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All Hands on Deck: The Case for Incorporating Medically Assisted Treatment into the Criminal Justice System in South Carolina

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ALL HANDS ON DECK: THE CASE FOR INCORPORATING MEDICALLY ASSISTED TREATMENT INTO THE CRIMINAL JUSTICE SYSTEM IN SOUTH CAROLINA

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I. INTRODUCTION

In a country that boasts over one and a half million prisoners, the American criminal justice system has become the second highest source of referrals to treatment for drug dependency.[1] However, drug treatment within the criminal justice system is still quite limited and often takes place in programs such as drug courts.[2] The overwhelming majority of drug-dependent defendants ("justice-involved population") is either treated outside the system or not treated at all.[3] Furthermore, research indicates that incarceration in and of itself is inadequate to address drug dependency, especially when compared with the overarching goal of incarceration to reduce recidivism and make communities safer.[4] These gaps become increasingly visible at a time when the country is embroiled in an opioid epidemic that is driven in part by illicit drug-seeking behavior.

South Carolina, much like the rest of the nation, is substantially affected by this opioid epidemic. Not only has the state seen a sharp increase in opioid-related overdose deaths and hospitalizations, but it has also experienced ripple effects in its economy and criminal justice system. These effects were severe enough that in December 2017, Governor Henry McMaster issued two executive orders to address this public health emergency. One order directed the South Carolina Department of Health and Human Services (DHHS) to

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1. *See* E. ANN CARSON, U.S. DEP'T OF JUSTICE, NCJ 251149, PRISONERS IN 2016 (2018); KELLEY SMITH & ALEXANDER STRASHNY, CTR. FOR BEHAVIORAL HEALTH STATISTICS & QUALITY, CHARACTERISTICS OF CRIMINAL JUSTICE SYSTEM REFERRALS DISCHARGED FROM SUBSTANCE ABUSE TREATMENT AND FACILITIES WITH SPECIALLY DESIGNED CRIMINAL JUSTICE PROGRAMS 2 (April 26, 2016).

2. "In 2011, there were 1.7 million discharges from substance abuse treatment programs. Of these, about 588,000 discharges—or 34.4 percent—were referred to treatment through the criminal justice system. This was the second highest referral source following individual [and] self-referrals. The largest share of criminal justice referrals was via probation/parole (35.9 percent), followed by state [and] federal[,] and other court referrals (15.7 and 14.3 percent, respectively)." SMITH & STRASHNY, *supra* note 1, at 2.

3. Redonna K. Chandler et al., *Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety*, 301 J. AM. MED. ASS'N 183, 183 (2009) (citation omitted).

4. *Id.*

limit initial opioid prescriptions for acute and post-operative pain to a maximum of five days for state Medicaid recipients.[5] The second order directed the creation of the South Carolina Opioid Emergency Response Team (OERT).[6] Jointly led by the South Carolina Law Enforcement Division (SLED) and the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS), the OERT is comprised of both state agencies and private stakeholders. It is tasked with developing a multifaceted plan to address the opioid emergency in South Carolina. Specifically, the OERT plan suggests that Medically-Assisted Treatment (MAT), an evidence-based practice to treat opioid use disorders (OUDs), is underutilized in South Carolina in general, and in the state's criminal justice system in particular.[7] Furthermore, since drug use and the criminal justice system are intimately intertwined, it will benefit the state's criminal justice institutions to incorporate these practices. This "all hands on deck" approach will not only reduce opioid related overdose deaths but will also reduce recidivism and make communities safer. This Article will outline the main historical events that led to the opioid epidemic and how the criminal justice system can help curb its effects on the state's justice-involved population.

