used to supplant operating funds in current or future budgets. All expenditures from these accounts must be documented, and the documentation made available for audit purposes and upon request by a person under the Freedom of Information Act.

Arresting drug offenders and seizing their assets is an important source of revenue for South Carolina law enforcement agencies, solicitors and state government. No state agency audits the amounts of forfeiture money gained or spent in South Carolina. The court records are considered sufficient.¹⁰⁵

Drug courts in South Carolina

Over a decade of research shows that to convince people to quit using drugs, drug courts work better than jail or prison, better than probation, and better than treatment alone. A recent study found that parents enrolled in family treatment drug courts were more likely than parents in traditional child welfare case processing to complete treatment and be reunited with their children.

Comprehensive research has also proven the cost effectiveness of drug courts.¹⁰⁶ However, drug courts in South Carolina have been limited in the numbers of participants due to various factors. These include the number of offenders eligible for the program and uncertain funding. For example, in the Charleston County Adult Drug Court, in 2008 just 68 were enrolled.

Not every South Carolina county has a drug court, though some are planned. The Aiken Juvenile Drug Court, with an average of 15 participants per year, closed in July 2010 for lack of funds.¹⁰⁷

How South Carolina drug courts work

Drug Courts are problem-solving courts designed for individuals who have committed crimes that are related to their substance abuse problems. The enrollment process is initiated through a criminal court. Drug court participation is voluntary. Their defense attorney, the solicitor or the criminal court judge, can refer participants to the program. Typically, if a victim is involved, the victim must give approval for the defendant to be admitted. Participants plead guilty as charged, and their sentences are then suspended or transferred to the drug court’s jurisdiction until they either complete the program or drop out.

¹⁰³ Ibid., Charleston County Organizational Report.

¹⁰⁴ Total revenue shown on the FY 2010 Charleston County Organizational Report, Sheriff’s Asset Forfeiture Budget, Run Date 05/05/09, Retrieved on Jan. 29, 2010 from www.charlestoncounty.org/departments/Budget/budgetpdfs/2010-Approved-Detail.pdf, and conversation with Mack Gile, Charleston County Budget Director, on Jan. 28, 2010.

¹⁰⁵ Phone conversation with Roger Heaton, Assistant Director of Special Operations, SLED, on Jan. 26, 2010.

¹⁰⁶ “Chapter 2: Reducing Drug Abuse and Addiction,” *National Drug Control Strategy 2009*, Office of National Drug Control Policy, Retrieved on Dec. 14, 2009 from www.whitehousedrugpolicy.gov/publications/policy/ndcs09/index.html

¹⁰⁷ Phone conversation with Serena McDaniel, Solicitor’s Office, Aiken, S.C., on Feb. 24, 2010.

Not every defendant qualifies for admission. Qualifications typically include being at least 17 years old (for adult programs); being dependant on a mood altering substance; being charged with an offense that is neither violent nor sexual; and not having a prior history of violent or sexual crimes. There may be an additional requirement that the offense being charged must have a high likelihood of incarceration. Many courts also require that the applicant live within commuting distance to the court and/or have reliable transportation. Applicants must also be motivated to change their lives, not just to avoid prison. Some courts, like the Charleston County Adult Court, could accommodate more participants, but not enough applicants are qualified.¹⁰⁸

Drug court programs last from six months to two years, and most at least twelve months. Additionally, a participant may be enrolled in the program for longer than the typical length if he or she fails to meet the program obligations. Some programs have multiple phases for the participants to fulfill. For example, the Charleston County program has three phases to complete, each with different obligations. After the program has been completed, some require participants to continue to attend Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings.

A typical drug court curriculum includes weekly court appearances before a strict judge, drug treatment, addiction-related recovery meetings, random drug and alcohol tests, program fees and curfew checks. Once participants complete the program, their charges are satisfied. If they fall behind, the sanctions could include anything from stiffer curfew checks to weekend jail sentences, and potentially, prison time. During the program, participants may be required to maintain gainful employment and to provide restitution to victims of their crimes, should they exist. If a participant fails to meet the terms required by the court at any time, he may be immediately referred to the Dept. of Justice to serve his original sentence in full, with no credit toward the sentence for participation in the program.

Once the drug court program has been completed, the defendant's sentence is also considered complete. In some situations, the crime may actually be expunged from the participant's record.

The size of South Carolina drug court programs varies in different parts of the state. Some counties have a very small number of participants. In the joint program run with participants from Chesterfield, Darlington, Dillon, and Marlboro Counties, just 31 people have graduated since the program began in 2007.¹⁰⁹ As programs have gained acceptance and popularity in the state, many programs have expanded quickly. The program in Spartanburg County initially only graduated 29 participants in the first five years of operation (2001 – 2006). However, as of 2008 over 164 applicants had been admitted to the program. Additionally, in 2009, that program expanded into Cherokee County to meet the demand.¹¹⁰

South Carolina drug courts are run out of different branches in the court system. Many are run through the criminal court, and either directly by or in close conjunction with the solicitor's office. Some programs are run through the family court system, and many

¹⁰⁸ Telephone conversation with Harry Cale, Financial Officer, Charleston County Adult Drug Court, Jan. 5, 2010.

¹⁰⁹ Fourth Judicial Circuit Solicitor's Office

¹¹⁰ "Successful Drug Court Program Expanding to Cherokee County," Retrieved on Dec. 14, 2009 from www.co.spartanburg.sc.us/govt/depts/sol/pr/2008/cherokee_drug_court.html

juvenile drug court programs are run this way. Some probate courts run a drug court program, like the Charleston County Adult Drug Court.

Where South Carolina drug courts are located There are special drug courts for adults and juveniles, and a few for families where the S.C. Dept. of Social Services (DSS) has found children at risk because of adult drug use.

Adult drug courts accept participants at least 17 years old. As of January, 2010 adult drug courts exist in the following South Carolina counties: Anderson, Beaufort, Berkeley, Charleston, Chesterfield/Darlington/Dillon/Marlboro (combined), Clarendon, Greenville/Pickens (combined), Greenwood/Laurens/Newberry/Abbeville (combined), Horry, Lee, Lexington/Edgefield/McCormick/Saluda (combined), Richland, Spartanburg/Cherokee (combined), Sumter, Williamsburg, and Union/York (combined).

Juvenile drug courts exist in these counties: Anderson/Oconee (combined), Charleston, Chesterfield/Darlington/Dillon/Marlboro (combined), Clarendon, Florence/Marion (combined), Greenville, Lancaster, Lee, Lexington, Oconee, Orangeburg, Richland, Sumter, Williamsburg, and York.

Family drug courts are in Clarendon, Lee, Sumter and Williamsburg as the need arises, and in Charleston.

A juvenile drug court is being planned in Beaufort County, and adult drug courts in Dorchester and Florence Counties.

There are no drug courts existing or planned in these counties: Aiken (closed in July 2010 for lack of funds), Bamberg, Barnwell, Calhoun, Chester, Fairfield, Georgetown, or Jasper.

Drug court success and failure statistics Drug court success and failure statistics are evaluations of drug courts. This variation reflects the diversity across drug courts in the characteristics of their participants (i.e., in the severity of their addiction, the types of drugs used, and criminal history) and in how the drug courts operate (i.e., program eligibility, treatment availability and quality, and court monitoring policies).

A national study of 2,020 graduates from 95 drug courts in 1999 and 2000, estimates that within one year after graduation, 16.4% of graduates had been arrested for a serious offense. Within two years the percentage rose to 27.5%. The study authors warn that these data should not be interpreted as suggesting that drug courts that perform particularly well and drug courts that perform poorly are easy to identify. There is no reason to assume that drug courts with the highest recidivism rates are the lowest performing drug courts. Rather, it appears that most drug courts with high recidivism rates are serving the most difficult to reach populations.

The drug courts with the lowest recidivism rates tend to accept offenders with the least severe problems, including participants whose primary drug used is alcohol or marijuana, and who are classified by the drug courts as having 'minimal' drug problems. In contrast, the drug courts with the highest recidivism rates tend to accept offenders who are primarily cocaine and heroin users, and who are classified by the drug courts as having 'moderate' or 'severe' drug problems. Recidivism does appear to be related to the size of the drug court, with higher recidivism among graduates of the largest drug courts.

The study authors conclude that recidivism estimates should not be considered in isolation: drug courts are complicated endeavors operating in multifaceted environments. Law enforcement policies and community attributes may make it relatively more difficult for some jurisdictions to meet these benchmarks. In addition, some drug courts will target very difficult and hard to serve populations. For these drug courts, achieving a recidivism rate that is much higher than certain benchmarks may actually demonstrate a large reduction in criminal offending. Therefore, no single estimate can, or should, be used to measure whether an individual drug court is successful.¹¹¹

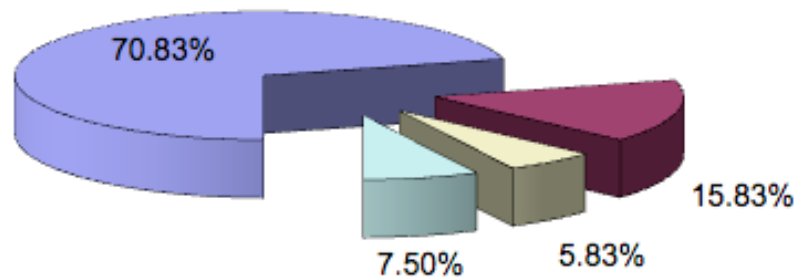
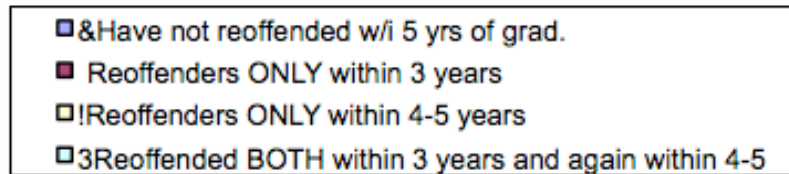
In South Carolina, the Spartanburg County Adult Drug Court admitted 164 people between June 2001 and October 2008. Of those participants, 85 have either graduated or are still active in the program. Over the past two fiscal years, 96% of their drug tests indicated no use of drugs or alcohol by the participants. During that period, the drug court collected and paid out more than \$24,400 in restitution to crime victims. Program participants also paid more than \$77,000 in program fees.¹¹²

¹¹¹ John Roban, Wendy Townsend, Avinash Singh Bhati, "Recidivism Rates for Drug Court Graduates: Nationally Based Estimates, Final Report," Roman, Townsend and Bhati; The Urban Institute, July 2003, Retrieved on Dec. 15, 2009 from www.ncjrs.gov/pdffiles1/201229.pdf

¹¹² "Successful Drug Court Program Expanding to Cherokee County," Retrieved on Dec. 14, 2009 from www.co.spartanburg.sc.us/govt/depts/sol/pr/2008/cherokee_drug_court.html

A survey done in 2009 for the Charleston County Drug Court showed the following results for ten years' participants:

Recidivism Rates in Charleston County Drug Court Program



TOTAL PARTICIPANTS SINCE 1999	NUMBER	PERCENTAGE
Number Enrolled (current/prior)	319	N/A
Number of Graduates	120	37.60%
Number Terminated	159	49.84%
OF THOSE WHO GRADUATED		
Have not reoffended within 5 years of graduation	85	70.83%
Reoffenders only within 3 years	19	16%
Reoffenders only within 4-5 years	7	5.83%
Reoffenders both within 3 years and again within 4-5 years	9	7.50%

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Advantages of drug courts

- Drug Courts Reduce Crime
 - The most rigorous and conservative scientific “meta-analyses” have all concluded that Drug Courts significantly reduce crime as much as 35 percent more than other sentencing options.

¹¹³ Statistics compiled based on General Sessions court records in Charleston, Berkeley, Dorchester and Colleton Counties since 1999. Provided by Charleston County Adult Drug Court, 2009

- Drug Courts Save Money
 - Drug Courts produce cost savings ranging from \$4,000 to \$12,000 per client. These cost savings reflect reduced prison costs, reduced revolving-door arrests and trials, and reduced victimization.
 - Drug Courts increase payments to child support
- Drug Courts Ensure Compliance
 - Drug Courts are six times more likely to keep offenders in treatment long enough for them to get better.
- Drug Courts Restore Families
 - Parents in Family Drug Court are more likely to complete treatment.
 - Children of Family Drug Court participants spend significantly less time in out-of-home placements such as foster care.
 - Family re-unification rates are 50% higher for the participants.¹¹⁴

How South Carolina drug courts have been funded South Carolina.¹¹⁵ The authors wanted to find out how the courts were funded, and in the end called their study “An Experience in Hodgepodge Budgeting.”

The authors found that creation of drug courts in South Carolina has been largely the product of local interests and initiatives. Local officials in a particular jurisdiction decide that establishing a drug court will be beneficial to their community. They then seek the means to create and operate the court. Turning to the state for funds is an option, but the lack of a centralized drug court system in the state means that obtaining permanent and stable state funding is unlikely, at least initially. Resource scarcity at the county level means that getting significant start-up money from that source, much less a long-term financial commitment is improbable as well. As a result, most drug courts in South Carolina were established using seed money from federal and state grants. This created two phases of financing: start-up and continuation.

Drug courts in South Carolina have drawn upon six major sources to provide the means of their operations: federal, state, and county funds; participation fees; donations, and other sources. Perhaps the most useful activity of many drug court administrators has been to lobby county and state officials.

During the start-up phase, drug courts are heavily dependent upon temporary grant funding. As this funding comes to an end, drug courts engage in a frantic search for resources that can sustain their operations. The result for most is a mishmash of budgeting arrangement that requires ingenuity, opportunism, and luck to build and maintain programs.

¹¹⁴ Lisa A. Smith, “The Verdict on Drug Court Is In,” Drug-Free Coalition of Tippecanoe County, Nov. 6, 2009, Retrieved on Dec. 26, 2010 from www.drugfreetippecanoe.org/blog/?p=53

¹¹⁵ Douglas, James W. and Hartley, Roger E., “Sustaining Drug Courts in Arizona and South Carolina: An Experience in Hodgepodge Budgeting,” *Justice System Journal*, Vol. 25, pp. 75-86, 2004. Available at SSRN: <http://ssrn.com/abstract=1416212>

Most drug courts require the participants to pay for participation in the program. The typical participation fee is \$25 per week and a one-time application fee (usually around \$100).¹¹⁶ However, this is not enough to fund the program. Most courts also apply for and receive startup grants for up to three years from the South Carolina Department of Public Safety.¹¹⁷ Some drug courts have received funding from other courts. One South Carolina drug court received startup money from the budget of the South Carolina Supreme Court's Chief Justice.¹¹⁸

The study authors concluded that that drug courts, almost from their inception, are forced to operate hodgepodge budgets, where ingenuity (i.e., establishing themselves as nonprofit entities so they can solicit donations), opportunism (i.e., lobbying), and luck (i.e., the legislature's coincidentally raising probate court fees in time to save a drug court) are likely to separate drug courts that succeed from those that fail. This hodgepodge budgeting system constrains drug courts by creating uncertainty and forcing court administrators to appease multiple masters, each of whom may have different goals and interests. The study conjectured that possibly these hodgepodge budgeting systems will reduce drug courts' long-term effectiveness by limiting their ability to finance sufficiently large caseloads. In fact, the study authors found some courts struggling to maintain caseloads averaging twenty-eight cases per court.

A change in 2010 in drug court funding

The General Assembly has funded all the state drug courts to some extent, but not all equally. Some courts have gotten funds from two pots of money, others from only one. Every year drug court funds have come from three state sources:

1. A surcharge fee of \$100 collected on monetary penalties for misdemeanor and felony drug offenses in state courts. The total surcharge amount has been shared among the 16 Judicial Circuits on a per capita basis for drug courts. In 2009 the total amount was \$1,604,731. The amount has varied from year to year based on the amount of fees collected.¹¹⁹

However, with passage of the Omnibus Crime Reduction and Sentencing Reform Act of 2010, the surcharge fee on every drug conviction was increased to \$150. This is expected to annually provide an additional \$800,000 to \$1,000,000 for the state's Judicial Circuits for drug courts. The new law also created the Sentencing Reform Oversight Committee, whose responsibilities include monitoring the costs and expenses of drug courts in the state.¹²⁰

116 Drug Court Application. Charleston County

117 Douglas, James W. and Hartley, Roger E., Sustaining Drug Courts in Arizona and South Carolina: An Experience in Hodgepodge Budgeting. Justice System Journal, Vol. 25, pp. 75-86, 2004. Available at SSRN: <http://ssrn.com/abstract=1416212>. Telephone call with Burke Fitzpatrick on Jan. 29, 2010 confirmed that the S.C. Dept. of Public Safety funds startup drug courts up to three years with money provided by the U.S. Dept. of Justice (JAG fund).

118 Douglas, James W. and Hartley, Roger E., Sustaining Drug Courts in Arizona and South Carolina: An Experience in Hodgepodge Budgeting. Justice System Journal, Vol. 25, pp. 75-86, 2004. Available at SSRN: <http://ssrn.com/abstract=1416212>.

119 Title 14-Courts, Chapter 1, General Provisions, S.C. Statute Section 14-1-213, Retrieved on Feb. 10, 2010 from www.scstatehouse.gov/code/t14c001.htm

119 The Omnibus Crime Reduction and Sentencing Reform Act of 2010. Retrieved on Aug. 8, 2010 from www.scstatehouse.gov/cgi-bin/query.exe?first=DOC&querytext=1154&category=Legislation&session=118&conid=5730918&result_pos=0&keyval=1181

2. An assessment of \$25 is charged for motions in courts of common pleas and in family courts. A portion of the total assessment collected has gone solely to the 3rd, 4th, and 11th Judicial Circuits. In 2009 the amount for each was \$150,000.¹²¹
3. Money from the state appropriations fund goes solely and directly to Richland (\$56,406), Kershaw (\$52,965), and Saluda Counties (\$38,000), and the 12th Judicial Circuit (\$150,000). These amounts are subject to the General Appropriations Act each year.

The reason the judicial circuits, counties and drug courts are not funded equally is because over the years various legislators, working for their individual constituents, managed to get these formulas inserted into South Carolina laws authorizing the funding.

The money mentioned above goes first to the state agency called the South Carolina Commission on Prosecution, which passes it on to the solicitor in the lead county in each judicial circuit. For example, in the 9th Judicial Circuit, composed of Charleston and Berkeley Counties, the solicitor decides how much and when to fund the three drug courts in that circuit, via the Charleston County Budget Office.¹²² The Charleston County Adult Drug Court is part of the Probate Court and funded through that court. The Charleston County Juvenile Drug Court is funded as part of the local DAODAS budget (though DAODAS has nothing to do with the drug court).¹²³

Examples of specific court funding

The annual cost to each drug court per participant varies. At the Spartanburg drug court, it is about \$4,500 (compared to more than \$16,400 to house someone in the Spartanburg County jail for the same time period,¹²⁴ or \$14,545 in a South Carolina state prison).¹²⁵ The offender also receives help to avoid committing more crimes.

The numbers for the Charleston County Adult Drug Court are similar. In 2009 the number of participants was 35 -40 throughout the year, at an average cost to the court of \$4300 for each person. The program was funded at \$195,906 for the year (through the state appropriation mentioned above, supplemented by money from the county's general fund). The drug court participants' fees of \$25 each week were refunded to the county to help compensate for the supplementary funding. Some private donations went to a separate fund set up to help with incentives and necessities for participants, such as temporary housing and transportation.¹²⁶ In Charleston County, two judges and the financial officer from the Probate Court donate time to run the Adult Drug Court. The only paid employees are two counselors and the drug court coordinator.¹²⁷

¹²¹ Article 5, Clerks of Court and Registers of Deeds, S.C. Statute Section 8-21-320, Retrieved on Feb. 10, 2010 from www.scstatehouse.gov/code/t14c001.htm

¹²² Information conveyed in a phone conversation by Paula Calhoon, Deputy Director, South Carolina Commission on Prosecution, Jan. 5, 2010, and in an email from her on Jan. 28, 2010.

¹²³ Charleston County Approved Budget Detail, FY 2009, Retrieved on Jan. 8, 2010 from www.charlestoncounty.org/departments/Budget/budgetpdfs/Detail2009.pdf. DAODAS is the South Carolina Dept. of Alcohol and Other Drug Abuse.

¹²⁴ "Successful Drug Court Program Expanding to Cherokee County," Retrieved on Dec. 14, 2009 from www.co.spartanburg.sc.us/govt/depts/sol/pr/2008/chokeee_drug_court.html.

¹²⁵ S.C. Dept. of Corrections Cost Per Inmate Fiscal Years 1988-2009, Retrieved in Dec. 2009 from www.doc.sc.gov/research/BudgetAndExpenditures/PerInmateCost1988-2009.pdf

¹²⁶ The Charleston County Adult Drug Court could accept up to 50 participants, but not enough applicants qualify for admission. Telephone conversation with Harry Cale, Financial Officer, Charleston County Adult Drug Court, Jan. 5, 2010.

¹²⁷ Ibid.

Pregnant women who use drugs

No aspect of illegal drug use is more controversial than drug use during pregnancy. The National Advocates for Pregnant Women says South Carolina stands alone in using child neglect and homicide statutes to punish women who are pregnant and engage in a behavior that might endanger a viable fetus.¹²⁸ Some states have laws requiring medical personnel to report these births to child welfare agencies, but our state goes further: By state statute 63-7-1660, the mother of such a baby has committed child abuse, a reportable offense and a crime.

The South Carolina law that sends alcohol or drug-using new mothers to prison:¹²⁹

It is presumed that a newborn is an abused or neglected child as defined in state statute 63-7-20, and that the child cannot be protected from further harm without being removed from the custody of the mother upon proof that:

- A blood or urine test of the child at birth, or a blood or urine test of the mother at birth, shows the presence of any amount of a controlled substance or a metabolite of a controlled substance, unless the presence of the substance or the metabolite is the result of medical treatment administered to the mother of the infant or the infant.
- The child has a medical diagnosis of fetal alcohol syndrome.
- A blood or urine test of *another* (italics added) child of the mother, or a blood or urine test of the mother at the birth of *another* (italics added) child showed the presence of any amount of a controlled substance or a metabolite of a controlled substance, unless the presence of the substance or the metabolite was the result of medical treatment administered to the mother of the infant or the infant.
- *Another* (italics added) child of the mother has a medical diagnosis of fetal alcohol syndrome.

Across the country, local and state agencies have found ways to prosecute pregnant women for drug use, but the courts often reject the cases, and judges in more than two dozen states have overturned decisions that criminalize pregnant addicts. South Carolina's state Supreme Court is alone in upholding the prosecution of pregnant women for the damage drugs might do to their unborn children.¹³⁰ Since 1989, at least 126 women in South Carolina have been arrested during their pregnancies, according to the National Advocates for Pregnant Women. Most were charged with drug and alcohol use that posed harm to the fetus the woman was carrying. During the same period, only about 80 pregnant women were arrested on similar charges in all other states combined.¹³¹

¹²⁸ "Pregnant and Parenting Women, Access to Treatment in South Carolina," National Advocates for Pregnant Women, Retrieved on Jan. 22, 2010 from www.advocatesforpregnantwomen.org/facts/pregnant.htm.