II. OPIOID-PROLIFERATION IN THE UNITED STATES

The current opioid-driven public health crisis in the United States did not arise *ex nihilo*. Rather, this "perfect storm" of mega-scale addiction to opioids and its destructive consequences has been in the making for almost three decades. From 1999 to 2017, more than 700,000 Americans died from drug overdoses, with opioids responsible for more than half of these deaths.[8] Over this time period, experts argue that the United States experienced three consecutive waves of opioid proliferation.[9] These waves are intrinsically unique and distinguishable from each other in that they each revolve around certain "types" of opioids and their diverse distribution methods. Consequently, each wave presented a myriad of challenges for legislators,

5. S.C. Exec. Order No. 2017-43 (Dec. 18, 2017).

6. S.C. Exec. Order No. 2017-42 (Dec. 18, 2017).

7. S.C. DEP'T OF ALCOHOL & OTHER DRUG ABUSE SERV., FOCUS AREA – TREAT AND RECOVER Annex 3-1 (2018).

8. Press Release, Centers for Disease Control and Prevention, New Data Show Growing Complexity of Drug Overdose Deaths in America (Dec. 21, 2018).

9. *Understanding the Epidemic*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/drugoverdose/epidemic/index.html (last updated Dec. 19, 2018) (citation omitted).

educators, law enforcement agencies, and public health officials, who have been engaged in containment efforts for nearly two decades.

A. The First Wave

It was not until the start of the new millennium that the country realized that it was embroiled in a large-scale public health crisis. In retrospect, it was the rapid increase in drug overdose deaths from 1999 onward—specifically those attributed to short-acting pharmaceutical painkillers such as oxycodone, hydrocodone, and hydromorphone—that caused leaders in the medical community to question some of the established pain management guidelines. Although these guidelines were originally intended to address the widespread problems of underassessment and undertreatment of pain in patients, their aggressive approach to pain eradication through the liberal use of opioids contributed to overdose deaths and development of drug dependency in the treated population.[10] Moreover, further contributing to this upward trend of opioid users were drug manufacturers, specifically Purdue Pharma. Shortly after the formulation of OxyContin® in 1995, Purdue aggressively sought to expand its use to "non-malignant pain markets."[11] Purdue's marketing tactics included all-expenses-paid pain management conferences for prescribers and a lucrative bonus system for its sales force.[12] Additionally, when selling the "benefits" of OxyContin® to its medical prescribers, Purdue consistently minimized the risks of opioid addiction in chronic pain patients who use pain medicine daily and for a prolonged period of time.[13] Purdue repeatedly cited studies in acute pain patients that showed that the development of addiction to opioids is rare in medical patients with no history of addiction.[14] As a result, between 1997 and 2002, dispensation of OxyContin® prescriptions for non-cancer patients increased by almost tenfold, and the aggregated sales of the medication ballooned from $44 million in 1996 to 2001 and in 2002, combined sales of nearly $3 billion.[15] Notwithstanding Purdue's actions, it

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10. DAVID W. BAKER, THE JOINT COMMISSION'S PAIN STANDARDS: ORIGINS AND EVOLUTION 2 (2017).

11. Art Van Zee, *The Promotion and Marketing of OxyContin: Commercial Triumph, Public Health Tragedy*, 99 AM. J. PUB. HEALTH 221, 222–23 (2009) (citing PURDUE PHARMA, OXYCONTIN MARKETING PLAN (1998)).

12. *Id.* at 221–22 (citing U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-04-110, PRESCRIPTION DRUGS: OXYCONTIN ABUSE AND DIVERSION AND EFFORTS TO ADDRESS THE PROBLEM (2003)).

13. *Id.* at 223 (citing U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 12).

14. *Id.* (citing Jane Porter & Hershel Jick, *Addiction Rare in Patients Treated with Narcotics*, 302 NEW ENG. J. MED. 123 (1980)).

15. *Id.* at 223 (citing U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 12).

certainly was not the only opioid manufacturer to enjoy a massive sales growth. In fact, between 1991 and 2013, opioid prescriptions in the United States rose from 76 million to 207 million per year.[16]