¹²⁹ Subarticle 11, Judicial Proceedings, S.C. Statute Section 63-7-1660, Retrieved on Jan. 4, 2010 from www.scstatehouse.gov/code/t63c007.htm.

¹³⁰ S. Chen, "Pregnant and addicted, mothers in South Carolina find hope," CNN, Oct. 7, 2009, Retrieved on 1/02/2010 at www.cnn.com/2009/LIVING/10/23/south.carolina.pregnant.addicts/index.html.

¹³¹ Ibid.

Of course, a woman who uses drugs in South Carolina can legally abort a fetus during the first twelve weeks of pregnancy.

The history of South Carolina's prosecution of pregnant women who use drugs

The MUSC Case - On October 27, 1997 in a case called *Whitner v. State*, the South Carolina Supreme Court declared that viable fetuses are "children." As a result, the court concluded that a pregnant woman who used an illicit drug, or engaged in any other behavior that might endanger the fetus, can be prosecuted as a child abuser and sentenced up to ten years in jail.

For five years, starting in 1989, the Medical University Hospital in Charleston, South Carolina, working in collaboration with the police and solicitor's office, instituted a policy of searching certain pregnant women for evidence of cocaine use, and reporting and facilitating their in-hospital arrest. Women were selectively searched through urine drug screening. If they tested positive they were arrested. All but one of the 30 women arrested at the hospital was African American.

Ten women filed suit, charging warrantless, unreasonable searches. In 2001 the United States Supreme Court agreed. More than 70 leading medical public health and civil rights organizations, as well as leading researchers, had joined amicus briefs opposing the hospital's policy. Not a single organization had defended the hospital policy.

Organizations ranging from the conservative Rutherford Institute to the American Civil Liberties Union, and medical groups including the American Medical Association, the American College of Obstetricians and Gynecologists and the American Public Health Association opposed the policy. Lynn Paltrow, Executive Director of the National Advocates for Pregnant Women, conceived of the Ferguson case, the first civil rights law suit to challenge a policy of arrest and the first to be decided by any federal court. Susan K. Dunn,¹³² and The Women's Law Project and the Center for Reproductive Law and Policy were co-counsel in this case.¹³³

The Regina McKnight Case – In 1999 Regina McKnight was a 26-year-old native of Horry County, South Carolina. Her IQ was measured at 72, i.e., "below average/borderline deficiency," and she had attended special education classes in high school. She was unable to obtain a permanent job thereafter. Until 1998 she lived with her mother, who helped her with daily needs. In 1998 her mother was killed by a hit and run driver. Left without the support system on which she had relied, Ms. McKnight quickly spiraled downward, becoming homeless, addicted to both cocaine and marijuana – and pregnant.¹³⁴

Regina McKnight was arrested in 1999, several months after she experienced a stillbirth at Conway Hospital in Myrtle Beach, S.C. Upon conviction she was given a twenty-year sentence, suspended to twelve years in prison with no chance for parole. Ms. McKnight's conviction was based on the jury's acceptance of the solicitor's claim that her cocaine use caused the stillbirth. Ms. McKnight had no prior arrest history and even prosecutors agreed that she had no intention of harming the fetus or losing the pregnancy. Through this conviction she became the first woman in South Carolina to be convicted of homicide by

¹³² Currently the staff attorney for the ACLU in South Carolina

¹³³ "NAPW PR: Victory in Ferguson," National Advocates for Pregnant Women, March 9, 2006, Retrieved Jan. 3, 2010 from http://advocatesforpregnantwomen.org/issues/criminal_cases_and_issues/napw_pr_supreme_court_victory_in_ferguson.php

¹³⁴ Petition for a Writ of Certiorari to the Supreme Court of South Carolina, Attorneys for the Petitioner, May 2003, Retrieved Jan. 3, 2010 from www.drugpolicy.org/docUploads/Petition_for_a_Writ_of_Certiorari.pdf

child abuse as a result of suffering an unintentional stillbirth.

Leading South Carolina and national medical, public health, and child welfare organizations and experts opposed the prosecution and conviction. They argued in an amicus (friend of the court) brief that women do not lose their rights to a fair trial upon becoming pregnant, and they challenged the state's evidence that cocaine use or anything else that Ms. McKnight did or did not do caused the stillbirth.

The medical and public health groups also raised concerns about the consequences of South Carolina's policy of arresting pregnant women with drug problems. In their brief, they cited the fact that threatening pregnant women with jail deters them from seeking prenatal care and other vital services.

In May 2008, the South Carolina Supreme Court unanimously reversed the 20-year homicide conviction, ruling that Ms. McKnight did not have a fair trial. The Supreme Court ruling concluded that Ms. McKnight's counsel was "ineffective in her preparation of McKnight's defense through expert testimony and cross-examination." The decision also indicated that the medical and scientific basis for her prosecution and that of other women in the state was based on outdated and inaccurate medical information.

Ms. McKnight was represented on the petition by C. Rauch Wise of the American Civil Liberties Union of South Carolina Foundation, Inc., and Matthew Hersh and Julie Carpenter of the law firm Jenner & Block for the DKT Liberty Project.¹³⁵

Many more arrests have occurred since the MUSC and McKnight cases

The National Advocates for Pregnant Women (NAPW) tries to keep track of women arrested for child abuse in South Carolina because of drug use. The charge in each case is either unlawful neglect of a child (a felony carrying a maximum sentence of ten years), or homicide by child abuse, (a felony with a maximum sentence of life and minimum sentence of ten years). For each case, NAPW has a case file with court records and/or news reports.¹³⁶

Year	Number arrested	County
2006	14 women arrested	Georgetown, Charleston, Cherokee, Spartanburg, Aiken, Union, Newberry
2007	12 women arrested	Union, Newberry, Lexington, Horry, Florence, Spartanburg, Cherokee, Charleston
2008	6 women arrested	Spartanburg, Richland, Oconee, Greenville, Edgefield
2009	8 women arrested	Pickens, York, Spartanburg, Greenwood, Florence, Greenville

¹³⁵ "Regina McKnight—Victory at Long Last," National Advocates for Pregnant Women, May 12, 2008, Retrieved Jan. 3, 2010 from http://advocatesforpregnantwomen.org/blog/2008/05/regina_mcknight_victory_at_lon.php

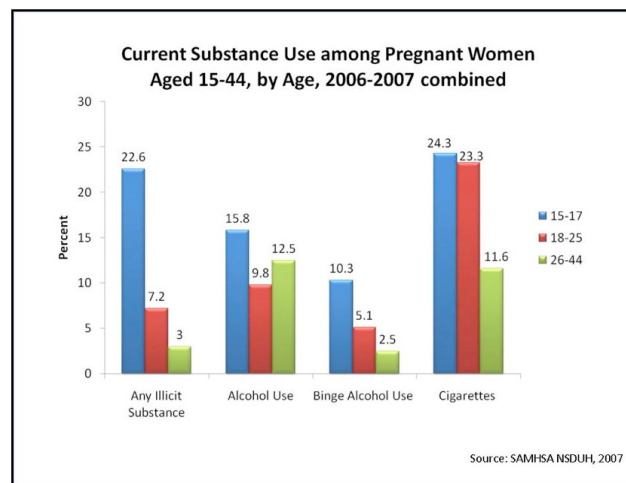
¹³⁶ "List of Women Arrested in South Carolina Because They Continued Their Pregnancy to Term in Spite of a Drug Problem: 2006-2009," Email on Nov. 9, 2009 from National Advocates for Pregnant Women

At the time this is being written, law enforcement officers are looking for a woman who gave birth and then immediately fled without her baby from a hospital in Rock Hill, South Carolina, on Nov. 10, 2009. The baby tested positive for cocaine and marijuana.¹³⁷

Is the South Carolina law justified or not?

The answer depends on whether one believes addicted pregnant women have a health problem, or a criminal disregard for the health and welfare of their babies.

While most pregnant women do not abuse illicit drugs, the chart below with combined 2006 and 2007 data from the National Survey on Drug Use and Health shows that among pregnant women ages 15 to 44, the youngest ones (ages 15 to 17) reported the greatest substance use, even greater than women of the same age who were not pregnant.¹³⁸



Unfortunately, the chart does not tell how many women used more than one of the legal and illicit substances.

Exposure to substances of abuse can (though it does not always) affect individuals across the lifespan, starting in utero.

The National Institute on Drug Abuse says that prenatal drug use has been associated with potentially deleterious and even long-term effects on exposed children. However, they say that estimating the full extent of the consequences of maternal drug abuse is difficult for many reasons. Multiple individual, family, and environmental factors—such as, nutritional status, extent of prenatal care, neglect or abuse, socioeconomic conditions, and many other variables—make it difficult to determine the direct impact of prenatal drug use on the child. Moreover, supportive home environments and quality parenting can ameliorate some negative outcomes in exposed children. Still, research has shown a number of legal and illegal drugs can have negative consequences, summarized below.

First, a legal substance—tobacco: Smoking during pregnancy is associated with several adverse outcomes for fetuses, including increased risk for stillbirth, infant mortality,

¹³⁷ "Police: Abandoned baby tests positive for cocaine, marijuana," T. Burbeck, Nov. 24, 2009, WCNC.com, Retrieved Jan. 3, 2010 from www.wcnc.com/news/local/Police-Abandoned-baby-tests-positive-for-cocaine-marijuana-72770447.html
¹³⁸ Results from the 2007 Survey on Drug Use and Health: National Findings, Drug Abuse and Mental Health Services Administration (SAMHSA), Retrieved Jan. 3, 2010 from www.oas.samhsa.gov/NSDUH/2k7NSDUH/2k7results.cfm#2.6

Sudden Infant Death Syndrome, preterm birth, and respiratory problems. Carbon monoxide and nicotine from tobacco smoke may interfere with fetal oxygen supply—and because nicotine readily crosses the placenta, it can reach concentrations in the fetus that are much higher than maternal levels. Nicotine concentrates in fetal blood, amniotic fluid, and breast milk, exposing both fetuses and infants to toxic effects. Smoking during pregnancy can also affect cognition and it is associated with behavioral problems. Also, smoking more than a pack a day during pregnancy nearly doubles the risk of the child's becoming addicted to tobacco if she starts smoking.

Even second-hand exposure to cigarette smoke can cause problems. For example, strong associations have been found between second-hand smoke and low birth weight and premature birth. Exposure during the *postnatal* period has been associated with a number of physical health outcomes, including Sudden Infant Death Syndrome, respiratory illnesses (asthma, respiratory infections, and bronchitis), ear infections and cavities, and increased medical visits and hospitalizations.¹³⁹

Another legal substance—alcohol: Drinking alcohol during pregnancy can cause a wide range of physical and mental birth defects. The term “fetal alcohol spectrum disorders” (FASDs) is used to describe the many problems associated with exposure to alcohol before birth. Each year in the United States, up to 40,000 babies are born with FASDs. These include mental retardation; learning, emotional and behavioral problems; and defects involving the heart, face and other organs. The most severe is fetal alcohol syndrome (FAS), a combination of physical and mental birth defects. Drinking alcohol during pregnancy increases the risk for miscarriage and premature birth, and may contribute to stillbirth.¹⁴⁰

Although many women are aware that heavy drinking during pregnancy can cause birth defects, many do not realize that moderate or even light drinking also may harm the fetus. In fact, no level of alcohol use during pregnancy has been proven safe. Therefore, the March of Dimes recommends that pregnant women not drink any alcohol throughout their pregnancy and while nursing.

Cocaine, marijuana, and other illegal drugs: Illicit drug use during pregnancy has been associated with a variety of adverse effects, though the National Institute on Drug Abuse (NIDA) says more research is needed to draw causal connections. While some effects may be subtle, they generally range from low birth weight to behavioral and cognitive deficits developmentally. For example, impaired attention, language, and learning skills, as well as behavioral problems, have been seen in children exposed to cocaine and marijuana, all of which can affect success in school. Methamphetamine exposure has been associated with fetal growth restriction, decreased arousal, and poor quality of movement in infants. And although use of heroin (an opiate) during pregnancy has been associated with low birth weight—an important risk factor for later developmental delay—the impact of prescription opiate abuse on pregnancy outcomes is an understudied research area that NIDA would like to grow.¹⁴¹

¹³⁹“Prenatal Exposure to Drugs of Abuse, A Research Update from the National Institute on Drug Abuse (NIDA),” May 2009, Retrieved on Jan. 3, 2010 from www.drugabuse.gov/tib/prenatal.html

¹⁴⁰“Drinking Alcohol During Pregnancy,” March of Dimes, Retrieved on Jan. 3, 2010 from www.marchofdimes.com/professionals/14332_1170.asp

¹⁴¹“Prenatal Exposure to Drugs of Abuse, A Research Update from the National Institute on Drug Abuse (NIDA),” May 2009, Retrieved on Jan. 3, 2010 from www.drugabuse.gov/tib/prenatal.html

Why South Carolina's prosecution of drug-using pregnant women may be justified:

Neonatal abstinence syndrome (NAS) is a group of problems that occur in a newborn exposed to drugs while in the mother's womb. This condition can be prevented by avoiding drugs during pregnancy. Neonatal abstinence syndrome occurs because a pregnant woman takes addictive illicit or prescription drugs such as amphetamines, barbiturates, cocaine, diazepam, marijuana and opiates (heroin, methadone, codeine).

These and other drugs pass through the placenta and reach the baby. The baby becomes addicted along with the mother. At birth, the baby is still dependent on the drug and symptoms of withdrawal occur. Exposure to drugs in the womb can lead to many health problems, including birth defects, low birth weight, premature birth, small head circumference, and sudden infant death syndrome.

The symptoms of neonatal abstinence syndrome depend on the type of drug the mother used, how much of the drug she was taking and for how long, and whether the baby was born full-term or early. Treatment helps relieve symptoms of withdrawal. How well the baby does depends in part on whether the mother and father continue to use drugs. Neonatal abstinence syndrome can last from 1 week to 6 months.

The National Institutes of Health cautions that it is important to have such a baby checked by a pediatrician. Many conditions can produce the same symptoms as neonatal abstinence syndrome.¹⁴²

Why South Carolina's criminalization of drug-using pregnant women may NOT be justified:

- False positives are common in drug tests on new moms. Up to 70% of initial checks can be wrong, according to studies by the University of Kansas Medical Center, U.S. Substance Abuse and Mental Health Services Administration, and the American Association for Clinical Chemistry.¹⁴³
- On February 25, 2004 thirty leading medical doctors, scientists and psychological researchers released a public letter calling on the media to stop the use of such terms as "crack baby" and "crack addicted baby" and similarly stigmatizing terms, such as "ice babies" and "meth babies." This broad group of researchers agreed that these terms lack scientific validity and should not be used.¹⁴⁴
- The American Medical Association believes that pregnant women will be likely to avoid seeking prenatal or open medical care for fear that their physician's knowledge of substance abuse or other potentially harmful behavior could result in a jail sentence rather than proper medical treatment.¹⁴⁵
- In 1999, estimates of the number of births complicated by maternal use of illegal drugs were 134,110; by tobacco use 694,220; and alcohol use 544,330.
- There is no required newborn screening test for alcohol, yet the effects of prenatal alcohol exposure are at least as severe as the effect of illegal drugs.

¹⁴²"Neonatal abstinence syndrome," MedlinePlus, National Institutes of Health, Retrieved on Jan. 4, 2010 from www.nlm.nih.gov/medlineplus/ency/article/007313.htm

¹⁴³ Troy Anderson, "False Positives Are Common in Drug Tests on New Moms," Los Angeles Daily News, June 29, 2008, Retrieved on Jan. 4, 2010 from www.highbeam.com/doc/1G1-180785565.html

¹⁴⁴"Top Medical Doctors and Scientists Urge Major Media Outlets to Stop Perpetuating 'Crack Baby' Myth," Feb. 25, 2005, National Advocates for Pregnant Women, Retrieved Jan. 3, 2010 from <http://advocatesforpregnantwomen.org/file/FFinalpress%2BLetter%20No%20More%20Crack%20Baby.pdf>

¹⁴⁵ "Legal Interventions During Pregnancy," Report of American Medical Association Board of Trustees, 264 JAMA 2663, 267 (1990), Retrieved on Jan. 3, 2010 from www.rhrealitycheck.org/blog/2007/10/01/woman-vs-fetus-myth

- There is no uniform national policy for dealing with drug use during pregnancy. State statutes are quite varied and range from no policies to strictly punitive policies.
- The developmental outcome of children exposed to drugs prenatally varies widely and is influenced by other factors related to maternal drug use, such as poor health, nutrition, depression, poverty and the child's environment after birth.
- For prevention to be effective, drug-using pregnant women need to perceive the health care system as friendly and supportive, not punitive.
- Most women who use drugs during pregnancy are multiple-drug users, but studies have not examined the effects of this on developmental outcome¹⁴⁶

The obligation of medical personnel when a woman gives birth to a baby with drug induced symptoms:

Many states have civil child welfare laws that require reporting to civil child welfare authorities when a newborn tests positive for an illegal drug. Reporting can result in a number of outcomes, from the family's being interviewed by the Department of Social Services, to the family's not being able to take their newborn home from the hospital and sometimes never regaining custody.

Some states also have laws that specifically say the state will treat the issue of drug and alcohol use during pregnancy as a public health issue, and the states sometimes create drug treatment programs for pregnant women, or give priority to pregnant women for treatment (meaning pregnant women are put at the top of waiting lists). Some state laws also mention that prenatal education should include information about drug and alcohol use during pregnancy. These public health approaches are favored by medical groups as likely to have the best health outcomes both for women and their babies.¹⁴⁷

In South Carolina, all newborn babies are not tested for alcohol or drugs. Doctors decide if the situation warrants testing, and when a newborn baby tests positive for illegal drugs, the hospital contacts the Dept. of Social Services, which typically reports it to law enforcement.¹⁴⁸

Treatment options for pregnant women

In South Carolina in 2007 there were 18 facilities offering specialized treatment for pregnant or postpartum women.¹⁴⁹

Prescription drug misuse

In 2008, over 15 million Americans age 12 and older had taken a prescription pain reliever, tranquilizer, stimulant, or sedative for nonmedical purposes at least once in the year prior to being surveyed. Addiction to prescription painkillers has become a largely unrecognized epidemic, experts say. In fact, prescription drugs cause most of the more than 26,000 fatal overdoses nationally each year. The number of overdose deaths from opioid painkillers — opium-like drugs that include morphine and codeine — more than tripled from 1999 to 2006, to 13,800 deaths that year, according to CDC statistics.¹⁵⁰

¹⁴⁶Barry M. Lester, "Substance Use During Pregnancy, Key Findings," Robert Wood Johnson Foundation, Reviewed on Jan. 3, 2010 at www.rwjf.org/pr/product.jsp?id=21248

¹⁴⁷ Email conversation with Katherine Jack, Staff Attorney, National Advocates for Pregnant Women, Nov. 5, 2009

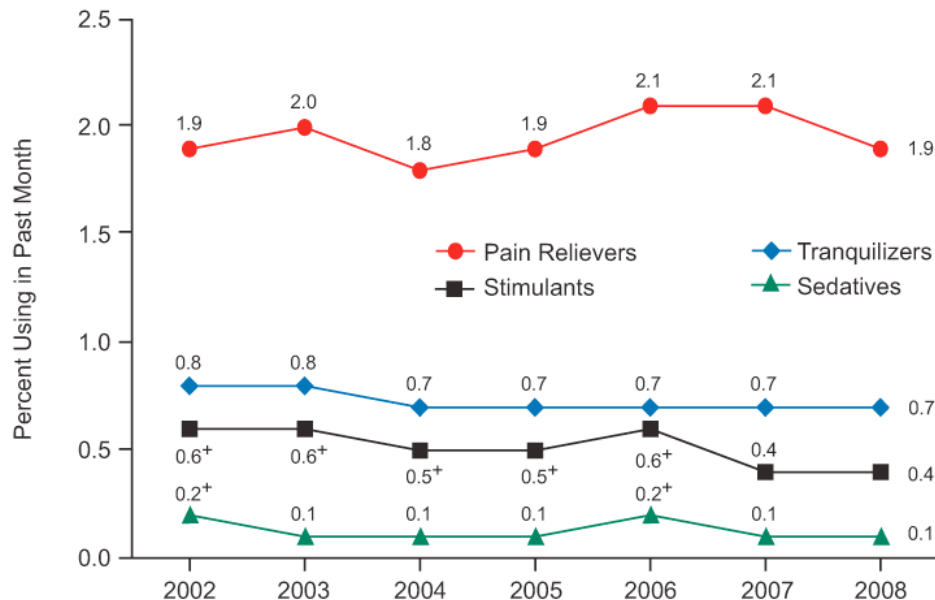
¹⁴⁸ South Carolina Dept. of Social Services (SCDSS) policy, conveyed by phone on Jan. 7, 2010 by Diana Tester, Research Director, SCDSS.

¹⁴⁹ "State Profile—South Carolina," National Survey of Substance Abuse Treatment Services (N-SSATS), Retrieved on Nov. 7, 2009 from www.dasis.samhsa.gov/webt/state_data/SC07.pdf

¹⁵⁰ "Prescriptions now biggest cause of fatal overdoses," *USA Today*, Oct. 2, 2009, Retrieved on Jan. 29, 2010 from www.usatoday.com/news/health/2009-09-30-drug-overdose_N.htm

Even so, prescription drug misuse decreased significantly between 2007 and 2008, according to the 2008 National Survey on Drug Use and Health (NSDUH).¹⁵¹

Past Month Nonmedical Use of Types of Psychotherapeutic Drugs among Persons Aged 12 or Older: 2002-2008



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Misuse of painkillers represents three-fourths of the overall problem. Hydrocodone is the most commonly diverted and abused controlled pharmaceutical in the United States.

Teenage prescription drug misuse is significant. The annual survey of national teen drug use, called Monitoring the Future, conducted by the University of Michigan, has documented rising rates of teenage prescription drug use. In 2009 the survey found that no prescription drug (with the possible exceptions of Adderall and OxyContin) appears to be increasing at the moment. However, the survey emphasized that these two dangerous and highly addictive narcotic drugs remain at high levels of use among American teens.¹⁵³

Prescription drug misuse by the military has markedly increased. About one in four soldiers admitted abusing prescription drugs, mostly pain relievers, in a one-year period, according to a Pentagon health survey released in December 2009. The study surveyed more than 28,500 U.S. troops last year, and showed that about 20% of Marines had also abused prescription drugs, mostly painkillers, in that same period. The survey showed that pain relievers were used illicitly at a rate triple that of marijuana or amphetamines, the next most widely abused drugs.¹⁵⁴

¹⁵¹ "Results from the 2008 National Survey on Drug Use and Health: National Findings," Substance Abuse and Mental Health Services Administration (SAMHSA), Retrieved on 12/31/09 from <http://oas.samhsa.gov/2k8nsduh/2k8Results.cfm#Ch2>

¹⁵² "New National Survey Reveals Significant Decline in Use of Prescription Drugs," SAMHSA News Release, Retrieved on 12/31/09 at [www.samhsa.gov/newsroom/advisories/090910NSDUH\)5111.aspx](http://www.samhsa.gov/newsroom/advisories/090910NSDUH)5111.aspx)

¹⁵³ Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E., "Teen marijuana use tilts up, while some drugs decline in use," Dec. 14, 2009, University of Michigan News Service: Ann Arbor, MI. Retrieved on 12/30/2009 from <http://www.monitoringthefuture.org>.