Notably, the pain guidelines and drug manufacturers were not the only catalysts for this epidemic. Blame and liability must be extended to drug wholesalers and pharmacies as well. As demand for opioids intensified, pharmaceutical wholesalers, such as H.D. Smith and Miami-Luken, were shipping exorbitant quantities of drugs all over the nation, while flagrantly disregarding red flags.[17] Take, for example, the case of Williamson, West Virginia, a tiny town of three thousand residents in rural Appalachia, where between 2008 and 2015, drug wholesalers shipped approximately 20.8 million painkillers.[18] Pharmacies, both chain and locally-owned, helped push these drugs out to communities. Although pharmacists share a corresponding responsibility with prescribers to ensure that prescriptions are issued for legitimate medical purposes, they too, ignored red flags.[19] In some instances, pharmacists accepted dubious prescriptions that were written by out-of-state physicians or failed to question obviously forged prescriptions. In other cases, pharmacists filled out prescriptions for numerous opioids, benzodiazepines, and tranquilizers, a combination that the pharmacists knew—or should have known—would result in one of two outcomes for their patients: severe drug dependency or overdose.[20] By the time the United States realized it was experiencing an epidemic, addiction to opioids was already out of control.[21]

The government's efforts to stem the first tidal wave of opioid addiction and overdose deaths culminated in the criminal prosecution of Purdue in 2007.

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16. Nora D. Volkow, America's Addiction to Opioids: Heroin and Prescription Drug Abuse (May 14, 2014) (transcript available at https://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2014/americas-addiction-to-opioids-heroin-prescription-drug-abuse).

17. Laurel Wamsley, *Drug Distributors Shipped 20.8 Million Painkillers to West Virginia Town of 3,000*, NPR (Jan. 30, 2018, 5:36 PM), https://www.npr.org/sections/thetwo-way/2018/01/30/581930051/drug-distributors-shipped-20-8-million-painkillers-to-west-virginia-town-of-3-00.

18. *Id.*

19. *See e.g.*, Complaint ¶¶ 56–57, at 17, Kentucky v. Walgreens Boots Alliance, Inc., No. 18-CCI-00846 (Boone Cir. Ct. June 14, 2018).

20. *See* Sari Horwitz & Scott Higham, *DEA Launches New Crackdown on Pharmacies and Opioid Over-Prescribers*, WASH. POST (Jan. 30, 2018), https://www.washingtonpost.com/world/national-security/dea-launches-new-crackdown-on-pharmacies-and-opioid-over-prescribers/2018/01/30/14cc20be-0600-11e8-94e8-e8b8600ade23_story.html?noredirect=on&utm_term=.f8aaec803007.

21. *See* Leonard J. Paulozzi et al., *Vital Signs: Overdoses of Prescription Opioid Pain Relievers—United States, 1999–2008*, 60 MORBIDITY & MORTALITY WKLY. REP. 1487, 1488 (2011) ("Substance abuse admission rate in 2009 was almost six times the rate in 1999.").

The company and its executives "pleaded guilty to a felony charge of 'misbranding' OxyContin® while marketing the drug by misrepresenting, among other things, its risk of addiction and potential to be abused."[22] The company also agreed to pay $634.5 million in combined fines.[23] Additionally, law enforcement entities, such as the Drug Enforcement Administration (DEA)'s Tactical Diversion Squads (TDS) and their state counterparts sought aggressive criminal prosecutions of rogue doctors, drug distributors, and pharmacies. Eventually, these combined efforts did result in reductions in the prescription and dispensation of opioids.[24] That said, these efforts did very little to address the widespread addiction to opioids. Moreover, the large number of opioid-dependent individuals and the limited availability of prescription opioids provided opportunities for criminal organizations to push a cheaper and more potent opioid product: heroin.[25]

B. The Second Wave

The rise in heroin use brought with it a second wave of opioid saturation, which peaked by 2013. From 2002 to 2013, heroin-related overdoses increased by 286%, with more than eighty percent of users admitting to the misuse of prescription opioids before initiating heroin use.[26] Furthermore, this newly imported heroin was quite different than the "stepped-down," Colombian-sourced, white-powder heroin to which users were accustomed.[27] This new heroin was black, tar-like sticky, and extremely potent, reaching purity levels between sixty percent and eighty-four percent.[28] Additionally, unlike the Colombian-sourced heroin, the majority of this heroin was

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22. Barry Meier, *Origins of an Epidemic: Purdue Pharma Knew Its Opioids Were Widely Abused*, N.Y. TIMES (May 29, 2018), https://www.nytimes.com/2018/05/29/health/purdue-opioids-oxycontin.html.