¹⁵⁴ Greg Zoraya, "U.S. Troops admit using prescription drugs," *USA Today*, Dec. 17, 2009, Retrieved on Dec. 30, 2009 from www.usatoday.com/news/military/2009-12-16-milhealth_N.htm

In South Carolina, the Drug Enforcement Agency (DEA) says that diversion of OxyContin®, hydrocodone products (such as Vicodin®), and pseudoephedrine continues to be a problem. The primary methods of diversion are the illegal sale and distribution by health care professionals and workers, and “doctor shopping” (going to a number of doctors to obtain prescriptions for a controlled pharmaceutical). Other methods of illegally acquiring prescription drugs include traditional drug dealing, theft from pharmacies or homes, illicitly acquiring prescription drugs via the Internet, and from friends or relatives.

Methadone, benzodiazepines, MS Contin®, and fentanyl were also identified by the DEA as among the most commonly abused and diverted pharmaceuticals in South Carolina. Some Schedule II drugs are reportedly taken in combination with Schedule III or IV drugs or the non-controlled Soma ®.¹⁵⁵ (For an explanation of drug schedules, see Appendix A in this report.)

The South Carolina Prescription Monitoring Program

To respond to prescription drug abuse, in 2006 the South Carolina General Assembly passed a law creating the statewide Prescription Monitoring Program (PMP).¹⁵⁶ The law’s intent is to improve the state’s ability to identify and stop the diversion of prescription drugs in an efficient and cost effective manner, without impeding the appropriate medical use of licit controlled substances. The federal government had urged South Carolina to pass this law (44 others have also passed it or are considering a similar law)¹⁵⁷ and the federal government provided funding to set up the PMP. The General Assembly assigned responsibility for establishing and maintaining the PMP to the Bureau of Drug Control (BDC) at the South Carolina Dept. of Health and Environmental Control (DHEC).

The South Carolina PMP law mandates tracking all drugs in Schedules II, III and IV by dispensers (mainly pharmacies, but also some physicians and veterinarians) and by prescribers (physicians and veterinarians).¹⁵⁸ Any dispenser of these narcotic drugs must file a monthly report to the PMP or pay a fine up to \$2,000 and go to prison for up to two years. The dispenser’s report includes specific information about the prescription, the prescriber and the patient.

This information must be kept confidential from all except certain people. They include law enforcement officers and prosecutors involved in a bona fide, specific, drug related investigation involving a designated person; pharmacists; prescribers; DHEC personnel, regarding Medicaid recipients; and a few others. A patient may request information about his or her own record. Anyone who illegally discloses PMP records commits a felony punishable by a fine up to \$10,000 and ten years in prison.

In January 2008 the PMP at DHEC began receiving prescription reports. At the end of 2009 it had monitored over 18 million prescriptions.¹⁵⁹ Of course, not all have been problematic.

¹⁵⁵ U.S. Drug Enforcement Administration (DEA), South Carolina 2009, Retrieved on Dec. 30, 2009 from www.justice.gov/dea/pubs/state_factsheets/southcarolina.html

¹⁵⁶ “Prescription Monitoring Program,” S.C. Statute Section 44-53-1610, Retrieved on Dec. 30, 2009 from www.scstatehouse.gov/code/t44c053.htm

¹⁵⁷ U.S. Drug Enforcement Administration (DEA), Office of Diversion Control, State Prescription Drug Monitoring Programs (as of Sept. 2009), retrieved from http://www.deadiversion.usdoj.gov/faq/rx_monitor.htm#4 on Dec. 30, 2009

¹⁵⁸ See Appendix A in this document for explanations of drug schedules and examples of the drugs they cover.

¹⁵⁹ All specific information about the South Carolina PMP was derived from a phone conversation with Wilbur Harling at that agency on Dec. 30, 2009.

(South Carolina's estimated population in 2009 was 4,479,800.)¹⁶⁰

A typical scenario involving the PMP might be this: A patient complains of insomnia to a physician, who intends to write a prescription for Ambien (a schedule IV drug, widely prescribed). But first, should the physician want to know if the patient has been prescribed narcotics by another doctor (since 2008, when the agency began collecting information), the physician can query the PMP on-line about it. Upon receiving the prescription, the patient asks a pharmacy to fill it. Should the pharmacist have concerns about the patient's prior use of narcotics, the pharmacist also can query the PMP on-line. (But nothing in the law *requires* a pharmacist or physician to obtain information about a patient from the PMP.)

If this is the first time the patient has bought a narcotic since the PMP began keeping dispenser reports, the doctor and pharmacist will find no information about the patient in PMP records. The pharmacy's monthly report will cause an initial record to be created for the patient at the PMP, and any subsequent scheduled prescriptions for the patient will be added to that record. (In the case of veterinarians, PMP records are kept in the name of the animal, at the address of its owner.)

The purpose of the PMP is to stop prescription drug abuses. DHEC's own drug control enforcement is done through its Bureau of Drug Control (BDC), with a mission to regulate controlled substances and enforce the law. To do this, the BDC uses South Carolina licensed pharmacists who are also commissioned as state law enforcement officers. Currently 15 of the BDC's 16 pharmacists are law enforcement officers, with the power to arrest drug offenders. Typically, they request information from the PMP about specific individuals after having been informed about possible abuses by pharmacies and doctors.¹⁶¹

The BDC typically conducts 750 to 850 annual site inspections of pharmacies, hospitals and practitioners. Inspectors make sure that registrants are properly maintaining records and storing controlled substances securely. The BDC receives 750 to 1,000 complaints each year involving diversion of controlled substances from legal outlets. The complaints come from other federal, state and local agencies, health care professionals, and concerned citizens. About 450-500 of the complaints typically result in the arrest and prosecution of individuals in state or federal court. Approximately 25% of those prosecuted are health care professionals.

Should any law enforcement agency have suspicions about someone it is investigating for drug offenses, the agency can request a report about someone from the PMP and use that information to supplement other existing evidence. In 2008 and 2009 law enforcement (including the BDC and other agencies) made about 60,000 inquiries about potential drug offenders. Prescribers made about 40,000 inquiries, and pharmacists around 25,000.

Using its dispenser records, the PMP, itself, has not yet referred drug offenders to law enforcement, though eventually the PMP hopes to be proactive and do this. They plan to first validate information to be sure it is accurate. So far the PMP has not issued

¹⁶⁰ "Population Finder South Carolina," U.S. Census Bureau, Retrieved on Jan. 3, 2010 at http://factfinder.census.gov/servlet/SAFFPopulation?_event=Search&_name=&_state=04000US45&Submit.x=9&Submit.y=4&_county=&_cityTown=&_zip=&_sse=on&_lang=en&pctxt=fph

¹⁶¹ "Drug Control-Prescription Monitoring Program," South Carolina Dept. of Health and Environmental Control (DHEC), Retrieved on Jan. 22, 2010 from www.scdhec.gov/administration/drugcontrol.

performance reports, though it is collecting information to see what impact it is having on investigative (law enforcement) organizations.

The South Carolina PMP will shortly use up its initial federal funding grant, and it will then operate through fees of \$125 annually from participating physicians, pharmacies and hospitals.

Collateral casualties and unintended consequences

Children living with drug abusers

Combined data from 2002 to 2007 indicate that about 8.3 million children under 18 years of age lived with a parent who was dependent on or abused an illicit drug. Fathers were twice as likely as mothers to use drugs.¹⁶² Parental substance dependence and abuse can have profound effects on children, including child abuse and neglect, injuries and deaths related to motor vehicle accidents, and increased odds that the children will become substance dependent or abusers themselves.¹⁶³

An increasing number of children in the United States are exposed to toxic chemicals because methamphetamine laboratories are being operated in or near their homes. In addition, these children often are abused or neglected by the parents, guardians, or others who operate these laboratories.¹⁶⁴ In South Carolina manufacturing or selling methamphetamine in the presence of a child carries a special penalty of up to 5 years in prison for a first offense.¹⁶⁵

Children with parents in jail or prison

Across the nation, more than 2,000,000 children had a parent in prison in 2009.¹⁶⁶ In South Carolina, it is estimated that approximately 82,286 children had a parent in prison, jail or under community supervision in 2008.¹⁶⁷ In South Carolina prisons 78% of women are mothers and 63% are fathers.¹⁶⁸ The average age of children with an incarcerated parent is eight years old, and 22% of the children are under the age of five.¹⁶⁹ In 2007 one in 15 black children, one in 42 Latino children, and one in 111 white children had an incarcerated parent.¹⁷⁰

Children with incarcerated mothers may be at increased risk for separation trauma, child abuse and neglect, poor academic performance, substance abuse, juvenile delinquency and ultimately, adult criminal activity. They are more likely to end up in foster care or other

¹⁶²"Children Living with Substance Dependent or Substance-Abusing Parents: 2002 to 2007," National Survey on Drug Use and Health, April 16, 2009, Retrieved on Jan. 27, 2010 from <http://oas.samhsa.gov/2k9/SAparents/SAparents.pdf>.

¹⁶³*Ibid.*

¹⁶⁴"Children at Risk," U.S. Dept. of Justice, Information Bulletin, July 2002, Retrieved on Jan. 27, 2010, from www.justice.gov/ndic/pubs1/1466/1466p.pdf.

¹⁶⁵"Parental Drug Use as Child Abuse: Summary of State Laws, South Carolina", Child Welfare Information Gateway, Retrieved on Jan. 27, 2010 from www.childwelfare.gov/systemwide/laws_policies/statutes/drugexposedall.pdf.

¹⁶⁶Keith Phucas, "Studying the affects (sic) of parents in prison," *The Times Herald*, June 8, 2009, Retrieved on Jan. 27, 2010 from www.timesherald.com/articles/2009/06/08/news/doc4a2c8f428ad64568647785.txt.

¹⁶⁷Robin Kimbrough-Melton, Dee Rogers, Donna Happach, "The Impact of Female Incarceration on Children," South Carolina Adult and Juvenile Female Offender Task Force, May 2008.

¹⁶⁸"Profile of Inmates in Institutional Count as of June 30, 2009," S.C. Dept. of Corrections, Retrieved on Jan. 27, 2010 from www.doc.sc.gov/research/InmatePopulationStats/ASOF_InstitutionalCountProfile_FY09.pdf.

¹⁶⁹"Statistics Concerning Children of Prisoners," DeMossNews.com, Retrieved on Jan. 27, 2010, from www.demossnewspond.com/pf/additional/statistics_concerning_children_of_prisoners.

¹⁷⁰"Incarcerated—Parents and Their Children, Trends 1991 – 2007," The Sentencing Project, Feb. 2009, Retrieved on Jan. 27, 2010 from www.sentencingproject.org/doc/publications/publications/inc_incarceratedparents.pdf

agency placements.¹⁷¹ Children of incarcerated parents are five times more likely than their peers to commit crimes.¹⁷² Human Rights Watch calls children of incarcerated drug offenders the collateral casualties of the war on drugs.¹⁷³

Spread of disease by intravenous drug users

The primary health risk associated with injection drug use, aside from the complications caused by the drug, itself, is the transmission of blood-borne pathogens via the sharing of needles. Health experts are most concerned about the spread of HIV and hepatitis among injection drug users. The Centers for Disease Control and Prevention estimates that injection drug use causes more than one-third of all HIV/AIDS cases in the United States, and not only puts users at risk, but also exposes their sexual partners and children.¹⁷⁴ From 1981 - 2008 in South Carolina, 18,320 cases of AIDS were diagnosed, with 8,601 deaths.¹⁷⁵

Drugged Driving

No per se Drugged Driving laws exist for South Carolina. It is illegal to drive a motor vehicle while under the influence of drugs and/or alcohol, no matter what the amounts of those substances may be, if the driver's physical abilities have become impaired in any way. It does not matter if the drugs are legal, over the counter medications like antihistamines, nor does it matter if the driver has a prescription to take the drugs.¹⁷⁶

In 2007 South Carolina had 4,862 alcohol and/or drug related traffic collisions, in which 324 people died and 3,446 were injured. One person was injured or killed in a DUI crash every 2.1 hours.¹⁷⁷

A major problem for law enforcement in proving the crime is that traces of marijuana can be detected in the blood stream and urine for as much as thirty days after its original use. This means that a person can submit to a blood or urine test at the request of law enforcement and test positive for marijuana even though the driver had not used marijuana for days or even weeks.

Drug overdoses and accidental death

Because illegal drugs are of unknown strength and contain unknown impurities, they carry the risk of overdose and death. And because drugs are illegal and users are subject to arrest, people who overdose may not be taken to a hospital in time to save their lives. In the past, most overdoses were due to illegal narcotics, such as heroin, with most deaths in big cities. However, prescription painkillers have now surpassed heroin and cocaine as the leading cause of fatal overdoses.

¹⁷¹ Robin Kimbrough-Melton, Dee Rogers, Donna Happach, "The Impact of Female Incarceration on Children," South Carolina Adult and Juvenile Female Offender Task Force, May 2008.

¹⁷² E. Mosely, "Incarcerated-Children of Parents in Prison Impacted," DefenderNetwork.com, Texas Dept. of Criminal Justice, Go Kids Articles, July 6-12, 2008, Retrieved on Feb. 2, 2010 from www.tdcj.state.tx.us/pgm&svcs/gokids/gokids-articles-incarcerated-children-of-parents-impacted.html.

¹⁷³ "Collateral Casualties," Human Rights Watch, June 22, 2002, Retrieved on Jan. 27, 2010, from www.hrw.org/en/node/24493/section/2.

¹⁷⁴ Hugh C. McBride, "Using Syringe Exchange Programs to Stop the Spread of Disease Among IV Drug Users," Drug Addiction, Retrieved on Jan. 27, 2010, from www.drug-addiction.com/syringe-exchange.htm.

¹⁷⁵ "South Carolina STD/HIV/AIDS Data," *STD/HIV Division Surveillance Report*, Dec. 31, 2008, Retrieved on Jan. 27, 2010 from www.scdhec.gov/health/disease/stds/docs/HIVSTD_SurvRpt_Dec2008.pdf

¹⁷⁶ "Frequently Asked Questions About Drinking and Driving," DuiSouth Carolina.com, Retrieved on Jan. 29, 2010 from www.duisouthcarolina.com/faqs.cfm.

¹⁷⁷ *South Carolina 2007 Traffic Collision Fact Book*, p. 10, S.C. Dept. of Public Safety, Retrieved on Jan. 29, 2010 from www.scdps.org/ohs/2007%20FACTBOOK.pdf

In South Carolina, 2,194 patients were discharged from hospitals for drug related conditions in 2006. There were 11,104 drug related discharges from emergency rooms for that year.¹⁷⁸ Twenty-two deaths were reported in 2007 due to multiple drug use and use of other psychoactive substances.¹⁷⁹

Corruption of officials

Law enforcement officers, prison guards, solicitors, and even judges are not immune from the temptation to profit from the black market status of drugs. Stories abound about corrupt police in Mexico and corrupt legislators in Afghanistan, but corruption also occurs in the United States, including South Carolina. A report by the General Accounting Office (GAO) in 1998 concluded that the extent of drug-related corruption in the United States is unknown because of a lack of centralized, systematically gathered data.¹⁸⁰ That is still true today, and no agency in South Carolina tracks incidences of drug-related corruption in the state.¹⁸¹ However, an anti-drug war organization, DRCNet, collects corruption reports from volunteer reporters throughout the country. For example, in December 2009 it reported on a Darlington, S.C. police officer arrested for drug trafficking, and a Chesterfield County, S.C. Sheriff's deputy arrested for manufacturing methamphetamine.¹⁸²

Roadblocks to reentry

After a drug offender completes the penalty prescribed by the court, with all the associated losses of freedom, money, employment and family that may entail, the personal price has still not been paid. Numerous legal barriers exist for all people with criminal records, but there are extra obstacles for ex-drug offenders.

Federal student financial aid: Since 2000, over 200,000 students have been ineligible for federal loans, grants, and work-study because of the HEA (Higher Education Act) Aid Elimination Penalty for drug offenses. The law was scaled back in 2006 and 2008 to the following: The application for aid asks about convictions for possessing or selling illegal drugs (but not about any other type of crime) during a period of enrollment for which a student was receiving federal student aid (grants, loans, and/or work-study). A conviction makes the student ineligible for federal aid for that school year, unless the student can pass two unannounced drug tests administered by a government-approved treatment program, without having to complete the program, itself. Also, if a student is convicted of a drug offense after receiving federal aid money, the student must notify the school's Financial Aid Dept. immediately and pay back all aid received after the conviction.¹⁸³

¹⁷⁸ Rob McManus, Editor, *Altered States in the Palmetto State: Statistical Indicators of Illegal Drug Use*, pp. 98 – 102, June 2008, South Carolina Dept. of Public Safety, Retrieved on Jan. 29, 2010, from www.scdps.org/ojp/statistics/Altered%20States%20in%20SC.pdf.

¹⁷⁹ "South Carolina Detailed Mortality Statistics 2007, Volume II Annual Vital Statistics Series," p. 58, S.C. Dept. of Health and Environmental Control, Retrieved on Jan. 29, 2010 from www.scdhec.gov/co/phsis/biostatistics/an_pubs/DMS_2007.pdf.

¹⁸⁰ "Law Enforcement Information on Drug-Related Police Corruption," United States General Accounting Office, May 1998, Retrieved on Jan. 27, 2010, from www.csdp.org/research/gaocrptn.pdf.

¹⁸¹ Phone conversation with Roger Heaton, Assistant Director of Special Operations, SLED, on Jan. 26, 2010.

¹⁸² "Law Enforcement: This Week's Corrupt Cops Stories," Drug War Chronicle, Issue #613, 12/18/09, Retrieved on Jan. 27, 2010 from http://stopthedrugwar.org/chronicle/613/police_drug_corruption.

¹⁸³ "Brief History of the Aid Elimination Penalty," Students for Sensible Drug Policy, Retrieved on Feb. 2, 2010 from <http://ssdp.org/campaigns/hea>.

To get a South Carolina tuition grant, a student must wait one year after two drug offenses or any “adjudicated delinquency.”¹⁸⁴

Employment: Few employers are willing to hire anyone with a criminal record, and conviction records are available on the Internet through SLED (South Carolina Law Enforcement Division) for a small fee. Drug tests are commonly required for job applicants. Some jobs are prohibited to people with drug convictions, at least for a period of years, such as would-be cab drivers with drug convictions in North Charleston.¹⁸⁵

Public assistance and food stamps: Anyone with a drug felony conviction is ineligible for food stamps forever. Households with someone who has a drug felony conviction are also ineligible for food stamps.¹⁸⁶

The South Carolina law that determines eligibility for public assistance:
“SECTION 43-5-1190. Eligibility denied on ground of alcohol or drug problem; treatment program required.

A Family Independence (i.e., welfare) recipient who, while receiving FI benefits, has been identified as requiring alcohol and other drug abuse treatment service, or who has been convicted of an alcohol related offense or a controlled substance violation, or gives birth to a child with evidence of the effects of maternal substance abuse, and the child subsequently is shown to have a confirmed positive test performed on a suitable specimen within twenty-four hours of birth, is ineligible for FI assistance, unless the recipient submits to random drug tests and/or participates in an alcohol or drug treatment program approved by the Department of Alcohol and Other Drug Abuse Services. Upon completion of the program, if a subsequent random test or subsequent conviction for a controlled substance violation occurs, the recipient is ineligible for FI benefits. Benefits may be reinstated at a later time upon reapplication, if the recipient first undergoes a conciliation assessment, including review and/or modification of the prescribed individual treatment program and agreement, and then agrees to comply with its terms and demonstrates compliance for a period of not less than sixty days.”¹⁸⁷

¹⁸⁴Title 59, Chapter 113, Tuition Grants, SC Statute Section 59-113-20, Retrieved on Feb. 2, 2010 from www.scstatehouse.gov/cgi-bin/query.exe?first=DOC&querytext=scholarship&category=Code&conid=5272267&result_pos=0&keyval=1222

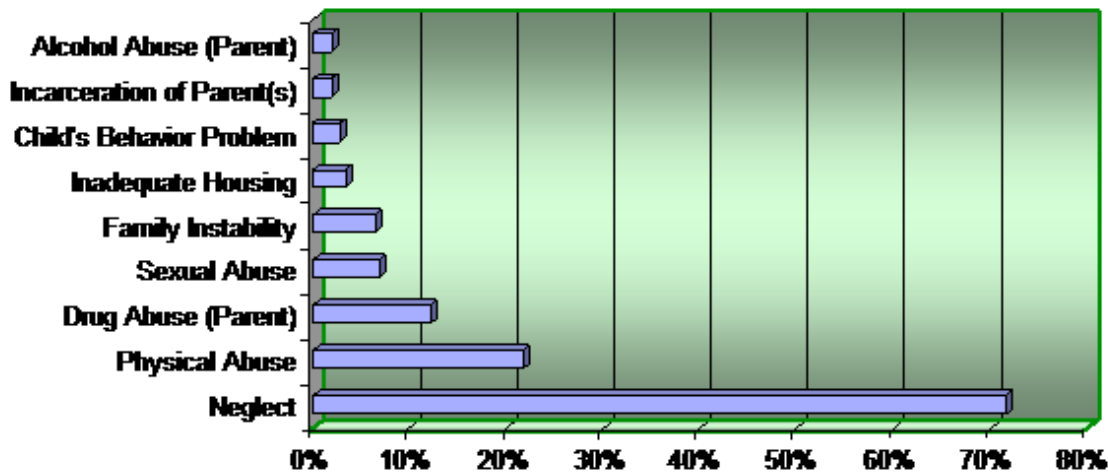
¹⁸⁵ Schuyler Kropf, “Committee denies cabbie licenses,” *Post and Courier*, Feb. 11, 2010

¹⁸⁶ South Carolina Dept. of Social Services (SCDSS) policy, conveyed by email on Jan. 26, 2010 from Diana Tester, Research Director, SCDSS.

¹⁸⁷Article 9, South Carolina Independence Act, S.C. Statute Section 43-5-1190, Retrieved on Feb. 2, 2010 from www.scstatehouse.gov/code/t43c005.htm,

Removal of children from their home due to parental drug abuse

Primary Removal Reasons from Care, FY0809



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Note that alcohol abuse is far less likely than drug abuse to lead to removal of children from their homes, though alcoholism is more common and at least as detrimental to the family.