23. *Id.*

24. *See* Anne Schuchat et al., *New Data on Opioid Use and Prescribing in the United States*, 318 J. AM. MED. ASS'N 425, 425 (2017) (citing Gery P. Guy Jr. et al., *Vital Signs: Changes in Opioid Prescribing in the United States, 2006–2015*, 66 MORBIDITY & MORTALITY WKLY. REP. 697, 698 (2017)).

25. Lindsy Liu et al., *History of the Opioid Epidemic: How Did We Get Here?*, NAT'L CAP. POISON CTR., https://www.poison.org/articles/opioid-epidemic-history-and-prescribing-patterns-182 (last visited Mar. 29, 2019).

26. *Id.*

27. *See* Sarah G. Mars et al., *The Textures of Heroin: User Perspectives on "Black Tar" and Powder Heroin in Two U.S. Cities*, 48 J. PSYCHOACTIVE DRUGS 270 (2016) (citation omitted).

28. Press Release, U.S. Dep't of Justice, Nearly 200 Arrested in Multi-Million Dollar Heroin Smuggling Operation (June 15, 2000), https://www.justice.gov/archive/opa/pr/2000/June/341crm.htm.

cultivated by Mexican organizations and exported from a small state in western Mexico called Nayarit.[29] Most importantly, it was considerably cheaper than other heroin products or prescription drugs, and its suppliers made it highly accessible to consumers by utilizing a pizza shop "home delivery" like system.[30] Unfortunately, although federal and local law enforcement agencies had invested considerable resources to stem the supply of black tar heroin, these efforts came up short and only provided anecdotal solutions at best.[31]

C. The Third Wave

Alongside the rise in the demand for heroin, in 2013, the United States began experiencing a third wave of opioid proliferation, this time involving synthetic opioids such as fentanyl. Fentanyl "is 50 to 100 times more potent than morphine."[32] It is classified as a Schedule II drug, with a great potential for abuse and dependency.[33] In appropriate medical settings, fentanyl is prescribed in microgram dosages, mainly by oncologists, to treat pain in cancer patients.[34] On the illicit side, fentanyl and other synthetic opioids are manufactured clandestinely and range in variety to include drugs such as furanylfentanyl, acrylfentanyl, and carfentanil, an elephant tranquilizer that is 100 times more potent than fentanyl.[35] The Centers for Disease Control and Prevention (CDC) has estimated that from November 2016 to November 2017 synthetic opioids were responsible for more than 27,000 overdose deaths—more than prescription drugs and heroin combined.[36] According to the DEA,

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29. *See id.*

30. *E.g.*, Christine Lagorio, *DEA Busts 'Home-Delivery' Heroin Ring*, CBS NEWS (Aug. 15, 2006, 4:42 PM), https://www.cbsnews.com/news/dea-busts-home-delivery-heroin-ring.

31. *See generally* SAM QUINONES, DREAM LAND 317 (2016) (discussing how law enforcement efforts to stem the flow of black tar heroin from Mexico were unsuccessful).

32. *What is fentanyl?* U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/drugoverdose/opioids/fentanyl.html (last updated Dec. 19, 2018).

33. *See* U.S. DEP'T OF JUSTICE, CONTROLLED SUBSTANCES (2018) [hereinafter CONTROLLED SUBSTANCES LIST], https://www.deadiversion.usdoj.gov/schedules/orangebook/c_cs_alpha.pdf.

34. *See Fentanyl*, U.S. DRUG ENF'T ADMIN., https://www.dea.gov/factsheets/fentanyl (last visited Mar. 29, 2019).

35. UTTAM DHILLON, U.S. DRUG ENF'T ADMIN., 2018 NATIONAL DRUG THREAT ASSESSMENT 21, 32 (2018).

36. Health Alert Network, *Rising Numbers of Deaths Involving Fentanyl and Fentanyl Analogs, Including Carfentanil, and Increased Usage and Mixing with Non-opioids*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION (July 11, 2018, 1:00 PM), https://emergency.cdc.gov/han/han00413.asp (citing *Vital Statistics Provisional Drug Overdose*

most of these illicit synthetic opioids are likely manufactured in China.[37] They enter the country in parcel packages directly from China or from China through Canada, or they are smuggled across the southwest boarder from Mexico.[38] Once in the country, these smuggled drugs are usually distributed via domestic mail services.[39] From a law enforcement perspective, the parcel-delivery methods make the interdiction of U.S.-bound packages containing China-sourced fentanyl and fentanyl analogues extremely difficult. Findings from a 2018 bipartisan congressional report from the United States Senate Permanent Subcommittee on Investigations revealed that in 2017 more than 318 million packages entered the United States without containing any Advanced Electronic Data (AED).[40] This means that the United States Postal Service and other federal authorities had no way of knowing who sent these packages, where these packages were going, or what these packages contained.[41] Consequently, the congressional report provided suggestions for improving the detection of packages containing illicit drugs;[42] however, their implementation is likely to take considerable time and would require extensive cooperation with countries such as China.

III. THE OPIOID EPIDEMIC IN SOUTH CAROLINA

A. In Numbers

Affected by all three waves, South Carolina was not spared from the epidemic's path of destruction. With respect to prescribing practices, data from the South Carolina Prescription Drug Monitoring Program (PDMP) confirms that an alarming number of opioids are dispensed every year across the state.[43] Between 2014 and 2017, South Carolina averaged 4.54 million

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Death Counts, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm (last updated Feb. 13, 2019).

37. DRUG ENF'T ADMIN., U.S. DEP'T OF JUSTICE, DEA-DCT-DIR-001-17, vii, 68 (2016).

38. *Id.* at 68, 70.

39. *Id.*

40. STAFF OF S. SUBCOMM. ON INVESTIGATIONS, 115TH CONG., COMBATTING THE OPIOID CRISIS: EXPLOITING VULNERABILITIES IN INTERNATIONAL MAIL 6 (Comm. Print 2018).

41. *Id.*

42. *Id.* at 11–13.

43. The program, which is housed by the South Carolina Department of Health and Environmental Control (DHEC), Bureau of Drug Control, was established in 2006 pursuant to the passage of the South Carolina Prescription Monitoring Act. S.C. CODE ANN. § 44-53-1610 (2018). The Act's stated purpose is to "improve the state's ability to identify and stop the illegal

opioid prescriptions per year.[44] This amount is quite remarkable considering the state's population consists of only 4.9 million people, a factor that ranked South Carolina sixth in the nation for opioid prescriptions per capita.[45] This data has a strong correlation to the state's mortality information from DHEC's division of Vital Statistics and the National Institute on Drug Abuse: from 2013 to 2017 opioid-related overdose death rates in the state tripled, from 5.2 to 15.5 deaths per 100,000 persons (from 247 total deaths in 2013 to 748 in 2017).[46] The main contributor to this sharp upsurge was fentanyl-related deaths, which increased by 179% (from 130 to 362 deaths) between 2015 and 2017.[47] Furthermore, between 2014 and 2017, hospitalizations due to opioid overdose increased by forty-eight percent, from 7,633 patients in 2014 to 10,873 patients in 2017.[48] And finally, first responders' utilization of naloxone, an opioid overdose antidote, soared by seventy-three percent, from 4,187 in 2014 to 7,278 in 2017.[49]

B. In Legislation

Concerned with this public health crisis, the South Carolina General Assembly has taken several legislative steps to address the multifarious nature of this epidemic. In 2014, the state legislature passed Senate Bill 840, which modified the requirements for drug dispensers to report to the PDMP on a daily—rather than monthly—basis.[50] This change not only increased the efficiency of the PDMP to track data in real time, but it also positively

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diversion of prescription drugs. . . ." *Id.* § 44-53-1620. The PDMP mandates that dispensers report any and all prescriptions of Schedule II, III, and IV drugs to the program's database. *Id.* § 44-53-1640 (2018 & Supp. 2018).