Foster Care and Adoption: Foster care and adoption are denied to anyone with a felony drug conviction.¹⁸⁹

Public housing: South Carolina public housing authorities follow the federal policy. While it is up to the discretion of each housing authority, most likely an application from an ex-drug offender would be denied. The admission standards require eight years to pass from the date of arrest for either a drug offense (from misdemeanor marijuana possession to felony trafficking) or a violent offense before a housing application would even be considered. Proof of rehabilitation may favorably impress the housing authority to reconsider the ban. There is a lifetime ban on public housing for anyone convicted of distributing or manufacturing methamphetamines, the same ban as for registered sex offenders. Should a member of a family already living in public housing be convicted of a drug offense (even misdemeanor marijuana possession), the family will be required to vacate the property and wait three years to reapply for housing. The family does have the right to appeal its case to a magistrate.¹⁹⁰

Driver's license: Every drug offender's driver's license is revoked for six months, even if the offense did not involve a vehicle. Special restricted licenses may be available for school or work.

¹⁸⁸S.C. Dept. of Social Services (SCDSS) policy, conveyed by email on Feb. 10, 2010 from Diana Tester, Research Director, SCDSS

¹⁸⁹ Ibid., Feb. 11, 2009

¹⁹⁰ Phone conversation with Stephen Wright, Director of Community Security for the Charleston Housing Authority, on Jan. 26, 2010

Chapter 6

Substance Abuse Treatment in South Carolina

Before discussing treatment and addiction, it is important to observe that people use drugs, as they do alcohol, because they like the way it makes them feel. And, as with alcohol, not all users become addicted to drugs.

Those who do become addicted often have devastating consequences. The Robert Wood Johnson Foundation calls substance abuse (drugs and alcohol) “the nation’s #1 health problem.”¹⁹¹ To what extent can treatment overcome addiction?

The nature of addiction and effective treatment

Nearly all addicted individuals believe at the outset that they can stop using drugs on their own, and most who want to stop try to stop without treatment. Although some people are successful, many attempts result in failure to achieve long-term abstinence. Drug-induced changes in brain function can have many behavioral consequences, including an inability to exert control over the impulse to use drugs despite potentially devastating consequences—the *defining characteristic of addiction*.

Drug addiction is a complex illness. Many people do not realize that addiction is a brain disease. Some individuals are more vulnerable than others to becoming addicted, depending on genetic makeup, age of exposure to drugs, other environmental influences, and the interplay of all these factors.¹⁹²

Decades of scientific research and clinical practice have lead to the following principles of effective treatment:

- Addiction is a complex but treatable disease that affects brain function and behavior, and no single treatment is appropriate for everyone.
- Treatment needs to be readily available.
- Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.
- Remaining in treatment for an adequate period of time (at least 3 months) is critical. Recovery from drug addiction is a long-term process and frequently requires multiple episodes of treatment.
- Counseling—individual and/or group—and other behavioral therapies are the most commonly used forms of drug abuse treatment.

¹⁹¹ *Substance Abuse: The Nation’s Number One Health Problem*, Robert Wood Johnson Foundation, Feb. 2001, Retrieved on Feb. 4, 2010 from www.rwjf.org/pr/product.jsp?id=15707

¹⁹² “Principles of Drug Addiction and Treatment,” Second Edition, National Institute on Drug Abuse (NIDA), National Institutes of Health, U.S. Dept. of Health and Human Services, Retrieved on Feb. 4, 2010 from www.drugabuse.gov/PDF/PODAT/PODAT.pdf

- Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
- An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.
- Many drug-addicted individuals also have other mental disorders.
- Drug use during treatment must be monitored continuously, as lapses during treatment do occur.¹⁹³

COMPARISON OF RELAPSE RATES BETWEEN DRUG ADDICTION AND OTHER CHRONIC ILLNESSES

Percentage of Patients Who Relapse

TYPE 1 DIABETES



DRUG ADDICTION



HYPERTENSION



ASTHMA



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DAODAS— South Carolina's state treatment agency

The South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) is the cabinet-level agency for alcohol and other drug abuse programming. The agency reports directly to the Governor and is responsible for advising the executive branch of state, the General Assembly and other state agencies regarding alcohol and other drug abuse issues. The department's mission is to ensure the provision of quality services to prevent or reduce the negative consequences of substance use and addictions.

Recognizing the need for direct services for the general public, as well as for specific high-risk groups, the department offers a wide array of prevention, intervention and treatment services through a community-based system of care. Although services are coordinated at the state level through DAODAS, the department in turn subcontracts with 33 county alcohol and drug abuse authorities to provide direct services to citizens in all 46 counties of the state.

Each year, about 50,000 South Carolinians receive direct intervention and/or treatment services through the county authorities. In addition, these local agencies coordinate

¹⁹³ Ibid.

¹⁹⁴ Ibid.

thousands of prevention activities each year that reach South Carolinians of all ages. Since their creation in 1973, the county authorities have provided intervention and treatment services to more than 1 million South Carolinians and touched the lives of millions of additional individuals and families through the many prevention activities coordinated by this system.

The primary source of funding for prevention and treatment programs managed by DAODAS is the Substance Abuse Prevention and Treatment Block Grant. The Substance Abuse and Mental Health Services Administration (SAMHSA) in Washington, D.C provide this grant. It currently provides almost 50% of the department's funding for direct services coordinated by the county alcohol and drug abuse authorities. Approximately 30% is provided by state funds appropriated through the South Carolina General Assembly, and the remaining 20% comes from Medicaid and other federal grants.¹⁹⁵

Getting (and not getting) treatment

Nationally, in 2007 the criminal justice system was the largest single source of referrals to the substance abuse treatment system—approximately 670,000 of the 1.8 million admissions. The majority of these referrals were from parole and probation offices. The people referred were almost twice as likely to be employed either full or part-time as other admissions.

Drug courts also require treatment for participants. Although a full description of South Carolina drug courts can be found in Chapter 5 of this document, it is worth noting here that drug courts restrict the number of participants they can enroll, due to limited capacity and various eligibility requirements to participate. A study in 2008 found that expanding that number required by the courts to undergo treatment would yield enormous benefits in public safety and the related costs associated with arrests.¹⁹⁶

How many people in South Carolina get treatment?

In 2009 DAODAS and its provider network served 49,459 people with alcohol and drug problems.¹⁹⁷ The national Treatment Episode Data Set (TEDS) chart for 2007 (the latest information we could find) on the next page compares the reasons why South Carolinians sought treatment for problems with alcohol and various drugs. TEDS is an admission-based system. Thus, for example, an individual admitted to treatment twice within a calendar year would be counted as two admissions. These 29,924 admissions in South Carolina do not include all admissions to substance abuse treatment in the state in 2007, just facilities that are licensed or certified by DAODAS to provide substance abuse treatment, or are tracked by the agency for other reasons.¹⁹⁸

¹⁹⁵ "About Us," DAODAS, Retrieved on Jan. 26, 2010 from www.daodas.state.sc.us/about_us.asp

¹⁹⁶ Avinash Singh Bhati; John K. Roman; Aaron Chalfin, *To Treat or Not to Treat: Evidence on the Prospects of Expanding Treatment to Drug-Involved Offenders*, May 2008, Urban Institute, Justice Policy Center, p. xii, Retrieved on Jan. 5, 2010 from www.ncjrs.gov/pdffiles1/nij/grants/222908.pdf

¹⁹⁷ "Accountability Report, FY 2008-2009, DAODAS, p. 1, Retrieved on Feb. 16, 2010 from www.daodas.state.sc.us/documents/FY09AccountabilityReport.pdf

¹⁹⁸ "Treatment Episode Data Set (TEDS) Highlights – 2007," SAMHSA, Retrieved on Jan. 26, 2010 from www.dasis.samhsa.gov/teds07/tedshigh2k7.pdf

Admissions by State or jurisdiction, according to primary substance of abuse: TEDS 2007
Percent distribution

[Based on administrative data reported to TEDS by all reporting States and jurisdictions. Comparisons among States should be made with caution.]

State or jurisdiction	All admissions	Primary substance at admission															Total
		Alcohol		Opiates		Cocaine		Marijuana/hashish	Stimulants		Tranquillizers	Sedatives	Hallucinogens	PCP	Inhalants	Other/none specified	
		Alcohol only	With secondary drug	Heroin	Other opiates	Smoked cocaine	Other route		Methamphetamine/amphetamine	Other stimulants							
Rhode Island	11,390	24.6	15.4	20.2	9.7	10.3	3.6	14.9	0.2	*	0.7	0.1	0.1	*	*	0.2	100.0
South Carolina	29,924	30.1	16.2	1.1	4.3	10.3	3.9	19.2	2.0	*	0.5	0.4	0.1	*	0.1	11.7	100.0
South Dakota	15,739	48.9	29.2	0.2	1.1	0.5	0.6	12.1	5.7	*	*	*	*	--	0.3	1.3	100.0
Tennessee	10,278	22.0	14.9	n/c	16.9	17.0	4.7	13.8	2.8	0.1	*	2.8	1.1	--	0.1	3.9	100.0
Texas	45,418	11.9	11.9	9.0	6.5	13.4	10.6	23.4	10.6	--	0.3	1.8	0.1	0.4	0.1	0.1	100.0
Utah	14,129	21.7	12.7	11.9	5.5	6.1	2.3	13.8	25.0	*	0.4	0.1	0.1	*	0.1	0.2	100.0
Vermont	8,063	30.6	20.9	5.5	18.6	4.0	4.3	14.2	0.4	0.1	0.6	0.2	*	--	0.1	0.5	100.0
Virginia	31,781	16.5	20.0	6.6	5.1	12.0	4.3	18.1	1.1	0.2	0.5	0.2	0.1	0.3	0.1	15.0	100.0
Washington	38,062	16.8	24.7	6.6	3.6	5.7	2.0	20.2	16.7	--	0.3	0.1	0.3	*	*	2.7	100.0
West Virginia	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡	‡
Wisconsin	29,834	51.2	19.1	3.1	4.2	8.5	1.9	9.2	1.2	*	0.2	0.1	0.1	*	*	1.2	100.0
Wyoming	4,496	42.1	20.3	0.5	2.5	0.5	1.2	17.4	13.7	0.2	0.2	0.6	0.1	*	0.2	0.5	100.0

n/c: State does not collect these data. In Tennessee, Heroin admissions are included in Other opiates.

* Less than 0.05 percent.

-- Quantity is zero.

‡ No data, or less than a full calendar year of data, submitted.

SOURCE: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 10.6.08.

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How many South Carolinians need treatment but don't get it?²⁰⁰

The National Survey on Drug Use and Health (SAMHSA) defines unmet treatment as an individual who meets the criteria for abuse of, or dependence on, illicit drugs or alcohol according to the *DSM-IV*,²⁰¹ but who has not received specialty treatment for that problem in the past year.

The most common reasons reported for not receiving treatment were not being ready to stop using the substance, the cost of treatment, the perceived stigma of obtaining treatment, and not knowing where to go.²⁰² Lee Dutton, Assistant Director of South Carolina's Dept. of Alcohol and Other Drug Abuse Services (DAODAS) told us that some people lack the education as to what is available for intervention and treatment, and that in many instances people don't even recognize they have a problem till they hit "rock bottom."²⁰³

DAODAS estimates that in 2009 approximately 236,000 people in South Carolina suffered from substance abuse problems requiring immediate intervention and treatment, and that same year DAODAS and its provider network met the needs for 49,459 people, leaving 186,541 with unmet treatment needs in 2009. (See the DEODAS chart for 2009 on the next page.) Lee Dutton says that South Carolina's unmet treatment need rate is in-line with national statistics.²⁰⁴ However, SAMHSA says that in 2006 – 2007 South Carolina was one of the top ten states with highest unmet treatment needs.²⁰⁵

¹⁹⁹ Ibid.

²⁰⁰ "States in Brief—South Carolina," SAMHSA, Dec. 2008, Retrieved on Jan. 26, 2010 from www.samhsa.gov/statesinbrief/2009/SOUTH_CAROLINA_508.pdf

²⁰¹ *The Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association

²⁰² *2003 National Survey on Drug Use and Health*, SAMHSA, Retrieved on Nov. 7, 2009 from www.oas.samhsa.gov/nhsda/2k3nsduh/2k3Results.htm#highlights

²⁰³ Email from Lee Dutton, Asst. Director at DAODAS, on Feb. 5, 2010.

²⁰⁴ Ibid.

²⁰⁵ "Needing But Not Receiving Treatment for Illicit Drug Problems," SAMHSA. Retrieved on Jan. 26, 2010 from www.oas.samhsa.gov/2k7/state/Ch5.htm#Fig5-21

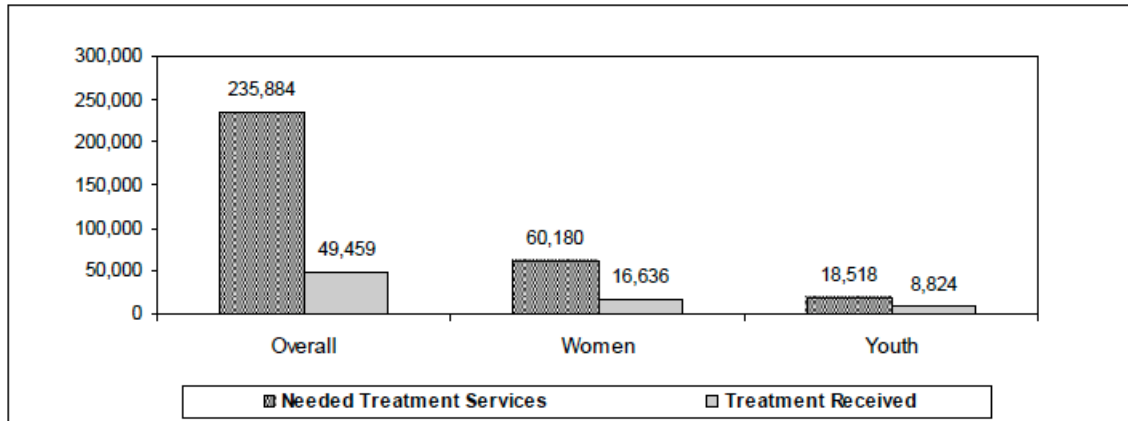


Chart 1. (Source: DAODAS Division of Operations, Management Information and Research Section; FY09 Unique Unduplicated Clients, DCSL Based, Special Demographics; Numbers based on definitions as included in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision [DSM-IV-TR]).

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There is an important payoff for ready access to community treatment. States with a drug treatment admission rate higher than the national average send, on average, 100 fewer people to prison per 100,000 in the population, than do states with below-average drug treatment admissions.²⁰⁷

Where South Carolinians go for treatment

In 2006 there were 104 facilities in South Carolina, of which 27 were private non-profit (26%), 30 were private for-profit (29%), and 29 (28%) were owned or operated by the state government.²⁰⁸ Although facilities may offer more than one modality of care, the majority of facilities (92) offered some form of outpatient treatment, and 23 offered some form of residential care.²⁰⁹ Access to treatment is available in every county of the state and readily accessible. There may be a short waiting period for bedded services, particularly in the DAODAS adolescent inpatient center located in Orangeburg, and shorter waiting periods for inpatient women's services.²¹⁰

How long treatment lasts and how people pay for it²¹¹

Substance abuse services are individualized in South Carolina. Average lengths of stay vary by level of care and severity of illness. For intensive outpatient program services, the 'best practice' level of care for most individuals in 2009 was a stay lasting 61.26 days.

DAODAS figures the average cost for all treatment in 2009 was \$829 per treatment "episode." This cost is across all levels of care, from basic outpatient treatment to long-term residential treatment and acute detoxification. The reasonable cost benchmark in the

²⁰⁶ "Accountability Report, FY 2008-2009, DEODAS, p. 1, Retrieved on Feb. 6, 2010 from www.daodas.state.sc.us/documents/FY09AccountabilityReport.pdf

²⁰⁷ *Substance Abuse Treatment and Public Safety*, Justice Policy Institute, p. 2, Jan. 2008, Retrieved on Jan. 26, 2010 from www.justicepolicy.org/images/upload/08_01_REP_DrugTx_AC-PS.pdf

²⁰⁸ For a county-specific list of state and private providers see the Directory of Alcohol and Other Abuse Services in South Carolina at www.daodas.state.sc.us/documents/TreatmentDirectory-06.pdf

²⁰⁹ "States in Brief—South Carolina," SAMHSA, Dec. 2008, Retrieved on Jan. 26, 2010 from www.samhsa.gov/statesinbrief/2009/SOUTH_CAROLINA_508.pdf

²¹⁰ Email from Lee Dutton, Asst. Director at DAODAS, on Feb. 5, 2010.

²¹¹ Information about DAODAS in this section provided by email on Feb. 5, 2010 by Lee Dutton, Asst. Director of that agency.

Access to Recovery Grant recently offered through the Department of Health and Human Services (SAMHSA) identified an ideal range of costs for treatment services: from \$1,000 to \$5,000. The Drug and Alcohol Services Information System, a division of SAMHSA, estimated that outpatient care was \$1,433 and residential care was \$3,840. Taken together, South Carolina is below the range for appropriate costs.

As recipients of federal and state funds, DAODAS providers of substance abuse services cannot deny services based on an inability to pay for services. A financial assessment is completed on all individuals indicating economic hardship, and people are not turned away because of a lack of money.

Private health insurance plans vary in coverage of substance abuse and mental health services. However, the recent federal act addressing parity for substance abuse and mental health services, called the Paul Wellstone Act, goes a long way in achieving parity for those plans that do cover such services. The act does not require that substance abuse or mental health services be included, but it does bar employers and group health plans from providing less coverage for these services than they do for physical ailments if provided in the health care plan. Insurers cannot set higher co-payments and deductibles, or stricter limits on treatment for substance abuse and mental health services. The act covers employers with 50 or more employees. In South Carolina, most businesses have fewer than 50 employees and thus the reach of the federal law may be limited in our state.

The chart on the next page shows the variety of ways people pay for treatment. Nationally, from 2002 - 2004 an estimated 44% of people who received treatment paid at least a portion of the cost with their own savings or earning. The majority (53%) used two or more sources of payment, including private insurance, Medicaid, and other public assistance.²¹²

²¹² "Sources of Payment for Substance Use Treatment," SAMHSA, 2006, Retrieved on Jan. 27, 2010 from <http://oas.samhsa.gov/2k6/pay/pay.htm>

Table 1. Sources of Payment for Last or Current Substance Use Treatment among Persons Aged 12 or Older Who Received Treatment in the Past Year: 2002, 2003, and 2004

Source of Payment	Alcohol Use Treatment (Percent)	Illicit Drug Use Treatment (Percent)	Alcohol or Illicit Drug Use Treatment (Percent)
Private Health Insurance	24.9	28.2	25.9
Medicare	11.4	15.6	12.1
Medicaid	13.5	18.6	14.2
Public Assistance Program Other than Medicaid	16.1	17.9	15.9
Own Savings or Earnings	47.3	37.7	43.9
Family Members	17.2	20.6	17.8
Courts	9.2	11.9	9.5
Military Health Care	5.2	4.3	4.9
Employer	6.8	5.9	6.2
Free	8.0	5.3	7.1

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Is drug addiction treatment worth its cost?

Substance abuse costs the United States over one half-trillion dollars annually, and treatment can help reduce these costs. Drug addiction treatment has been shown to reduce associated health and social costs by far more than the cost of the treatment itself. Treatment is also much less expensive than its alternatives, such as incarcerating addicted persons. For example, the average national cost for one full year of methadone maintenance treatment (to replace heroin) is approximately \$4,700 per patient, whereas one year of imprisonment cost \$14,545 in South Carolina in 2009.

Drug addiction treatment reduces drug use and its associated health and social costs. According to several conservative estimates, every \$1 invested in addiction treatment programs yields a return of between \$4 and \$7 in reduced drug-related crime, criminal justice costs, and theft. When savings related to health care are included, total savings can exceed costs by a ratio of 12 to 1. Major savings also stem from fewer interpersonal conflicts; greater workplace productivity; and fewer drug-related accidents, including overdoses and deaths.²¹⁴

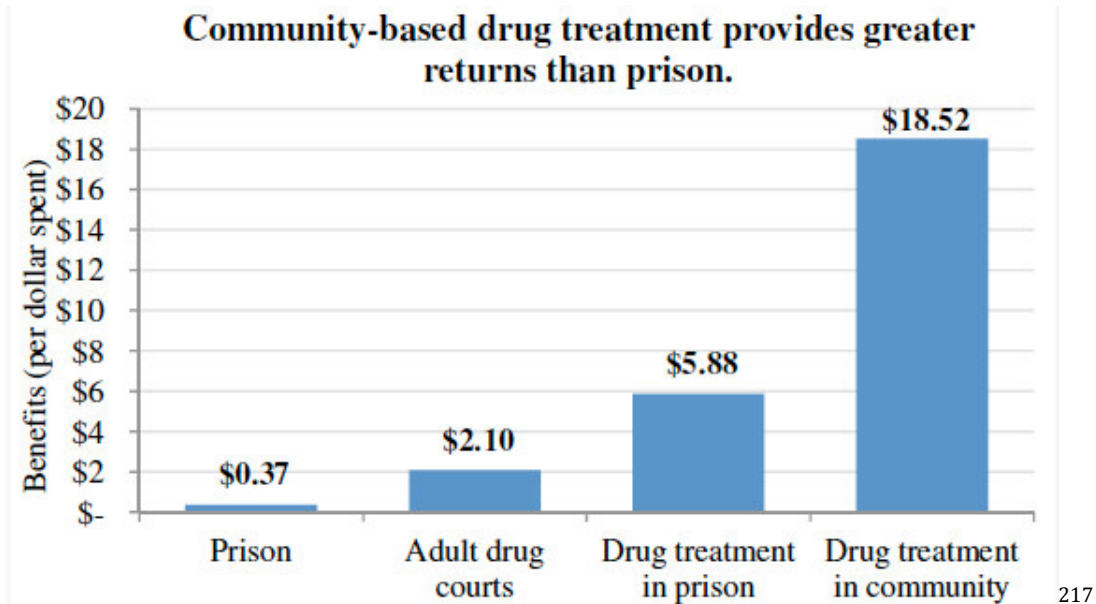
Several states have expanded drug treatment options as alternatives to prison for drug offenses. (See Chapter 8 in this document for more about this.) A RAND Corporation study estimated that treatment is 15 times more effective at reducing drug-related crime than

²¹³ Ibid.

²¹⁴ "Principles of Drug Addiction and Treatment," Second Edition, National Institute on Drug Abuse (NIDA), National Institutes of Health, U.S. Dept. of Health and Human Services, Retrieved on Jan. 27, 2010 from www.drugabuse.gov/PDF/PODAT/PODAT.pdf

incarceration.²¹⁵ Studies show that treatment can cut drug abuse in half, reduce criminal activity up to 80%, and reduce arrests up to 64%.²¹⁶

The Washington State Institute for Public Policy (WSIPP) found not only that drug treatment conducted within the community is extremely beneficial in terms of costs, especially compared with prison, but also that it is second only to treatment-oriented supervision in reducing recidivism rates. As the following chart shows, every dollar spent on drug treatment in Washington State was estimated to return \$18.52 in benefits to society, based on that state's particular costs.



Incarceration and substance abuse treatment

As the preceding chart illustrates, research has shown that the initiation of drug treatment prior to involvement with the criminal justice system is the most beneficial and effective means of delivering services to drug-involved people. Though drug treatment in a prison setting is helpful, drug-involved people are better served with drug treatment programs in the community. Community-based drug treatment programs encourage successful transition to communities, which reduces the chance that a person will become involved in crime or the criminal justice system in the future.²¹⁸

²¹⁵ Jonathan P. Caulkins, C. Peter Rydell, William Schwabe, and James Chiesa, *Mandatory Minimum Drug Sentences: Throwing Away the Key or the Taxpayers' Money?* RAND, 1997, Retrieved on Jan. 29, 2010 from www.fathom.com/media/PDF/2172_ss.pdf

²¹⁶ Center for Substance Abuse Treatment. The National Treatment Improvement Evaluation Study (NTIES). SAMHSA Publication No. SMA-97-3156. 1997, Retrieved on Jan. 29, 2010 from www.recoverymonth.gov/Resources-Catalog/2007/Targeted-Outreach/Recovery-Month-Toolkit-2007-Insurance-Providers.aspx

²¹⁷ "Substance Abuse Treatment and Public Safety," Justice Policy Institute, Jan. 2008, Retrieved on Jan. 30, 2010 from www.justicepolicy.org/images/upload/08_01_REP_DrugTx_AC-PS.pdf

²¹⁸ Ibid.

Nonetheless, increased use of drug treatment within the criminal justice system, whether it is mandated treatment through drug courts or optional treatment through transitional and aftercare programs, has been shown to reduce re-arrest and new arrest rates, as well as drug use.

Treatment in prison and jail settings can be effective, said researcher Faye Taxman of George Mason University, when testifying before the South Carolina Sentencing Reform Commission on June 26, 2009.²¹⁹ However, she said most correctional programs do not meet the criteria for effective programs because:

- They are too short (under 90 days).
- They tend to focus on education, not changing how offenders think (cognitive behavior).
- The programs are geared for everyone; offenders need programs that target their risk and need level.
- The staff of the treatment programs are generally not certified counselors, and therefore often do not have the clinical skills to change the behavior of offenders.

Treatment for incarcerated drug abusers should include continuing care, monitoring, and supervision after incarceration and during parole.²²⁰ South Carolina provides very few facilities specifically designed for re-entering ex-offenders apart from the Dept. of Probation, Parole and Pardons.

Treatment in South Carolina prisons²²¹

In 2006 the South Carolina Dept. of Corrections (SCDOC) held 22,871 inmates in its prisons. Of those 10,451 reported having a substance abuse problem, 45% of all inmates. In the prison system just 672 treatment beds were and are available today.

The SCDOC began providing substance abuse treatment in 1994. (Volunteers through Inmate Services and the chaplains provide Alcoholics Anonymous and Narcotics Anonymous programs.) In 2008, 4,485 inmates participated in treatment programs offered in 4 of the 28 state institutions:

Women's Recovery Academy: Located at the Leath Correctional Institution in Greenwood, SC, this is a 96-bed residential program for adult female offenders. The program is designed to provide offenders with 6-9 months of structured programming that is gender specific and uses a Therapeutic Community Model treatment approach.

Goodman Addiction Treatment Unit: Located at the Goodman Correctional Institution in Columbia, SC, this is a 47-bed residential program for young straight-time sentenced and youthful offender²²² females. The program is designed to provide offenders with 6 months of structured programming that is gender and age specific. The program uses a Therapeutic Community Model treatment approach.

²¹⁹ Faye S. Taxman, Ph.D., "4 Questions About Treatment and Correctional Programs," Retrieved on Dec. 15, 2009 from Retreat Presentations at www.scstatehouse.gov/citizensinterestpage/SentencingReformCommission/SentencingReform.html

²²⁰ *Principles of Drug Addiction Treatment: A Research Based Guide*, National Institute on Drug Abuse, Retrieved on Dec. 15, 2009 from www.drugabuse.gov/podat/faqs2.html

²²¹ All information provided by the S.C. Dept. of Corrections, 2009. Retrieved on Dec. 8, 2009 from www.doc.sc.gov and various emails as described elsewhere.

²²² Inmates sentenced under the Youthful Offender Act (aged 17 – 25) serve an indeterminate sentence of 1 – 6 years.

Correctional Recovery & Straight Ahead Academies: Located at the Turbeville Correctional Institution in Turbeville, SC, this is a 272-bed program for youthful offender males (17-25). The participation length is typically 6-9 months and is designed to address substance abuse, cognitive and behavioral issues specific to this age group.

The Horizon Addiction Treatment Unit: Located at the Lee Correctional Institution in Bishopville, SC, this is a proposed 384-bed residential program for males serving an adult straight-time sentence (256 beds are currently operational). The program is designed to address substance abuse, criminal-thinking and other life skill issues using a Therapeutic Community Model treatment approach for 6 months. Court ordered and conditionally paroled offenders with identified substance abuse program needs are assigned priority admission status.

The Screening, Identification & Orientation Program screens and identifies all newly admitted male and female offenders for potential substance abuse program needs. Inmates are admitted to substance abuse treatment based on the following criteria:

- Must be DOC-identified as chemically dependent and/or court-ordered to treatment;
- Have no current or past sex crime convictions;
- Offenders with pending charges must receive additional DOC approval;
- Must be medically cleared if medical restrictions exist at time of admission;
- Offenders classified as mentally ill must be medically and therapeutically stabilized prior to admission. Written approval from DOC's Division for Mental Health Services is required prior to admission review and approval;
- No documented history of assaulting behavior 6 months prior to admission.
- Must have no need for 24 hour medical care;
- Must be 17-25 years of age and sentenced as a Youthful Offender;
- Must meet custody/security level for the assigned institution;
- Must have at a minimum appropriate remaining sentence length from max out or one year from earliest parole eligibility date at time of admission.

Each prison serves a different segment of the prison population. The process of getting an inmate into treatment begins when the inmate enters the SCDOC. He or she is evaluated for need of treatment by a substance abuse professional, using the Texas Christian University Drug Dependency Screen (TCUDDS). (This is a free assessment tool for the SCDOC, and includes self-reporting by the inmate about substance abuse issues.)

Those with a substance abuse problem have this information noted on their prison records. Within 6 – 9 months of those inmates' expected release from prison, regardless of sentence length, the inmates are transferred to one of the 4 prisons that provide substance abuse treatment. This is not optional for the inmates. (Also, during an inmate's stay in prison, if

her or she is not already on the substance abuse track, the inmate may request to be put on it, which may be granted upon evaluation.)

**SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
2006 OFFENDER INFORMATION**

	#	%
Agency Population	22,871	
Report Substance Abuse Problem	10,451	45
Prior Commitments	5,192	42
Prior Criminal History	9,641	72
Report Having Children	8,680	65
Average Education Level	10.6	
Average Reading Score	8.4	
With Mental Health Problems	1,165	9
# Substance Abuse Treatment Beds *	672	
Average Time Served (in years) **	11.9	
Average Age @ Admission (in years) **	31	
Releases Completing ATU7/04-6/05	1,109	

Treatment provider personnel are either state employees (at Goodman and Lee prisons) or contracted through a for-profit agency (called the Correctional Educational Center) at Turbeville and Leath prisons.

Most (95%) of substance abuse treatment personnel have academic degrees, either from two-year programs, four-year programs, or master's level programs. However, only 10% of all substance abuse treatment personnel are certified professional substance abuse counselors. The SCDOC does not require certification or pay for personnel to obtain it.²²³ Although it would be an enhancement of an employee's qualifications, employees are reportedly reluctant to spend the money for certification that is not required.

Treatment lasts from 6 – 9 months, based on the individual's progress, and each inmate has an Individual Treatment Plan based on the inmate's needs and goals. Treatment is both educational in nature and based on changing how offenders think (cognitive behavior).

Inmates sentenced under the Youthful Offender Act (aged 17 – 25) serve an indeterminate sentence of 1 – 6 years, and they are similarly evaluated, and participate in similar substance abuse programs.

Funding for the substance abuse program has varied over the years. It began in 1998 with a federal grant that provided 75% of the money required, with the state providing the rest. Gradually the federal contribution decreased to the point in 2009 where the state now provides 100% of the program cost, over \$1 million. Several times over the past years the treatment programs have faced closure due to budget cuts. In fact, in two of the four

²²³ Certification is generally considered essential for the most effective treatment providers. DAODAS requires that all counselors in county agencies must be certified within 3 years of hire.

prisons, the substance abuse programs were shut down for 6 months in 1997, and for 9 months in 2008.

The Office of Public Safety applies for grants for the SCDOC.

The SCDOC cannot serve all inmates who need treatment. No prison other than the existing 4 has started an additional program, and one of the existing 4 has 128 beds available to expand that program if funds should become available. On the other hand, inmates who do not need such an intensive program do not get any help in their prisons. The current program is a one-size-fits-all, in-patient treatment model. The SCDOC would like to have substance abuse programs at each of its 28 institutions, but funding is not available to do that.

Are the programs working as shown by the prison recidivism statistics? It is not possible to say for sure, since statistics are not available for the same periods of time for the overall SCDOC population, as the 4 prisons with treatment programs.

The recidivism rate for the 4 prisons with treatment is the following:

SUBSTANCE ABUSE PROGRAMS AT LEATH, STATE PARK/GOODMAN, TURBEVILLE AND LEE										
FY 2006 RELEASEE RECIDIVISM RATES										
	LEATH		ST. PARK/GOODMAN		TURBEVILLE		LEE		TOTAL	
Number of inmates completing ATU programs FY 2000-2006:	861		390		1,039		1,396		3,686	
Number of inmates completing ATU programs FY 2000-2006, released during FY 2006	162		86		165		239		652	
Number of inmates completing ATU programs FY 2000-2006, who were released during FY 2006, and returned to SCDC within 3 years (recidivated)	42		19		95		92		248	
3 YEAR RECIDIVISM RATE - BY PROGRAM AND TOTAL RATE	25.9%		22.1%		57.6%		38.5%		38.0%	
RECIDIVISTS BY RELEASE TYPE:										
MAXOUT	9	21.4%	4	21.1%	0	0.0%	23	25.0%	36	14.5%
MAXOUT-YOA	0	0.0%	0	0.0%	6	6.3%	0	0.0%	6	2.4%
PAROLE	13	31.0%	2	10.5%	0	0.0%	15	16.3%	30	12.1%
PAROLE-YOA	0	0.0%	6	31.6%	89	93.7%	0	0.0%	95	38.3%
PROBATION	19	45.2%	7	36.8%	0	0.0%	47	51.1%	73	29.4%
COMMUNITY SUPERVISION	1	2.4%	0	0.0%	0	0.0%	7	7.6%	8	3.2%
TOTAL	42	100.0%	19	100.0%	95	100.0%	92	100.0%	248	100.0%
NOTE: The female ATU program at State Park moved to Goodman in October, 2001										

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The overall 3-year recidivism rate for the South Carolina Dept. of Corrections (for prisoners released) in 2003 (as determined in 2006, the latest year for which this statistic is available) was 32.7%.²²⁵ (Nationally, within three years of their release, 67% of former prisoners are rearrested and 52% are re-incarcerated, according to Confronting Confinement, a U.S.

²²⁴ S.C. Dept. of Corrections, provided by email on Feb. 2, 2010.

²²⁵ S.C. Dept. of Corrections, Retrieved on Jan. 29, 2010 from www.doc.sc.gov/research/SpecialReports/RecidivismRatesofInmatesReleasedDuringFY1998-FY2003.pdf

prison study by the Commission on Safety and Abuse in America's Prisons, in June 2006.²²⁶ We cannot explain the difference between South Carolina's and national recidivism rates.)

Inmates may fail to complete programming if they develop a health problem that changes the kind of facility where they must be housed; if the inmate cannot comply with the rigors of the program; if an inmate with whom an inmate cannot associate, is already participating in the program. Successful completion means that the inmate has completed all requirements of the program and has demonstrated change to the satisfaction of the staff.

Upon release from prison, all the programs refer inmates to local aftercare programming (AA, NA, Vocational Rehabilitation, etc) in an effort to maintain a support system on the outside. It is not unusual for graduates of the program to maintain contact with the treatment staff at the institutions if they have questions, problems, etc. Annually, the staffs of all four programs have a Recovery Celebration event. Inmates who have made the successful transition back into the community are often invited and share their journey with others.

Treatment in South Carolina jails

Characteristics of South Carolina jails²²⁷

Each of South Carolina's 46 counties has a jail except for Lee and Orangeburg Counties, which share a jail, and there are a few city jails where people stay for 24 hours or less. Sheriffs run 33 of the jails, which are responsible to their county councils for financial assistance; the rest are run by county governments, like Richland County, and the jail administrator works for the county administrator. All jails get their money through county appropriations, with some from the federal government, but nothing from the state.

Jails are not under the authority of the South Carolina Dept. of Corrections, but minimum standards are required of jails, and the Dept. of Corrections inspects them to make sure the standards are met. The South Carolina Jail Accreditation Council has developed a state jail accreditation program that requires even higher standards, but so far no jail has reached this level. This higher standard would help make jails safer for employees, inmates and the public, and reduce suicides and lawsuits.

Occupying the jail cells are people who either await trial and can't make bond, or have been denied bond; people with misdemeanor sentences of 90 days or less; people arrested on bench warrants for failure to pay child support; and federal prisoners housed at jails under a rental agreement. South Carolina jails are rated at a capacity of 9,973, but many of them are overcrowded.²²⁸

For this study, we tried to find out how many people are currently in jail in South Carolina for a drug offense, along with other information about the offenders. We were unsuccessful. There is no central database of people arrested in all SC county jails.

²²⁶ *Confronting Confinement*, June, 2006, Vera Institute of Justice, Retrieved on Feb. 1, 2010 from www.vera.org/download?file=2845/Confronting_Confinement.pdf

²²⁷ All information in this section is from a phone conversation with Jeffrey B. Moore, Exec. Dir. of the S.C. Sheriffs' Association, Nov. 2, 2009.

²²⁸ "Statistics for the State of South Carolina," National Institute of Corrections, Retrieved on Jan. 3, 2010 at <http://nicic.gov/Features/StateStats/?State=SC>

There is an existing jail database under the auspices of the S.C. Dept. of Corrections, but few jails have contributed to it. Jeffrey B. Moore, Executive Director of the South Carolina Sheriffs' Association, told us that eight or ten years ago he got a federal Byrne Grant to pay for the software to develop the database by The Solutions Group, headed by Dr. Joseph Johnson at the University of South Carolina's Dept. of Physics, and students wrote several criminal justice programs for it. The South Carolina General Assembly passed a law requiring all jails to provide their information to the database, but most refuse because they think it will take too much of their time and the counties don't want to pay \$10,000 for the custom software needed to export data from the jails' existing diverse jail management systems. About six jails do contribute data to the central database. There is no punitive part of the law for non-compliance. The original purpose of the database was to track people with communicable diseases, like TB and HIV/AIDS, and to inform the S.C. Dept. of Corrections about who is in jail, their trial dates and possible sentences, so that the Dept. of Corrections can better plan for new prisoners.

How South Carolina jails address the need for treatment

Although we did not find exact statistics (see above), it is reasonable to assume that just as in South Carolina prisons (where statistics are known and current), more people are in South Carolina jails for drug offenses than for any other reason. Unlike prisons, many inmates remain in jail for only a brief time, but others may be serving sentences for months, or even stay up to two years or more while awaiting trial. Therefore, we wanted to find out if jails are providing substance abuse treatment for inmates, so we contacted a representative sample of county jails (19 of the 45)²²⁹ to ask that question. This is what we found:

- Some jails offer no substance abuse programs at all. Reasons included the size and transient nature of their population, lack of funds for treatment professionals, lack of space, and lack of volunteers.
- Some jails offer only Alcoholics Anonymous (AA) and Narcotics Anonymous (NA)²³⁰ programs run by volunteers, or would like to run them if volunteers were available, which they often are not.
- Some jails without on-site programs drive a few inmates to the local DAODAS facility for treatment.
- A few jails offer extensive substance abuse treatment programs (examples described below).

²²⁹ By phone and emails, Oct. – Dec. 2009, to jails in the following counties: Aiken, Anderson, Bamberg, Berkeley, Barnwell, Charleston, Cherokee, Chester, Clarendon, Dillon, Dorchester, Edgefield, Fairfield, Florence, Greenville, Greenwood, Horry, Jasper, Spartanburg.

²³⁰ In an email on Oct. 6, 2009, Mark Cowell, Director of the Charleston Center, defined AA, NA, drug education and substance abuse treatment: Treatment is a service provided by licensed or certified healthcare professionals and it requires a diagnosis of dependency. Education programs fall under the prevention category. ADSAP for DUI offenders, for instance, is an education program. Not everyone who gets stopped for a DUI has alcoholism, so mandated education is done to help them understand and learn about risks. Many people abuse alcohol or drugs, and then, for many reasons, stop, but some people develop the disease of addiction. It is just like some people with high blood pressure or high cholesterol are able to manage their condition with medication, diet and exercise, but others have heart attacks. AA and NA are peer-support programs in the category of long-term aftercare. Cowell said he would compare AA to an exercise program that someone follows after having had a heart attack. Once the patient has survived the heart attack and had surgery or stent or some other medical intervention, they then need to make behavioral changes to reduce the chance of another heart attack. AA is a behavioral activity that reduces the chance of a relapse. However, in any "chronic" illness, there is an expectation that a certain percentage will suffer setbacks...a second heart attack or a return to drug use.

- Only one jail charges inmates a fee to participate in treatment.²³¹
- Jails that have programs are often assisted by their county alcohol and drug facilities, but even those programs sometimes end because of funding cutbacks.
- No jail with a substance abuse treatment program has done a follow-up study to see if the program reduces recidivism.

Some jail treatment programs of note

- **Charleston County Detention Center:** Substance abuse treatment has been available since 1997. During the last fiscal year, 63,875 inmates spent at least one day in the jail. The treatment program in that period included 676 inmates (601 men, 75 women, 457 black, 191 white, and 10 Hispanic). No one was turned down from participating for lack of space in the program, but as many as 750 likely participants were excluded because they were too violent. Treatment is provided by four fulltime, on-site therapists and a program director, all either certified or in the process of certification. Treatment lasts from 12 – 16 weeks or longer, plus 8 weeks of aftercare at the Charleston Center (the Charleston County DAODAS facility for community treatment). The criterion for participation is that inmates must have at least one diagnosis of chemical dependency.

The programs at the jail are a mixture of treatment and education, because not everyone has a diagnosis of dependency. AA and NA programs by volunteers are available, as are volunteer staff from the Charleston Center who present educational material. Inmates also run their own meetings as often as they want. The program also coordinates people to come in from other volunteer resources in the community, such as Vocational Rehabilitation, SC Strong (a prison reentry jobs project), Family Services, Drug Court, to present information and services they can offer inmates. Like all other jail programs we found that there has not been a formal study to see if the Charleston County program has reduced recidivism, but outcome data is gathered by the Charleston Center on a random basis.²³²

- **Greenville County Detention Center:** Have provided treatment since November 2006. In 2008 there were 21,430 people who spent at least one day in the jail. That year 85 inmates participated in substance abuse treatment (52 men and 33 women). As many as 260 inmates wanted to participate, but there was no space for them. Treatment lasts 6 – 8 weeks. Inmates must have no controlled substances prescribed, but symptoms related to mental illness would not preclude them from treatment. To run the program the Greenville County Council provides funds for two on-site mental health counselors, who are either licensed professional counselors or certified addictions counselors.²³³
- **Horry County:** Now working under a grant to set up a substance abuse treatment program. It is a jail diversion program for non-violent, non-sex offenders, and it is contracted to Life Recovery Solutions LLC. At least 70% of inmate charges are drug and/or alcohol related, so they are trying to intervene, instead of just sentencing

²³¹ Charleston County Detention Center charges \$500 per inmate. If they meet federal poverty guidelines, they don't have to pay. Mark Kuhn, Charleston County Detention Center, on Oct. 26, 2009.

²³² Emails from Mark Kuhn, Administrator, Persons Incarcerated Entering Recovery, Charleston County Detention Center, and Mark Cowell, Director, Charleston Center, Oct. 26 – Nov. 12, 2009.

²³³ Phone and email with Marie Livingston, Mental Health Administrator, Greenville County Detention Center, Oct. 20 - 26, 2009.

offenders to jail. They hope that participants can have their sentence reduced. The program is modeled on The Healing Place in Louisville, Kentucky. While it may take two years to show results, they are confident it will. They expect to have a pod of participants in their minimum security facility by mid-February.²³⁴

²³⁴ Email and phone with Gareth Beshears, Program Service Director, Life Recovery Solutions LLC, on Dec. 12, 2009 and Jan. 4, 2010.

Chapter 7

African-Americans and Hispanics—Disproportionately Incarcerated for Drug Offenses

Nationally, more than 60% of people in prison are now racial and ethnic minorities. For black males in their twenties, 1 in every 8 is in prison or jail on any given day. These trends have been intensified by the disproportionate impact of the "war on drugs," in which three-fourths of all persons in prison for drug offenses are people of color.²³⁵ But read on, because the pendulum has started swinging in the opposite direction.

What is racial disparity?

(Editor's Note: We are indebted to The Sentencing Project for the following insights from their booklet, *Reducing Racial Disparity in the Criminal Justice System*.²³⁶)

Racial disparity in the criminal justice system exists when the proportion of a racial or ethnic group within the control of the system is greater than the proportion of such groups in the general population. The causes of such disparity are varied and can include differing levels of criminal activity, law enforcement emphasis on particular communities, legislative policies, and/or decision making by criminal justice practitioners who exercise broad discretion in the justice process at one or more stages in the system.

Illegitimate or unwarranted racial disparity in the criminal justice system results from the dissimilar treatment of similarly situated people based on race. In some instances this may involve overt racial bias, while in others it may reflect the influence of factors that are only indirectly associated with race. Moreover, in some cases disparity results from unguarded, individual- or institution-level decisions that are race-based. Structural racism, derived from the longstanding differential treatment of those with characteristics highly correlated with race (e.g., poverty) can cause or aggravate racial disparity as well.

How racial disparity happens

Statistics at the community and national level show the cumulative impact of racial disparity through each decision point in the criminal justice system. Decisions made at one stage contribute to increasing disparities at subsequent stages. For example, if bail practices result in minorities being detained before trial at greater rates than similarly situated whites, they will also be disadvantaged at trial and sentencing by having reduced access to defense counsel, community resources, and treatment options.

Issues of both race and class have an impact on the likelihood of involvement with the criminal justice system and treatment within the system. For instance, low-income individuals are generally overrepresented at every stage of the criminal justice system, and it is widely acknowledged that people of color are disproportionately low-income.