44. *South Carolina Opioid Summary*, NAT'L INST. ON DRUG ABUSE, https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/south-carolina-opioid-summary (last updated Feb. 2018) (citing XPONENT, IMS HEALTH (2016)).

45. *See Opioid Summaries by State*, NAT'L INST. ON DRUG ABUSE, https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state (last updated Feb. 2018).

46. *See South Carolina Opioid Summary*, NAT'L INST. ON DRUG ABUSE, https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/south-carolina-opioid-summary (last updated Feb. 2018); S.C. DEP'T OF HEALTH & ENVTL. CONTROL, DRUG OVERDOSE DEATHS: SOUTH CAROLINA (2017).

47. S.C. DEP'T OF HEALTH AND ENVTL. CONTROL, *supra* note 46.

48. Statistical data on file with the author.

49. Arnold Alier, Division Director of SC DHEC Bureau of EMS, Roundtable at the 51st Annual Conference of the South Carolina Association of Counties: South Carolina Opioid Epidemic (Aug. 6, 2018) (available at http://www.sccounties.org/Data/Sites/1/media/meetings/annual-conference/presentations/2018/opioid-roundtable_alier.pdf).

50. S. 840, 120th Gen. Assemb., Reg. Sess. (S.C. 2014).

impacted law enforcement's abilities to investigate cases involving forged prescriptions or apprehend individuals who unlawfully receive similar medications from multiple prescribers ("doctor shopping"). The following year, the legislature passed the South Carolina Overdose Prevention Act.[51] This Act sought to provide civil and criminal immunity to prescribers, pharmacists, caregivers, and first responders who engage in the prescription, dispensation, and administration of naloxone in suspected opioid overdose cases.[52] The Overdose Prevention Act paved the way for the development of critical preventative programs, such as the South Carolina Law Enforcement Officer Naloxone (LEON) program. Funded by DAODAS and deployed by DHEC, LEON trains law enforcement officers to recognize the signs and symptoms of an opioid-related overdose and further equips them with naloxone to administer.[53] In the two full years that LEON has been operational, the program has trained more than 7,600 law enforcement officers from over one hundred law enforcement agencies in all forty-six counties in South Carolina.[54] Collectively, these trained law enforcement officers have administered the life-saving drug more than 580 times, saving the lives of close to 560 South Carolinians.[55]

In 2016, the General Assembly amended the Overdose Prevention Act to allow for a state-wide standing order for naloxone.[56] As a prescription-only drug, naloxone ordinarily requires consultation with a physician before it can be obtained. However, the statewide standing order eliminates that requirement and essentially shifts the status of naloxone to a "behind-the-counter" medication.[57] During the 2018 legislative session, the Overdose Prevention Act was amended again to include immunity for "Community Distributors."[58] The law defines Community Distributors as "organization[s], either public or private that provide substance use disorder assistance and services, such as counseling, homeless services, advocacy, harm-reduction, alcohol and drug screening, and treatment to individuals at risk of experiencing an opioid-related overdose."[59] In its 2018 report, the South Carolina House Opioid Abuse Prevention Study Committee noted that chronic illicit opioid users are not likely to spend money on naloxone or to walk into

51. S.C. CODE ANN. § 44-130-10 (2018).
52. *Id.* §§ 44-130-30 to -60 (2018).
53. *Opioid Epidemic*, S.C. DEP'T OF HEALTH AND ENVTL. CONTROL, https://www.scdhec.gov/opioid-epidemic (last visited Mar. 29, 2019).
54. Statistical data on file with the author.
55. Statistical data on file with the author.
56. H.R. 5193, 121st Gen. Assemb., Reg. Sess. (S.C. 2016).
57. *See* § 44-130-40.
58. H.R. 4600, 122nd Gen. Assemb., Reg. Sess. (S.C. 2018).
59. S.C. CODE ANN. § 44-130-20(2) (Supp. 2018).

pharmacies to obtain it.[60] Because Community Distributors tend to come into daily contact with this vulnerable population, the law now permits these organizations to purchase naloxone in bulk, without the need for the medication to be patient-specific, and to distribute it according to the prescribed guidelines.[61]