²³⁵ "Racial Disparity," The Sentencing Project, Retrieved on Jan. 24, 2010 from www.sentencingproject.org/template/page.cfm?id=122

²³⁶ "Reducing Racial Disparity in the Criminal Justice System," The Sentencing Project, 2008. Retrieved on Jan. 24, 2010 from www.sentencingproject.org/doc/publications/rd_reducingracialdisparity.pdf

These dynamics have been partially true in regard to drug offenses, where African Americans are particularly overrepresented in drug arrests. (Italics added.) Evidence of racially disparate treatment of drug arrestees is apparent by viewing the rate of reported drug use among African Americans. According to self-report data from the U.S. Department of Health and Human Services, African Americans constituted 14% of drug users in 2006, only slightly higher than their percentage in the general population. Yet African Americans represented 35% of those arrested in 2006 for drug offenses, 53% of drug convictions, and 45% of drug offenders in prison in 2004 (the most recent year for which prison data are available).

The next two tables show the disparity between use (1999-2005) and incarceration (2006).

TABLE 3: RACIAL/ETHNIC PROPORTION OF REGULAR DRUG USERS, 1999-2005

Year	White %	Black %	Hispanic %
1999	72.1	13.4	10.2
2000	74.8	11.5	9.1
2001	74.2	11.9	9.9
2002	71.8	13.3	10.7
2003	71.0	12.3	12.2
2004	70.7	12.7	11.7
2005	69.2	14.0	12.4

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TABLE 1 - Racial and Ethnic Rates of Incarceration

RACIAL/ETHNIC GROUP	RATE PER 100,000
White	412
Black	2,290
Hispanic	742

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Another factor that exacerbates the disparate rate of incarceration among minorities is criminal history: the more serious a prior criminal record, the greater the likelihood of receiving a prison term for a new offense. Arrest is partly a function of location; areas that experience more public reporting of crime and a greater police presence also have more arrests, so these are also the areas—predominately minority neighborhoods—that

²³⁷ Marc Mauer, *The Changing Racial Dynamics of the War on Drugs*, The Sentencing Project, April 2009, Retrieved on Jan. 24, 2010, from www.sentencingproject.org/doc/dp_raceanddrugs.pdf

²³⁸ Marc Mauer and Ryan S. King, *Uneven Justice: State Rates of Incarceration by Race and Ethnicity*, The Sentencing Project, July 2007, Retrieved on Jan. 24, 2010 from www.sentencingproject.org/doc/publications/rd_stateratesofinbyraceandethnicity.pdf

experience higher rates of incarceration. A study of young offenders' arrest, detention and incarceration rates found that, even adjusting for criminal history and seriousness of offense, minority youth were more likely than white youth to be detained, formally charged, transferred to criminal court and incarcerated. Having established a criminal record at an early age, both the likelihood of their future involvement in the system and the likelihood of receiving harsher punishments are increased.

In summary, says The Sentencing Project, claims that racial disparities in the criminal justice system reflect disparate minority offending in crime are incomplete. If law enforcement resources are heavily focused in poor neighborhoods, if the public safety strategy consists mostly of arrest and prosecution, and if there are insufficient economic, educational, and social service resources, racial disparities in criminal justice outcomes are inevitable.

The racial impact of the War on Drugs

The series of drug policies that collectively became known as the War on Drugs has had a profound impact on both the number and composition of people who are incarcerated for a drug offense. *As we have noted, people of color are imprisoned for drug offenses at rates that greatly exceed their proportion of the drug-using population.* (Italics added.) This is due in part to law enforcement practices, but is also related to drug sentencing policies that have been enacted since the 1980s at both the federal and state level. Every state now has some form of mandatory sentencing, often applying to drug offenses.

At the federal level, the mandatory five- and ten-year sentencing policies adopted for crack cocaine offenses in the 1980s have been the subject of much analysis and criticism for the racial disparities they produce relative to powder cocaine offenses. (*Editor's note: See "South Carolina Drug Laws" in Chapter 5 of this report for commentary on how the state has equalized formerly unequal crack and powder cocaine penalties.*) While the federal sentencing guidelines for crack and powder cocaine offenses were amended by the U.S. Sentencing Commission in 2010,²³⁹ mandatory penalties are still in place.²⁴⁰ Many analysts have contended that the racial disparities resulting from these laws could have been predicted in advance had lawmakers engaged in a rational assessment of likely outcomes. (See Chapter 8 in this document for more.)

Had these predictable effects been identified and considered early on, different responses to the drug problem might have been developed. Representatives of the communities most likely to be affected might have been actively engaged in thinking through a more comprehensive, less damaging, and more effective strategy for addressing local drug problems. More reasonable distinctions between minor and major drug offenses might have been enacted. Studies indicate that many drug sellers are in the drug trade primarily to support their own addiction.

The figures among those in jail are even starker: 68% of jail inmates surveyed met the criteria for substance abuse or dependence. In many of these cases, enrollment in a substance abuse treatment program would have been a more constructive option than

²³⁹ "Historic Reform: Congress Lowers Penalties for Crack Cocaine," The Sentencing Project, July 28, 2010. Retrieved on Aug. 8, 2010 from www.sentencingproject.org/detail/news.cfm?news_id=966&id=167

²⁴⁰ Congress is considering changes at this time.

prison, where offenders are likely to receive insufficient treatment for their problem. A range of alternative responses for minor offenders, including broadly available drug treatment, might have been established. The discretion required to accurately distinguish between low-level drug sellers and professionals in the drug trade might have been left to the courts, which explore the actual circumstances of the offense and the histories of the offenders. Large-scale public financing of policing and incarceration might have been shifted to a significant degree for education, prevention, and treatment programs in the communities where the problem was most pronounced.²⁴¹

The numbers tell the story

If current trends continue, one in three black males born today can expect to spend time in prison during his lifetime. The prevalence of imprisonment for women is considerably lower than for men, but many of the same racial disparities persist, with black women being more likely to be incarcerated than white women.²⁴²

Black children (and all children on average) of incarcerated parents are five times more likely than their peers to commit crimes. However, these at-risk children are largely ignored before they get in trouble. Often, they are left to fend for themselves emotionally, and the stress of child-rearing falls on a grandmother or another surrogate parent, or the children may end up in protective services. Common are mental health issues like depression, anxiety, post-traumatic stress disorder and feelings of abandonment.²⁴³

A significant development in the past decade has been the growing proportion of the Hispanic population entering prisons and jails. In 2005, Hispanics comprised 20% of the state and federal prison population, a rise of 43% since 1990. As a result of these trends, one of every 6 Hispanic males and one of every 45 Hispanic females born today can expect to go to prison in his or her lifetime. These rates are more than twice those for non-Hispanic whites.²⁴⁴

²⁴¹ *Reducing Racial Disparity in the Criminal Justice System*, The Sentencing Project, pp. 1-3, Retrieved on Jan. 24, 2010 from www.sentencingproject.org/doc/publications/rd_reducingracialdisparity.pdf

²⁴² Marc Mauer and Ryan S. King, *Uneven Justice: State Rates of Incarceration by Race and Ethnicity*, The Sentencing Project, July 2007, Retrieved on Jan. 24, 2010 from www.sentencingproject.org/doc/publications/rd_stateratesofincbyraceandethnicity.pdf

²⁴³ "Incarcerated-Children of Parents in Prison Impacted," Texas Dept. of Criminal Justice, Go Kids Articles, DefenderNetwork.com, E. Mosely, July 6-12, 2008, Retrieved on Feb. 2, 2010 from www.tdcj.state.tx.us/pgm&svcs/gokids/gokids-articles-incarcerated-children-of-parents-impacted.html

²⁴⁴ Marc Mauer and Ryan S. King, *Uneven Justice: State Rates of Incarceration by Race and Ethnicity*, The Sentencing Project, July 2007, Retrieved on Jan. 24, 2010 from www.sentencingproject.org/doc/publications/rd_stateratesofincbyraceandethnicity.pdf

TABLE 6 – Prison & Jail Incarceration Rates, 2005, By BLACK-TO-WHITE RATIO
Rate of Incarceration per 100,000 Population

State	White	Black	B-TO-W RATIO	State	White	Black	B-TO-W RATIO
District of Columbia	56	1065	19.0	Virginia	396	2331	5.9
Iowa	309	4200	13.6	Oregon	502	2930	5.8
Vermont	304	3797	12.5	Arizona	590	3294	5.6
New Jersey	190	2352	12.4	West Virginia	392	2188	5.6
Connecticut	211	2532	12.0	NATIONAL	412	2290	5.6
Wisconsin	415	4416	10.6	Michigan	412	2262	5.5
North Dakota	267	2683	10.0	Maryland	288	1579	5.5
South Dakota	470	4710	10.0	Indiana	463	2526	5.5
Rhode Island	191	1838	9.6	North Carolina	320	1727	5.4
New York	174	1627	9.4	Missouri	487	2556	5.2
New Hampshire	289	2666	9.2	Kentucky	561	2793	5.0
Pennsylvania	305	2792	9.2	Texas	667	3162	4.7
Utah	392	3588	9.2	Louisiana	523	2452	4.7
Minnesota	212	1937	9.1	Nevada	627	2916	4.7
Illinois	223	2020	9.1	South Carolina	415	1856	4.5
Nebraska	290	2418	8.3	Florida	588	2615	4.4
Montana	433	3569	8.2	Oklahoma	740	3252	4.4
Massachusetts	201	1635	8.1	Alaska	500	2163	4.3
Maine	262	1992	7.6	Idaho	675	2869	4.3
Kansas	443	3096	7.0	Tennessee	487	2006	4.1
Colorado	525	3491	6.6	Arkansas	478	1846	3.9
California	460	2992	6.5	Alabama	542	1916	3.5
Washington	393	2522	6.4	Mississippi	503	1742	3.5
Ohio	344	2196	6.4	Georgia	623	2068	3.3
Delaware	396	2517	6.4	Hawaii	453	851	1.9

* Incarceration rates based on data from the Bureau of Justice Statistics, *Prison and Jail Inmates at Midyear 2005*. New Mexico and Wyoming have been excluded due to lack of data on race and ethnicity.

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NOTE: We include these numbers from 2005 with both prison and jail populations to show South Carolina's relative position. We do not have population statistics from 2009 for South Carolina jails (see Chapter 5) but South Carolina admission prison numbers for 2009 are shown on the following page:²⁴⁶

²⁴⁵ Marc Mauer and Ryan S. King, *Uneven Justice, State Rates of Incarceration by Race and Ethnicity*, The Sentencing Project, July 2007, Retrieved on Jan. 24, 2010 from www.sentencingproject.org/doc/publications/rd_stateratesofincbyraceandethnicity.pdf

²⁴⁶ S.C. Dept. of Corrections, Retrieved on Feb. 4, 2010 from www.doc.sc.gov/research/statistics.jsp

Total admitted to South Carolina prisons in 2009 for all offenses combined:

Black males:	5,355	White males:	2,816
Black females:	578	White females:	664
Other males:	344	Other females:	21

Total admitted to South Carolina prisons in 2009 for the offense of dangerous drugs:

Black males:	1,823	White males:	452
Black females:	127	White females:	129
Other males:	85	Other females:	8

But the disproportionate numbers are changing a bit—at state levels across the nation

(Note: In this section we are indebted to The Sentencing Project, for the following information from their booklet, *The Changing Racial Dynamics of the War on Drugs*.)²⁴⁷

There has been a significant shift in the racial composition of people incarcerated at the state level for a drug offense (Table 1)—but not in federal prisons (Table 2).

- The number of African Americans in state prisons for a drug offense declined by 21.6% from 1999-2005, a reduction of more than 31,000 persons.
- The number of whites incarcerated for a drug offense rose significantly during this period, an increase of 42.6%, representing an additional 21,000 persons in prison.

TABLE 1: DRUG OFFENDERS IN STATE PRISON BY RACE/ETHNICITY, 1999-2005

	1999	2000	2001	2002	2003	2004	2005	Change, 99-05
All Drug Offenders	251,200	251,100	246,100	265,000	250,900	249,400	253,300	0.8%
White #	50,700	58,200	57,300	64,500	64,800	65,900	72,300	42.6%
White %	20.2%	23.2%	23.3%	24.3%	25.9%	26.4%	28.5%	
Black #	144,700	145,300	139,700	126,000	133,100	112,500	113,500	-21.6%
Black %	57.6%	57.9%	56.8%	47.5%	53%	45.1%	44.8%	
Hispanic #	52,100	43,300	47,000	61,700	50,100	51,800	51,100	-1.9%
Hispanic %	20.7%	17.2%	19.1%	23.3%	20%	20.8%	20.2%	

²⁴⁷ Marc Mauer, *The Changing Racial Dynamic of the War on Drugs*, The Sentencing Project, April 2009, Retrieved on Feb. 4, 2010 from www.sentencingproject.org/doc/dp_raceanddrugs.pdf

TABLE 2: DRUG OFFENDERS IN FEDERAL PRISON BY RACE/ETHNICITY, 1999-2005

	1999	2000	2001	2002	2003	2004	2005	Change, 99-05
All Drug Offenders	71,757	76,041	80,888	84,674	89,325	91,646	95,211	32.7%
White #	16,492	17,547	18,303	19,346	20,539	21,176	22,251	34.9%
White %	23%	23.1%	22.6%	22.9%	23%	23.1%	23.4%	
Black #	31,097	33,068	35,537	36,718	38,341	39,353	40,812	31.2%
Black %	43.3%	43.5%	43.9%	43.4%	42.9%	42.9%	42.9%	
Hispanic #	23,095	24,337	25,939	27,388	29,010	29,493	30,279	31.1%
Hispanic %	32.2%	32%	32.1%	32.4%	32.5%	32.2%	31.8%	

What happened to cause the changes at the state level?

- The use of crack cocaine has declined substantially since the peak years of the late 1980s.
- As use of crack cocaine was declining in the 1990s, so too were the methods of its sale in many cases. In criminologist Richard Curtis's ethnographic studies in Brooklyn, N.Y., he found that by the late 1990s many drug sellers had shifted their transactions to indoor locations as well as limited their sales to people known to them.
- Arrests and convictions may have declined because of the crack factors above, along with fewer long sentences associated with crack cocaine.
- There remains debate regarding the degree to which drug courts may have a "net-widening" effect; that is, do they divert people from a term of incarceration or bring under court supervision people who might otherwise not be processed in the court system? There are not yet definitive findings in this regard, but it is likely that at least in some jurisdictions there are people charged with a drug offense who are diverted from a prison term due to drug court programming. Whether such an outcome disproportionately benefits African Americans is in part a function of the location of such diversion programs. To the extent that they are located in urban areas with heavy concentrations of people of color as defendants, this may be the case.

While these trends are welcome as a possible indication of a change in policy and practice, they need to be tempered by an assessment of the overall scale of incarceration and punishment. Even with the declines noted here, there are still 900,000 African Americans incarcerated in the nation's prisons and jails. To place this in context, at the time of the *Brown v. Board of Education* decision in 1954, that figure was 100,000.

Many of the driving forces that have contributed to these record numbers still remain very much in place. The high level of drug arrests, widespread adoption of mandatory sentencing policies, increase in length of prison terms, and other policies continue to drive the prison population even as crime rates have generally declined for more than a decade. And despite the decline in the number of African Americans incarcerated for a drug offense, the overall record number of people in prison for a drug offense still persists. While the racial

dynamics of incarceration for drug offenses have shifted, there remains the question of whether massive imprisonment for drug problems is either an effective or compassionate strategy.²⁴⁸

Racial disparities in South Carolina

It is too soon, at this writing (August, 2010) to accurately predict how the sentencing reforms enacted by the South Carolina General Assembly in 2010 will change the following racial statistics in future years. No doubt these statistics will change, for the intent of the reforms was to stop sending low-level, non-violent drug offenders to jail or prison. See Chapter 1 in this report for details about changes in drug laws enacted by the Omnibus Crime Reduction and Sentencing Reform Act of 2010.

And as we noted in Chapter 5 of this report in the section called “South Carolina Drug Laws,” for many years South Carolina’s sentences were much harsher for crack cocaine offenses than similar ones for powder cocaine. In 2005 and 2010, the General Assembly equalized all penalties for crack and powder cocaine.

Full state-level statistics in 2009 for the South Carolina Dept. of Corrections show a ratio of four black men to one white:

MSO Category Dangerous Drugs broken down by Ethnicity and Gender for Inmates Admitted in FY 2009			
Ethnicity / Race	Male	Female	Total for Ethnicity / Race
AMERICAN INDIAN	2	0	2
ASIAN	6	1	7
BLACK	1,823	127	1,950
HISPANIC	65	2	67
OTHERS	11	5	16
PACIFIC ISLANDER	1	0	1
WHITE	452	129	581
Total for Gender	2,360	264	2,624

²⁴⁹

As discussed before in this report, blacks are more likely to use crack than powder cocaine, for economic reasons, and police are more likely to make arrests in crowded, lower economic neighborhoods, where blacks are more likely to live. Therefore, the next chart showing the most frequently reported drug offense that sent inmates to South Carolina prisons should not be surprising.

²⁴⁸ Ibid.

²⁴⁹ Provided by email on Nov. 16, 2009 by the South Carolina Dept. of Corrections.

Possession of crack cocaine was the most frequently reported drug offense among inmates admitted to SCDC.

**TOP TEN DRUG OFFENSES
PRISON DRUG ADMISSIONS
FY 00 – FY 07**

Offense	Number	Percent
Crack possession	10,774	17.7%
Cocaine possession	5,237	8.6%
Crack distribution	4,726	7.8%
Marijuana possession	3,979	6.5%
Marijuana poss. with	3,954	6.5%
Cocaine distribution	3,762	6.2%
Cocaine poss. with	3,590	5.9%
Crack poss. with	3,265	5.4%
Crack distribution in proximity of a school	3,230	5.3%
Mfg. or dist. crack, 2nd offense	2,307	3.8%

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It is not surprising, either, that blacks should be disproportionately represented among clients of the South Carolina Dept. of Probation, Parole and Pardons, as shown below.

**SCDPPPS DRUG ADMISSIONS BY RACE
FY 96 – FY 07**

Race	Number	Percent
Asian	80	0.1%
Black	65,430	65.6%
Hispanic	592	0.6%
Native American	108	0.1%
Other	272	0.3%
White	33,327	33.4%
Total	99,809	100.0%

Notes: SCDPPPS defined Hispanic as a racial category, not as an ethnicity category. Twenty two offenders were missing race data. The percent column does not add up to 100 due to rounding.

Source: SCDPPPS, offender records.

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²⁵⁰ Rob McManus, Editor, *Altered States in the Palmetto State: Statistical Indicators of Illegal Drug Use*, p. 56, June 2008, South Carolina Dept. of Public Safety, Retrieved on Jan. 29, 2010, from www.scdps.org/ojp/statistics/Altered%20States%20in%20SC.pdf

²⁵¹ Ibid., p. 88.

Chapter 8

Alternatives to the War on Drugs

Why alternative policies may be needed

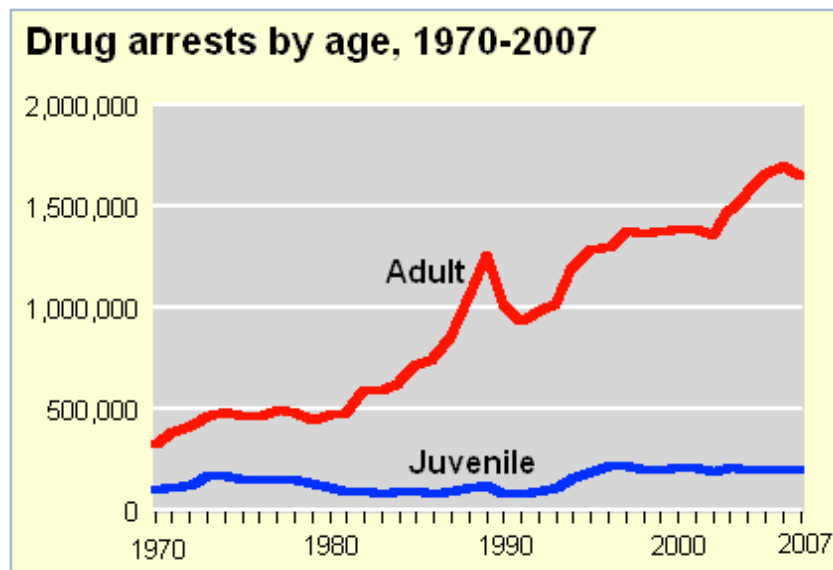
After spending more than a trillion tax dollars to fight the 40-year-old War on Drugs, and after making more than 39 million arrests for nonviolent drug offenses, while separating families and destroying many lives through prison convictions, these are the results:²⁵²

Percent of the U.S. population addicted to drugs:

1914 – 1.3%

1970 – 1.3%

2004 – 1.3%



²⁵² Bureau of Justice Statistics, Key Facts at a Glance, Retrieved on 2/02/2010 from <http://bjs.ojp.usdoj.gov/content/glance/drug.cfm>

Street price and purity of illegal drugs:

Drug	Price per gram 1981	Purity	Price per gram 2007	Purity
Powder cocaine ²⁵³	\$613.10	40%	212.82	64%
Crack cocaine	\$345.00 (1986)	85%	167.15	75%
Methamphetamine	433.40	45%	185.81	61%
Heroin	\$1,887.61	11%	\$364.01	36%
Marijuana ²⁵⁴	\$7.81 (1986)	3.44%	\$10.41	7.18% Fed 1.92% State or local

Legalize and regulate all drugs²⁵⁵

Superior Court Judge James P. Gray in Los Angeles is a former prosecutor, criminal defense attorney in the Navy JAG Corps, and a Republican. He does not use drugs or approve of their use. Even so, for years he has been on a mission to legalize and regulate the distribution of all drugs, while holding drug users responsible for their conduct, and putting society's efforts into programs that he says do work.

This is his motivation: Years on the bench seeing failed drug laws, overcrowded prisons, and obscenely wealthy drug sellers. Observation that the drug-related corruption of public officials and private citizens has been responsible for revolutionary movements and worldwide terrorism, and that drug-addicted people are unnecessarily committing crimes and contracting dangerous diseases, which they are spreading to other people.

Judge Gray argues that legalizing drugs much like alcohol would make drugs easier to control, regulate and police through this legal market than our current illegal one. Now there are no controls at all on illegal drugs under our policy of zero tolerance—except those implemented by drug dealers. Legalized drugs would eliminate the crime and violence associated with current illegal drug sellers, and avoid the impurities in drugs that cause dangerous overdoses.

Judge Gray's picture of legalization would allow only adults to buy drugs at state-licensed package stores for far less than the cost of current street drugs, eliminating the profitability of illegal sales. Drugs would never be advertised. Along with the dose would be a sterile disposable needle (when appropriate) and educational materials about the dangers of using drugs, and information about organizations that could assist the user in quitting drugs. The FDA would monitor the quality of the drugs. Transfer or sale of a drug to a minor, or driving under the influence, would be severely punished.

²⁵³ Office of National Drug Control Policy, July 2008. The Price and Purity of Illicit Drugs: 1981 – 2007. Same source for crack, meth, heroin and marijuana

²⁵⁴ National Center for Natural Products Research (NCNPR), Research Institute of Pharmaceutical Sciences (De. 16, 2007—March 15, 2008. Potency Monitoring Project, Quarterly Report 100. University of Mississippi

²⁵⁵ Why Our Drug Laws Have Failed and What We Can Do About It, Judge James P. Gray, Temple University Press, 2001.

As to whether or not legalizing drugs would increase their use, Judge Gray is unsure. He cites the experience of Holland, where people can use marijuana without being arrested, but fewer people use it there than in the United States. (Note: This is true in other countries, also, and described later in this chapter.)

Judge Gray cites programs that he believes do work: Educational programs that tell people the truth about drugs. Needle exchange programs (more on this later in this chapter). Medical marijuana (more later in this chapter). Letting doctors instead of police decide on appropriate medications for illnesses, while holding doctors accountable for any possible abuses. Early intervention in juvenile problems before they become offenders. Community policing. Strictly administered probation for nonviolent offenders (more later in this chapter). Drug treatment available on demand for all who want and need it. Drug courts for appropriate nonviolent but problem drug users. Drug substitution and maintenance programs. Safe passage to seek medical care. Repeal of mandatory minimum sentences for nonviolent criminal offenses.

The following ad appeared in the National Review, the New Republic, the American Prospect, The Nation, Reason Magazine, and The Progressive in the winter of 2008.²⁵⁶

***If hard drugs such as heroin or cocaine were legalized
would you be likely to use them?
99% SAY "NO"***

Zogby International asked that question of 1,028 likely voters. Ninety-nine out of 100 said "No." Only 0.6 percent said "Yes."¹

Drug War advocates have always insisted that addiction would explode if drugs were legalized. But that argument comes apart under the weight of the evidence. While a poll can't predict actual drug use, it clearly shows that most of us avoid hard drugs because of common sense – not fear of arrest.

And that's always been the case. At the beginning of the last century when a virtual free market for drugs existed, use rates were lower than they are today.² Drug use and addiction – along with crime, violence and corruption – only began to climb after the advent of drug prohibition in 1914.³

Isn't it time to end the War on Drugs? Let's turn addiction problems over to the people who dealt with them effectively before 1914 – doctors, nurses and health care professionals.

Common Sense for Drug Policy

www.CommonSenseDrugPolicy.org www.DrugWarFacts.org
www.ManagingChronicPain.org www.MedicalMJ.org
www.TreatingDrugAddiction.org
info@cspd.org

1. Zogby America Poll of Likely Voters 10/24/07 thru 10/27/07, "If hard drugs such as heroin or cocaine were legalized, would you be likely to use them?" sponsored by StoptheDrugWar.org, full results and other info online at stopthedrugwar.org. 2. Speaking out against drug legalization, [US Drug Enforcement Administration](http://www.USDrugEnforcementAdministration.gov), and Courtwright, David T., "Dark Paradise: A History of Opiate Addiction in America" (Cambridge, MA: Harvard University Press, 2001), p. 9; 3. Courtwright, "Dark Paradise," 2001.

Full source notes for the above ad are available [by clicking here](#).

Decriminalize marijuana and other drugs for personal use

Many people are confused by the terms “legalization” and “decriminalization.” Legalization means “to make legal or lawful.”²⁵⁷ Decriminalization means “to reduce or abolish criminal penalties for.”²⁵⁸

The major benefits of decriminalizing drugs in small amounts for personal use are to avoid the arrest, prosecution, and court disposition of thousands of people each year, with the related financial costs, and free the criminal justice system to focus on more important public safety matters.

Marijuana is the drug most often decriminalized by states. In South Carolina possession of one ounce or less of marijuana, first offense, is a misdemeanor with a possible sentence of up to 30 days in jail and a fine of \$100 - \$200. For a subsequent offense it is a misdemeanor with a possible sentence of up to one year in prison and a fine of \$200 - \$1,000.²⁵⁹

Fourteen states already have medical marijuana laws, (more later in this chapter) and 13 have decriminalization laws. In the South only Mississippi and North Carolina have decriminalization laws.²⁶⁰

A good example of recent decriminalization took place in 2008 in Massachusetts, where voters approved a ballot initiative to decriminalize possession of small amounts of marijuana. Less than an ounce of marijuana is now punishable by a civil fine of \$100. This means someone found carrying even dozens of marijuana cigarettes will no longer be reported to the state’s criminal history board.²⁶¹ Those who are caught with an ounce or less get a ticket similar to a building code citation. They can appeal the civil infraction in court within 21 days or pay a \$100 fine. Juvenile violators must pay the fine and attend a drug abuse counseling course, or have the fine increased to \$1,000. The use of marijuana in public is only a civil offense if the smoker possesses an ounce or less.²⁶²

In 2009 a commission headed by three former Latin American presidents — Fernando Henrique Cardoso of Brazil, César Gaviria of Colombia and Ernesto Zedillo of Mexico — called on the governments of the region to break the taboo of discussing alternative drug policies such as decriminalization. The Supreme Court of Argentina recently ruled that it is unconstitutional to punish marijuana users if no other person is harmed by such use. Argentina, Ecuador and Brazil are considering decriminalization.²⁶³

²⁵⁷ *The American Heritage® Dictionary of the English Language, Fourth Edition*, Retrieved Feb. 01, 2010 from <http://dictionary.reference.com/browse/legalization>

²⁵⁸ *The American Heritage® Dictionary of the English Language, Fourth Edition*. Retrieved Feb. 01, 2010, from <http://dictionary.reference.com/browse/decriminalization>

²⁵⁹ CriminalDefenseLawyer.com, South Carolina Marijuana Laws, Retrieved on Feb. 1, 2010 from www.criminaldefenselawyer.com/marijuana-laws-and-penalties/south-carolina.htm

²⁶⁰ San Jose Mercury News, High Expectations? States weigh marijuana reform, Dec. 27, 2009, Retrieved on Feb. 1, 2010 from www.mercurynews.com/search/ci_14077159?nclick_check=1

²⁶¹ The Boston Globe, Marijuana decriminalization law goes into effect, Jan. 2, 2009, Retrieved on Feb. 1, 2010 from www.boston.com/news/local/breaking_news/2009/01/marijuana_decri_1.html

²⁶² The Boston Globe, Mass. Voters OK decriminalization of marijuana, Nov. 4, 2008, Retrieved on Feb. 1, 2010 from www.boston.com/news/local/breaking_news/2009/01/marijuana_decri_1.html

²⁶³ San Jose Mercury News, Get Serious About Decriminalizing Drugs; Others Are, Tim Lynch and Juan Carlos Hidalgo, Sept. 29, 2009, Retrieved on Feb. 1, 2010 from www.cato.org/pub_display.php?pub_id=10594

In other places, decriminalization does not stop with marijuana. Personal possession of small amounts of any drug is not a crime in Spain, Portugal, Italy, the Czech Republic, the Baltic states or Mexico.²⁶⁴

Portugal decriminalized all drugs for personal use in 2001. Drug possession for personal use and drug usage, itself, are still legally prohibited, but violations of those prohibitions are deemed to be exclusively administrative violations and removed completely from the criminal realm. Drug trafficking continues to be prosecuted as a criminal offense. Since that time the data show that decriminalization has had no adverse effect on drug usage rates, which are now among the lowest in the European Union, particularly when compared with countries that have stringent criminalization regimes. Sexually transmitted diseases and deaths due to drug usage have decreased dramatically. There has been no increase in drug tourism. Drug policy experts attribute these positive trends to the enhanced ability of the Portuguese government to offer treatment programs to its citizens—enhancements made possible, for numerous reasons, by decriminalization.²⁶⁵

The case against legalization and decriminalization²⁶⁶

The Drug Enforcement Administration argues the following:

1. We have made significant progress in fighting drug use and drug trafficking in America. Now is not the time to abandon our efforts.
2. A balanced approach of prevention, enforcement, and treatment is the key in the fight against drugs.
3. Illegal drugs are illegal because they are harmful.
4. Smoked marijuana is not scientifically approved medicine. Marinol, the legal version of medical marijuana, is approved by science.
5. Drug control spending is a minor portion of the U.S. budget. Compared to the social costs of drug abuse and addiction, government spending on drug control is minimal.
6. Legalization of drugs will lead to increased use and increased levels of addiction. Legalization has been tried before, and failed miserably
7. Crime, violence, and drug use go hand-in-hand.
8. Alcohol has caused significant health, social, and crime problems in this country, and legalized drugs would only make the situation worse.
9. Europe's more liberal drug policies (including decriminalization) are not the right model for America.
10. Most non-violent drug users get treatment, not jail time.

²⁶⁴The Economist, Virtually Legal, Nov. 12, 2009, Retrieved on Feb. 1, 2010 from www.economist.com/world/international/displaystory.cfm?story_id=14845095

²⁶⁵ Drug Decriminalization in Portugal, Executive Summary, P. 1, Glenn Greenwald, 2009, Cato Institute.

²⁶⁶ Drug Enforcement Administration, Speaking Out Against Drug Legalization, May 2003. Retrieved on Jan. 31, 2010 from www.justice.gov/dea/demand/speakout/speaking_out-may03.pdf

Make arrests for drug possession the lowest police priority

While municipalities cannot change a state drug law, they can direct local law enforcement where to concentrate its efforts. For example, a police department called upon to investigate noisy college parties may be instructed to quiet the party, but not check IDs of partygoers to see if they are old enough to drink alcohol. This policy recognizes that the officers' time is limited and better spent on pursuit of other crimes.

So it is that a number of municipalities in the United States have ordered their police and sheriffs to make arrests for drug possession their lowest law enforcement priority.

In 2008 voters in the city of Fayetteville joined Eureka Springs to become the second city in Arkansas to pass an initiative declaring marijuana enforcement a lowest law enforcement priority. Two-thirds of voters supported the initiative that makes the investigation, citation, arrest, and prosecution of marijuana offenses the lowest law enforcement and prosecutorial priority.

Voters in Hawaii County, Hawaii, also approved an ordinance making marijuana the lowest law enforcement priority. The ballot initiative passed with 58% of the vote. The ordinance calls upon law enforcement and prosecutors to neither arrest nor prosecute adults for the personal use of marijuana, and requires that the county not accept any funds earmarked for the enforcement of marijuana offenses.²⁶⁷

Many other municipalities have enacted similar policies, including Denver, CO; Haily, ID; Missoula County, MT; Santa Barbara, Santa Monica and Santa Cruz, CA; and Seattle, WA.²⁶⁸

Use harm reduction

Harm reduction is a set of practical strategies to reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use, to abstinence. Harm reduction strategies meet drug users "where they're at," addressing conditions of use along with the use itself. Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction.

Some of the most advocated harm reduction strategies include syringe access and safe injection sites.

Syringe access (*South Carolina prohibits this*)

In December 2009, Congress repealed a 21-year-old ban on federal financing for programs that supply clean needles to drug addicts. The bill brought an end to a long and bitter struggle between the public health establishment—which knew from the beginning that the ban would cost lives—and ideologues in Congress who had closed their eyes to studies showing that making clean needles available to addicts slowed the rate of infection from H.I.V., the virus that causes AIDS, without increasing drug use.

²⁶⁷The Sentencing Project, *The State of Sentencing 2008: Developments in Policy and Practice*, Feb. 2009, Retrieved on Feb. 1, 2010 from www.sentencingproject.org/detail/publication.cfm?publication_id=205&id=106

²⁶⁸ DrugSense, *Community Audits and Initiatives Project*, Retrieved on Feb. 1, 2010 from www.drugsense.org/caip

But the shift in policy came too late for the tens of thousands of Americans—drug addicts and their spouses, lovers and unborn children—who have died from AIDS and AIDS-related diseases. Many of these people would not have become infected had Congress followed sound medical advice and embraced the use of clean needles. Congress voted to withhold federal money in 1988, at the very height of the AIDS epidemic.

Fortunately, not all state and local governments followed the federal lead. In New York, for example, AIDS researchers who pioneered needle exchange programs on the Lower East Side and elsewhere managed over several years to cut the infection rates among addicts by about 80 percent by supplying them with clean syringes and enrolling them in drug treatment programs.²⁶⁹ In 2005 Henry J. Kaiser Foundation counted 118 sites either authorized by various states or not prohibited by them to distribute clean needles.²⁷⁰

Safe Injection Facilities (*The US and South Carolina do not allow this*)

Safe Injection Facilities (SIFs) are legally protected places where drug users consume pre-obtained drugs in a non-judgmental environment, and receive health care, counseling, and referrals to other health and social services, including drug treatment.

The first SIFs opened in Switzerland in the mid-1980s. Now there are sixty-five SIFs in twenty-seven cities and eight countries: Switzerland, Germany, the Netherlands, Spain, Australia, Norway, Luxembourg, and Canada. There are none in the US yet.²⁷¹

Evaluations of the SIF in Vancouver, Canada, have demonstrated several positive outcomes:

- The SIF has been “associated with reductions in public drug use and publicly discarded syringes and reductions in syringe sharing among local injecting drug users.”²⁷²
- Drug users who use the facility are more likely to enter detox programs, especially if they have had contact with the on-site substance use counselor.²⁷³
- A number of overdoses have occurred at the SIF, and were managed in the facility by staff through the administration of oxygen, naloxone, and calls for ambulance support. Importantly, none of the overdose events at the DCF resulted in a fatality.²⁷⁴

²⁶⁹ New York Times, Righting a Wrong, Much Too Late, Dec. 25, 2009, Retrieved on Feb. 1, 2010 from www.nytimes.com/2009/12/26/opinion/26sat3.html

²⁷⁰ Henry J. Kaiser Foundation, statehealthfacts.org, Sterile Syringe Exchange Programs, 2005, Retrieved on Feb. 1, 2010 from www.statehealthfacts.org/comparetable.jsp?ind=566&cat=11&sub=130&yr=16&typ=5

²⁷¹ Harm Reduction Coalition, Safer Injection Facilities, Retrieved on Feb. 1, 2010 from www.harmreduction.org/article.php?list=type&type=94

²⁷² Kerr, et al. “Impact of a medically supervised safer injection facility on community drug use patterns: a before and after study,” *BMJ*, Vol. 332, Jan. 28, 2006, p.222.

²⁷³ Wood, et al. “Attendance at Supervised Injecting Facilities and Use of Detoxification Programs,” *New England Journal of Medicine*, Vol. 354: 23, p.2512-2513.

²⁷⁴ Kerr, et al. “Drug-related overdoses within a medically supervised safer injection facility,” *International Journal of Drug Policy*, 2006.

Use a smarter prevention tactic

This study recognizes but does not cover the significant and costly efforts by South Carolina, principally through state agencies DHEC and DAODAS, to prevent substance abuse use that includes tobacco. DAODAS and its local partners have achieved a steady, three-year decline in the number of retail vendors that break the law by selling tobacco to minors.²⁷⁵ The South Carolina Youth Smoking Act charges DHEC (Dept. of Health and Environmental Control) with tobacco use prevention.²⁷⁶ Nonetheless, more could and should be done.

Tobacco Smoking Prevention

At the National Center on Addiction and Substance Abuse (Columbia University) research has shown that if kids don't smoke tobacco, abuse alcohol or use other drugs till they are 21, their risks of ever doing so are profoundly diminished.²⁷⁷ This research says that tobacco is the most common gateway drug to other drugs: teens who are current smokers are more than 5 times likelier to drink, 13 times likelier to use marijuana, and almost 7 times likelier to use other illegal drugs like cocaine and heroin, than nonsmokers.²⁷⁸

Statistics from the Campaign for Tobacco Free Kids show even higher correlations between kids who smoke tobacco and kids who use drugs.²⁷⁹

We could find no evidence that South Carolina anti-smoking campaigns have publicized the gateway effect of tobacco on many kids who go on to use harder drugs.

The Campaign for Tobacco Free Kids says that 18% of teens in South Carolina smoke, and every year 5,500 kids under 18 become new daily smokers.²⁸⁰ Unfortunately, South Carolina has ranked among the worst states in the nation in smoking prevention efforts, according to the American Lung Association and the Campaign for Tobacco Free Kids. In a 2010 report by the American Lung Association, South Carolina scored all "Fs" for efforts on tobacco prevention and control spending, smoke-free air laws and rules, taxing cigarettes and helping smokers kick the habit.²⁸¹

The U.S. Centers for Disease Control and Prevention (CDC) recommends that South Carolina spend \$62.2 million a year to have an effective, comprehensive tobacco prevention program. In 2010 South Carolina will spend \$3.2 million for tobacco prevention and cessation, including both state (with a line item from the General Fund) and federal funds. This is just 5.2% of the CDC's recommendation and ranks South Carolina 44th among the states in the funding of tobacco prevention programs. South Carolina's spending on tobacco

²⁷⁵ DAODAS Accountability Report, 2008-2009, P. 41, Retrieved on Feb. 6, 2010 from www.daodas.state.sc.us/documents/FY09AccountabilityReport.pdf

²⁷⁶ Youth Smoking Act, S.C. Statute Section 44-128-10, Retrieved on Feb. 4, 2010 from www.scstatehouse.gov/code/t44c128.htm

²⁷⁷ The National Center on Addiction and Substance Abuse at Columbia University (CASA), Shovel Up II: The Impact of Substance Abuse on Federal, State and Local Budgets, P. 17, May 2009.

²⁷⁸ The National Center on Addiction and Substance Abuse at Columbia University (CASA), Tobacco: The Smoking Gun, Retrieved on Feb. 1, 2010 from www.casacolumbia.org/absolutenm/articlefiles/380-Tobacco-The%20Smoking%20Gun.pdf

²⁷⁹ Campaign for Tobacco Free Kids, Smoking and Other Drug Use. Retrieved on Aug. 8, 2010 from <http://sn131w.snt131.mail.live.com/default.aspx?wa=wsignin1.0>

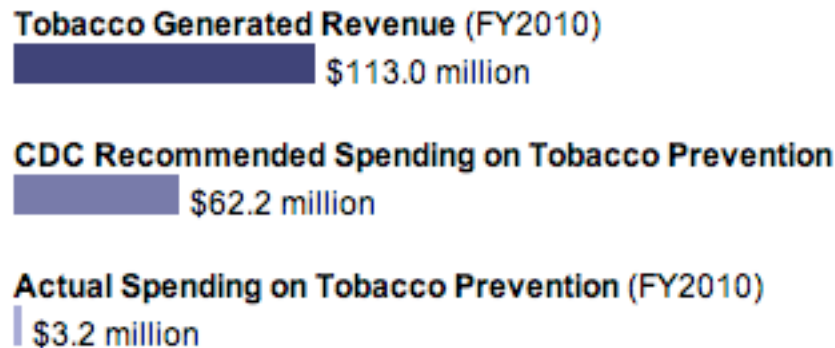
²⁸⁰ Campaign for Tobacco Free Kids, The Toll of Tobacco in South Carolina, Retrieved on Feb. 6, 2010 from www.tobaccofreekids.org/reports/settlements/toll.php?StateID=SC

²⁸¹ American Lung Association, "South Carolina Fails American Lung Association's State of Tobacco Control Annual Report Card," Jan. 12, 2010, Retrieved on Feb. 4, 2010 from www.lungusa.org/associations/states/south-carolina/news/press-releases/SC-SOTC-2009.html

prevention in 2010 amounts to 2.8% of the estimated \$113 million in tobacco-generated revenue the state collects each year from tobacco settlement payments and tobacco taxes.

No tobacco settlement funds have been dedicated to tobacco prevention since 2003, even though the South Carolina Youth Smoking Act (a law) says that DHEC's smoking prevention efforts should be funded by tobacco settlement money.²⁸²

South Carolina Tobacco Income and Prevention Amounts



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However, There Was Some Good News in 2010

In 2010, the South Carolina General Assembly passed a law raising the cigarette tax fifty cents per pack, up to a tax total of \$.57. This makes the state 42nd in the nation in tobacco tax rank (the state average tax is \$1.45 per pack).²⁸⁴ In particular, the cigarette tax law annually allocates \$5 million from the tax revenue to the newly created Smoking Prevention and Cessation Trust Fund, under the direction of the South Carolina Dept. of Health and Environmental Control (DHEC), for a statewide smoking prevention and cessation program. These funds may not be appropriated or used for any other purpose.²⁸⁵

²⁸² Campaign for Tobacco-Free Kids, South Carolina, Dec. 9, 2009, Retrieved on Feb. 1, 2010 from www.tobaccofreekids.org/reports/settlements/state.php?StateID=SC. Also S.C. Statute 44-128-40 (Youth Smoking Act Funding) Retrieved on Feb. 6, 2010 from www.scstatehouse.gov/code/t44c128.htm

²⁸³ Ibid.

²⁸⁴ "State Cigarette Excise Tax Rates and Rankings," Campaign for Tobacco Free Kids, Retrieved on Aug. 8, 2010 from www.tobaccofreekids.org/research/factsheets/pdf/0097.pdf

²⁸⁵ Cigarette Tax Act of 2010, Retrieved on Aug. 8, 2010 from www.scstatehouse.gov/cgi-bin/query.exe?first=DOC&querytext=3584&category=Legislation&session=118&conid=5730987&result_pos=0&keyval=1183584

Legalize medical marijuana

At the end of 2009, 14 states and the District of Columbia (see chart on following page) had laws that let residents use marijuana medicinally. People typically use it to alleviate chronic pain (particularly nerve pain caused by diabetes, AIDS, and hepatitis); manage movement disorders and muscle spasticity (especially for multiple sclerosis patients); as an anti-nausea and anti-vomiting agent (for those, say, undergoing chemotherapy); and as an appetite stimulant (yes, as in "the munchies") for those with wasting diseases like AIDS and cancer. Another 15 states are weighing legislation or ballot initiatives that could turn them into medical marijuana states by next year.²⁸⁶

In November 2009 the American Medical Association, which represents about 250,000 doctors, voted to ask the federal government to revisit the classification of marijuana as a Schedule I drug (see How Drugs Are Classified in Appendix A of this report) because that status inhibits research on its potential medical benefits. This policy is not an endorsement of legalization. The AMA believes there appears to be a potent therapeutic use of the bioactive compounds in that substance, but because of the way the government has scheduled marijuana, it is very difficult to study.²⁸⁷

²⁸⁶ CNNMoney.com, Fortune, How marijuana became legal, Roger Parloff, Sept. 28, 2009, Retrieved on Feb. 1, 2010 from http://money.cnn.com/2009/09/11/magazines/fortune/medical_marijuana_legalizing.fortune/index.htm

²⁸⁷ NPR, SHOTS NPR'S Health Blog, AMA Broadens Its Social Agenda, Scott Hensley, Nov. 12, 2009, Retrieved on Feb. 1, 2010 from www.npr.org/blogs/health/2009/11/what_is_the_ama.html

14 Legal Medical Marijuana States and DC

Laws, Fees, and Possession Limits

I. Fourteen states and DC have enacted laws that legalize medical marijuana:

State	Year Passed	How Passed (Yes Vote)	ID Card Fee	Possession Limit	Accepts other states' registry ID cards?
1. Alaska	1998	Ballot Measure 8 (58%)	\$25/\$20	1 oz usable; 6 plants (3 mature, 3 immature)	Unknown *
2. California	1996	Proposition 215 (56%)	\$66/\$33	8 oz usable; 18 plants (6 mature, 12 immature)**	No
3. Colorado	2000	Ballot Amendment 20 (54%)	\$90	2 oz usable; 6 plants (3 mature, 3 immature)	No
4. DC	2010	Amendment Act B18-622 (13-0 vote)	---	2 oz dried; limits on other forms to be determined	Unknown
5. Hawaii	2000	Senate Bill 862 (32-18 House; 13-12 Senate)	\$25	3 oz usable; 7 plants (3 mature, 4 immature)	No
6. Maine	1999	Ballot Question 2 (61%)	----	2.5 oz usable; 6 plants	Yes
7. Michigan	2008	Proposal 1 (63%)	\$100/\$25	2.5 oz usable; 12 plants	Yes
8. Montana	2004	Initiative 148 (62%)	\$25/\$10	1 oz usable; 6 plants	Yes
9. Nevada	2000	Ballot Question 9 (65%)	\$150 +	1 oz usable; 7 plants (3 mature, 4 immature)	No
10. New Jersey	2010	Senate Bill 119 (48-14 House; 25-13 Senate)	-----	2 oz usable	Unknown
11. New Mexico	2007	Senate Bill 523 (36-31 House; 32-3 Senate)	\$0	6 oz usable; 16 plants (4 mature, 12 immature)	No
12. Oregon	1998	Ballot Measure 67 (55%)	\$100/\$20	24 oz usable; 24 plants (6 mature, 18 immature)	Yes
13. Rhode Island	2006	Senate Bill 0710 (52-10 House; 33-1 Senate)	\$75/\$10	2.5 oz usable; 12 plants	Yes
14. Vermont	2004	Senate Bill 76 (22-7) HB 645 (82-59)	\$50	2 oz usable; 9 plants (2 mature, 7 immature)	No
15. Washington	1998	Initiative 692 (59%)	-----	24 oz usable; 15 plants	No

[**Editor's note:** 13 states require proof of residency to be considered a qualifying patient for medical marijuana use. Only Oregon has announced that its 1998 law legalizing medical marijuana is not limited to state residents. [Karen O'Keefe, JD](#), Director of State Policies for Marijuana Policy Project (MPP), told ProCon.org in a July 27, 2010 email that "Patients and their caregivers can cultivate in 13 of the 14 states. Home cultivation is not allowed in New Jersey or the District of Columbia and a special license is required in New Mexico."]

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The case against medical marijuana

The Drug Enforcement Administration (DEA) says that medical marijuana already exists. It is called Marinol, a pharmaceutical product widely available through prescription. It comes in the form of a pill and is also being studied by researchers for suitability via other delivery methods, such as an inhaler or patch. The active ingredient of Marinol is synthetic THC, which has been found to relieve the nausea and vomiting associated with chemotherapy for cancer patients and to assist with loss of appetite with AIDS patients. Smoked marijuana, says the DEA, contains more than 400 different chemicals, including most of the hazardous chemicals found in tobacco smoke. There is four times the level of tar in a marijuana cigarette, for example, than in a tobacco cigarette.

Marinol has been studied and approved by the medical community and the Food and Drug Administration (FDA), the nation's watchdog over unsafe and harmful food and drug products. Since the passage of the 1906 Pure Food and Drug Act, any drug that is marketed in the United States must undergo rigorous scientific testing. The approval process

²⁸⁸ ProCon.org, 14 Legal Medical Marijuana States and DC, Retrieved on Aug. 8, 2010 from <http://medicalmarijuana.procon.org/view.resource.php?resourceID=000881>

mandated by this act ensures that claims of safety and therapeutic value are supported by clinical evidence, and keeps unsafe, ineffective and dangerous drugs off the market.

The South Carolina Prescription Monitoring Program reports that some state physicians do prescribe Marinol. In 2008 – 2009, out of 18 million prescriptions for scheduled drugs, there were 2,386 prescriptions for Marinol.²⁸⁹

There are no FDA-approved medications that are smoked. Smoking is generally considered to be a poor way to deliver medicine.²⁹⁰

Reform sentencing practices

Enforce treatment instead of jail or prison

A few states have enacted mandatory drug treatment statutes requiring offenders convicted of low level drug crimes to receive treatment sentences. Among them are New York, Kansas, Hawaii, Arizona, and California. Each state places conditions on participation, and projects millions of dollars saved in jail and prison costs.

Five years after implementing the New York program, an evaluation by The National Center on Addiction and Substance Abuse (CASA) found that participants were significantly less likely to have been rearrested and more likely to be employed. CASA observed that the program is a promising example of what law enforcement can do to reduce the number of addicted drug offenders in America's prisons.²⁹¹

California's program, The Substance Abuse and Crime Prevention Act, became law in 2001. Now the state treats drug addiction as a public health problem. As soon as they are convicted of drug possession or being under the influence, first and second-time offenders are screened and referred to appropriate drug treatment programs, many run by non-profit organizations that are licensed and regulated by the state.

Legislators mandated that the program be studied from the beginning by researchers at the University of California at Los Angeles. The press release for the UCLA final report said, "The effectiveness of Proposition 36, a ballot measure approved by California voters in 2000 that offers treatment instead of incarceration for nonviolent drug offenders, is being undermined by inadequate funding, participants dropping out of treatment, and increased arrests for drug and property crimes. The good news, however, is that the initiative has saved taxpayers millions of dollars, several promising new programs have the potential to improve Proposition 36's results, and violent crime arrests have decreased more in California than nationally since the proposition's implementation."²⁹²

Presently California's government faces a massive financial deficit, and has proposed cutting Proposition 36 by 83% (from \$108 million in 2009 to \$18 million in 2010).

²⁸⁹ Information emailed by Cheryl Anderson, S.C. Prescription Monitoring Program, on Feb. 25, 2010. See Appendix A in this report for an explanation of drug schedules.

²⁹⁰ Drug Enforcement Administration, "Medical" Marijuana – The Facts, Retrieved on Feb. 1, 2010, from www.justice.gov/dea/ongoing/marinol.html

²⁹¹ The National Center on Addiction and Substance Abuse, Crossing the Bridge: An Evaluation of the Drug Treatment Alternative-to-Prison (DTAP) Program, March 2003, Retrieved on Feb. 2, 2010 from www.casacolumbia.org/absolutenm/articlefiles/379-Crossing%20the%20Bridge%20DTAP%20Evaluation.pdf

²⁹² Common Sense for Drug Policy, UCLA Prop. 36 2008 Final Study, Retrieved on Feb. 2, 2010 from www.csdp.org/news/news/sapca10_16_08.htm

Eliminate mandatory minimum sentences

Laws establishing mandatory minimum sentences have led to extremely long prison terms for many drug offenses that now keep non-violent people locked up for years. Many states have belatedly come to the conclusion that taking away judicial discretion has filled prisons to overflowing. Therefore, a number of states have passed laws relaxing or repealing mandatory minimum laws. A few examples include:

- **South Carolina, where in June, 2010 the Omnibus Crime Reduction and Sentencing Reform Act eliminated mandatory minimum sentences for first-time drug possession; made certain repeat drug offenders eligible for a suspended sentence; and removed the 10-year mandatory minimum sentence for violations of its drug-free school zone law.**²⁹³
- Michigan, where sweeping reforms of the state's mandatory minimum drug penalties passed in 1998 and 2003
- Mississippi, where the legislature amended the sweeping truth-in-sentencing law to allow nonviolent first-time offenders to regain parole eligibility after serving one-quarter of their prison sentence. These changes made more than 2,000 of the state's prisoners parole-eligible in 2001, and by April 2003, 900 had been released.
- Connecticut, where legislators in 2001 gave courts some leeway to relax mandatory minimum sentencing laws for sale or possession of drugs for "good cause," even within a "drug free" school zone
- Louisiana, where legislators repealed mandatory minimum sentences for simple drug possession and many other nonviolent offenses in 2001, and cut minimum sentences for drug trafficking in half. Prisoners were allowed to seek sentence reductions in some cases.²⁹⁴

Revise drug-free zone laws

The purpose of drug-free zone laws is to protect children nearby. In South Carolina this means it can be a separate criminal offense for a person to distribute, sell, purchase, manufacture, or to unlawfully possess with intent to distribute, a controlled substance while in, on, or within a one-half mile radius of the grounds of a public or private elementary, middle, or secondary school; a public playground or park; a public vocational or trade school or technical educational center; or a public or private college or university.²⁹⁵ In effect, this means almost every place in the state.

Until passage of the South Carolina Omnibus Crime Reduction and Sentencing Reform Act of 2010, an offender stopped by police in this type of location, even though merely carrying drugs, with no intention to sell drugs to kids and unaware of the proximity of a school, park or playground, was punished with extra drug offense penalties carrying multiple years in prison and fines. The new law requires intent to commit a controlled substance offense, and

²⁹³ Families Against Mandatory Minimums, FAMMGram, Spring 2010, South Carolina Enacts Sweeping Sentencing Reform. Retrieved on Aug. 8, 2010 from www.famm.org/Repository/Files/FGSpring10.pdf

²⁹⁴ Families Against Mandatory Minimums, FAMMGram, Fall 2009, State mandatory minimum reforms are far from rare, P. 9, Retrieved on Feb. 2, 2010 from www.famm.org/NewsandInformation/FAMMGram.aspx

²⁹⁵ South Carolina Code of Laws, Section 44-53-445.

intent to commit it within the proximity of a school, park or playground.²⁹⁶ Other states are also revising their laws to reflect the reality of the offense.²⁹⁷

Require racial and ethnic impact statements before passing criminal laws

Iowa passed racial impact study legislation in 2008, becoming the first state in the nation to do so. The legislation aims to develop steps to curtail Iowa's racial disparity in prison. According to the Sentencing Project, Iowa incarcerates black people at a rate 13 times higher than white people. This disparity is more than double the national average.

Other states and Congress are following Iowa's lead. Wisconsin Governor Jim Doyle issued an executive order in May supporting the creation of a Racial Disparities Oversight Commission, and Governor M. Jodi Rell of Connecticut signed legislation in June requiring examination of the racial and ethnic impact of new criminal sentencing laws prior to passage.²⁹⁸

South Carolina imprisons blacks 4.5 times more often than whites for dangerous drug convictions, although the rate of drug use in the state is roughly the same related to black and white proportions of the population. See Chapter 7 in this report for detailed information about the injustice caused by racial disparity in South Carolina drug laws.

Copy Hawaii's HOPE probation court success

Hawaii has transformed its numbers of probation violators by establishing a drug-court like response with certain and rapid punishment for violators. Probationers who participate in the Hawaii HOPE program get arrested less than half as often and for less serious crimes than those under traditional probation. It may be because they are getting off drugs, or simply leading more structured lives, but it is working.²⁹⁹ (Note: The S.C. Sentencing Reform Commission rejected this suggestion as part of their deliberations.)³⁰⁰

In FY2009, the Department of Probation, Parole, and Pardon (PPP) revoked 3,205 offenders to prison, accounting for 24 percent of all prison admissions, 66 percent of whom, or more than 2,100 offenders, were sent back to prison for non-criminal (technical) violations, such as failure to show up at the probation office, or alcohol and drug use, and did not involve a new criminal conviction.³⁰¹

²⁹⁶ Omnibus Crime Reduction and Sentencing Reform Act of 2010." Retrieved on Aug. 5, 2010 from www.scstatehouse.gov/cgi-bin/query.exe?first=DOC&querytext=1154&category=Legislation&session=118&conid=5730918&result_pos=0&keyval=1181

²⁹⁷ Justice Policy Institute, Disparity by Design, March 2006, Retrieved on Feb. 2, 2010 from www.justicepolicy.org/images/upload/06-03_REP_DisparitybyDesign_DP-JJ-RD.pdf

²⁹⁸ Families Against Mandatory Minimums, FAMMGram, Fall 2008, statenews, P. 11, Retrieved on Feb. 2, 2010 from www.famm.org/NewsandInformation/FAMMGram.aspx

²⁹⁹ Washington Monthly, Jail Break, Mark A.R. Kleiman, P. 57.

³⁰⁰South Carolina Sentencing Reform Commission Report to the General Assembly, Feb. 1, 2010, Retrieved on Feb. 8, 2010 from www.scstatehouse.gov/citizensinterestpage/SentencingReformCommission/CombinedFinalReport020110SigPage.pdf

³⁰¹ Ibid.

Appendix A: How Drugs Are Classified ³⁰²

The federal Controlled Substances Act of 1970 established the way in which drugs are classified into five schedules indicating their varying legality. The Drug Enforcement Administration (DEA) and the Food and Drug Administration (FDA) determine which substances are added or removed from the various schedules. (NOTE: South Carolina law says that all prescriptions for Schedule II, III and IV drugs must be tracked by the state's Prescription Monitoring Program. See Chapter 5 in this document for details.)

Schedule I

The drug or other substance has a high potential for abuse, and has no currently accepted medical use in treatment in the United States. There is a lack of accepted safety for use of the drug or other substance under medical supervision.

- Examples of Schedule I substances include marijuana, heroin, lysergic acid diethylamide (LSD), and methaqualone.

Schedule II

The drug or other substance has a high potential for abuse, and has a currently accepted medical use in treatment in the United States, or a currently accepted medical use with severe restrictions. Abuse of the drug or other substance may lead to severe psychological or physical dependence.

- Examples of Schedule II substances include morphine, phencyclidine (PCP), cocaine, methadone, methamphetamine, Dexedrine, and Ritalin.

Schedule III

The drug or other substance has less potential for abuse than the drugs or other substances in schedules I and II, and has a currently accepted medical use in treatment in the United States. Abuse of the drug or other substance may lead to moderate or low physical dependence, or high psychological dependence.

- Marinol (synthetic THC, one of the compounds found in marijuana), anabolic steroids, codeine and hydrocodone with aspirin or Tylenol®, and some barbiturates are examples of Schedule III substances.

Schedule IV

The drug or other substance has a low potential for abuse relative to the drugs or other substances in Schedule III, and has a currently accepted medical use in treatment in the United States. Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule III.

- Examples of drugs included in schedule IV are Rohypnol (the date-rape drug), Darvon®, Talwin®, Equanil®, Valium®, and Xanax®.

Schedule V

The drug or other substance has a low potential for abuse relative to the drugs or other

³⁰²“The Controlled Substance Schedule,” Dept. of Health and Human Services New Hampshire, Retrieved on Feb. 2, 2010 from www.dhhs.state.nh.us/DHHS/ATOD/controlled-substance.htm

substances in Schedule IV, and has a currently accepted medical use in treatment in the United States. Abuse of the drug or other substances may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule IV.

- Cough medicines with codeine are examples of Schedule V drugs.

Appendix B: South Carolina's Most Common Illegal Drugs³⁰³

Marijuana—Marijuana is the most prevalent illegal drug in South Carolina, with Mexico the most common source. There is also a smaller amount of domestic marijuana cultivation taking place within South Carolina. Marijuana is a mixture of dried and shredded flowers, leaves and seeds of the hemp plant (cannabis). It can be smoked, or mixed with a food or drink and consumed orally. The majority of people who use marijuana do not use other illegal drugs. Recent evidence suggests that tobacco is the first or “gateway” drug used by most children.³⁰⁴ No one has ever died from an overdose of marijuana.

Cocaine—Cocaine is an extremely powerful central nervous system stimulant or “upper.” It acts directly on the brain’s “pleasure centers,” causing changes in brain activity, and, by allowing a brain chemical called dopamine to remain active longer than usual, triggers cravings for more of the drug. Cocaine is available in two primary forms: (1) cocaine hydrochloride, an odorless white powder usually snorted or injected; and (2) cocaine alkaloid made into freebase or crack and is smoked, resulting in a faster, more intense high than injecting or snorting.³⁰⁵

Cocaine and crack cocaine continue to be among the most widely abused drugs throughout the state. Though cocaine was the most seized illicit drug in the state in the last year, it was also the only illicit drug showing a decline in seizures compared to the previous year. This is due to domestic and international law enforcement impeding the movement of cocaine through Mexico into the U.S. Because it has become increasingly difficult to transport cocaine into the U.S., some traffickers are supplementing their income by selling other drugs such as marijuana, MDMA and prescription drugs.³⁰⁶

Heroin—Approximately 1 percent of South Carolinians ages 18 and older have reported ever using heroin, and only 0.1 percent reported using it during the past year. Unfortunately, however, 2.3 percent of all South Carolina 8th, 10th, and 12th graders have reported using heroin at least once. Heroin is an opioid drug derived from morphine, but several times more powerful. Appearing as a white or brownish powder, it is usually diluted with sugar, quinine or other more dangerous substances before it is sold on the street. Heroin can be smoked, snorted or injected.³⁰⁷

Club Drugs—During the past year there has been a significant increase in Ecstasy distribution throughout South Carolina, with traffickers operating from Columbia distributing a significant portion that sold. Club drugs are a pharmacologically heterogeneous group of psychoactive compounds that tend to be used by teens and young adults at a nightclub, bar, rave, or trance scene. The drugs include MDMA/Ecstasy, Rohypnol—the date-rape drug, GHB, and ketamine.³⁰⁸ Club drugs are attractive to today’s youth because they are inexpensive and produce increased stamina and intoxicating highs. Because many are colorless, tasteless, and odorless, they can be secretly added to beverages

³⁰³ “South Carolina: Drug Climate,” National Substance Abuse Index, Retrieved on Jan. 30, 2010 from <http://nationalsubstanceabuseindex.org/south-carolina/index.php>

³⁰⁴ “Fact Sheet Marijuana,” DAODAS, Retrieved on Jan. 30, 2010 from www.daodas.state.sc.us/documents/marijuanafs.pdf

³⁰⁵ “Fact Sheet Cocaine,” DAODAS, Retrieved on Jan. 30, 2010 from www.daodas.state.sc.us/documents/cocaineafs.pdf

³⁰⁶ “South Carolina 2009,” U.S. Drug Enforcement Administration (DEA), Retrieved on Feb. 9, 2010 from www.justice.gov/dea/pubs/state_factsheets/southcarolinap.html

³⁰⁷ “Fact Sheet Heroin,” DAODAS, Retrieved on Jan. 30, 2010 from www.daodas.state.sc.us/documents/heroinfs.pdf

³⁰⁸ “Club Drugs Facts & Figures,” Office of National Drug Control Policy, Retrieved on Jan. 30, 2010, from www.whitehousedrugpolicy.gov/drugfact/club/club_drug_ff.html

by individuals who want to intoxicate or sedate others.³⁰⁹

Pharmaceutical Diversion—Diversion of OxyContin®, hydrocodone products (such as Vicodin®), and pseudoephedrine continues to be a problem in South Carolina. Primary methods of diversion being reported are illegal sale and distribution by health care professionals and workers, and “doctor shopping” (going to a number of doctors to obtain prescriptions for a controlled pharmaceutical). Methadone, benzodiazepines, MS Contin®, and fentanyl were also identified as being among the most commonly abused and diverted pharmaceuticals in South Carolina. Schedule II drugs are reportedly taken in combination with Schedule III or IV drugs, or the non-controlled Soma ®.³¹⁰

Methamphetamine (Meth)—While methamphetamine has a minor share of the drugs used in South Carolina, it is a highly addictive man-made stimulant that can cause aggression and violent or psychotic behavior. Many users report getting addicted from first use. It is one of the hardest drugs to treat.³¹¹

The primary traffickers of methamphetamine are both legal and illegal Mexican immigrants, though people still make it at home.³¹² DAODAS reports that the number of users seeking treatment has remained relatively stable at roughly 800 each year from 2006 – 2009. However, the number of meth labs found in the state tells a different story:³¹³

2005—251
2006—117
2007—77
2008—182
2009—211

Many chemicals used in making the drug are toxic. The federal Combat Methamphetamine Epidemic Act (CMEA) of 2006 established strict national controls for the sale of products containing ephedrine and pseudoephedrine.³¹⁴ All pharmacies must keep those products behind the counter and maintain logs with information about the people who buy them. Periodically, DEA agents visit the pharmacies to inspect the logs, looking for customers who might be using the products to make meth.³¹⁵

Meth labs are found in apartments, houses, motels, trailers, vehicles and storage units. They are not only dangerous to the people living where the meth is being made, but to the community where the home is located. Children living in meth labs or exposed to meth making are endangered. Being in or near a meth lab is extremely dangerous. The toxic nature of the ingredients leaves behind hazardous waste—six pounds of residue are generated by each pound of meth manufactured. It costs an average of \$2,500 to clean up a meth lab, but costs can run as high as \$10,000.

³⁰⁹ “Alcohol and Drug Information, Club Drugs,” SAMHSA, Retrieved on Jan. 30, 2010 from <https://ncadi.samhsa.gov/catalog/facts.aspx?topic=13&h=drugs>

³¹⁰ “South Carolina 2009,” U.S. Drug Enforcement Administration (DEA). Retrieved on Aug. 8, 2010 from www.justice.gov/dea/pubs/state_factsheets/southcarolina.html

³¹¹ “Exposing the Facts: Crystal Meth,” The NA Blog, Retrieved on Jan. 30, 2010 from <http://thenablog.com/2009/02/16/exposing-the-facts-crystal-meth>

³¹² John Monk, “Children hospitalized after home meth lab bust,” *The State*, Jan. 19, 2010, Retrieved on Feb. 4, 2010 from www.thestate.com/crime/story/1118026.html

³¹³ DEA, Charleston, SC, Feb. 2010.

³¹⁴ “Efforts to Control Precursor Chemicals,” Office of National Drug Control Policy, Retrieved on Feb. 4, 2010 from www.whitehousedrugpolicy.gov/publications/international/factsht/eff_contr_precursr_chem.html

³¹⁵ DEA, Charleston, SC, Feb. 2010.

Appendix C: Positions on Illegal Drugs
Adopted by the League of Women Voters of the Charleston Area
May, 2010

Illegal drug use should be considered a public health issue, and drug addiction should be addressed by substance abuse treatment programs instead of incarceration.

1. We support the following preventive measures:
 - Educational programs aimed at keeping children from using drugs;
 - Public education programs about tobacco's role as a gateway drug to illegal drug use;
 - Mandatory substance abuse education in all SC schools, public and private;
 - Educational programs about illegal drugs directed to adults;
 - Sterile needle and syringe programs for illegal drug users to prevent blood-borne diseases.
2. Official drug laws and policies should include:
 - Drug treatment programs as an alternative to incarceration;
 - Legal possession of medical marijuana, when prescribed by a physician;
 - Reliable and equitable state funding for all county drug courts.
3. Drug-addicted pregnant women should be given priority placement in drug abuse treatment programs. The LWVCA does not support criminal charges for the mother in cases where the newborn tests positive for drugs.
4. Adults who possess marijuana for personal use, adults who sell marijuana to other adults for personal use, and adults who possess illegal drugs other than marijuana for personal use, should at most be charged with a civil offense (which may include a fine), rather than a criminal offense (which may result in incarceration).
5. Programs for substance abuse treatment should be funded by all levels of the government, the private sector, and the drug user, with a sliding scale based on the ability to pay.
6. Any public fund savings resulting from the use of alternatives to incarceration should be used to support substance abuse treatment programs.

***Mapping the Elephant:
Illegal Drugs in South Carolina***

**A study by the League of Women Voters
Of the Charleston (S.C.) Area**

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