IV. THE SCIENCE OF ADDICTION

In its final 2018 report, the House Opioid Abuse Prevention Study Committee also recommended expanding access to Medically Assisted Treatment (MAT).[62] Years of medical research and numerous studies have confirmed MAT's effectiveness over abstinence-based treatment for opioid dependency.[63] However, understanding its efficacy requires a basic knowledge of the science of opioid addiction and the evolution of addiction treatment. Essentially, opioids activate areas in the brain and central nervous system that decrease the perception of pain, while at the same time increasing feelings of pleasure, euphoria, and relaxation.[64] It is the latter set of reactions that leads so many into addiction.[65] Often times, it begins with a legitimate use of opioids to control pain or a brief experimental use for recreational purpose.[66] As use of the opioids continues, the brain cells adapt to the intake dosage and begin to develop tolerance, which then requires a larger intake of opioids to achieve the same effects.[67] This, in turn, forms a complete physical dependency with severe withdrawal symptoms that can lead to an unrelenting drug-seeking behavior.[68] This physiological transformation is scientifically researched and proven, as both the American Society of Addiction Medicine

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60. S.C. H.R. OPIOID ABUSE PREVENTION STUDY COMM., FINAL REPORT, H.R. 122, at 14 (2018).

61. *See* S.C. CODE ANN. § 44-130-70 (Supp. 2018).

62. S.C. H.R. OPIOID ABUSE PREVENTION STUDY COMM., *supra* note 60, at 17.

63. *See generally* Björn Axel Johansson et al., *Efficacy of Maintenance Treatment with Naltrexone for Opioid Dependence: A Meta-analytical Review*, 101 ADDICTION 491 (2006); Lisa A. Marsch, *The Efficacy of Methadone Maintenance Interventions in Reducing Illicit Opiate Use, HIV Risk Behavior and Criminality: A Meta-Analysis*, 93 ADDICTION 515 (1998); Richard P. Mattick et al., *Buprenorphine Maintenance Versus Placebo or Methadone Maintenance for Opioid Dependence*, 2 COCHRANE DATABASE OF SYSTEMATIC REVS. at 1, 2 (Feb. 6, 2014).

64. *See Prescription Pain Medications (Opioids),* NAT'L INST. DRUG ABUSE FOR TEENS, https://teens.drugabuse.gov/drug-facts/prescription-pain-medications-opioids (last updated Mar. 19, 2017).

65. *Id.*

66. *Id.*

67. *Id.*

68 *Id.*

and the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), classify addiction as a "primary, chronic disease" of the brain.[69]

A. Drug Addiction as Chronic Disease

The use of the term "chronic" to describe addiction is not accidental. Other chronic diseases, such as diabetes and high cholesterol, require long-term and comprehensive treatments, often spanning patients' entire lifetimes.[70] Whether these diseases are acquired at birth or later in life, their treatments are multi-layered and include not only medications, but also specific diets, exercise regimens, and lifestyle choices.[71] Furthermore, patients who suffer from these chronic diseases are cared for and treated by a slew of professionals, including physicians, nurses, pharmacists, dieticians, psychologists, psychiatrists, and fitness trainers. In this respect, addiction is no different. Whether developed as the result of recreational drug use or the legitimate treatment of pain, once it is fully developed and manifested in a person, a multi-prong approach is needed to address it, and MAT functions as a crucial component of this approach.

The comparisons between OUD and other chronic diseases continue beyond the classification level. Similar to chronic diabetic patients without access to insulin, for example, OUD patients without access to medications are proven to have an increased chance of relapse and a reduced chance of remaining in treatment.[72] Furthermore, like chronic patients with high cholesterol who take statins as instructed but disregard their dietary instructions,[73] OUD patients who take medication but do not engage in behavioral treatment may not achieve the maximum benefits from MAT. The same comparative analysis applies to other common adverse factors shared by

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69. TREATING OPIOID ADDICTION AS A CHRONIC DISEASE, AM. SOC'Y ADDICTION MED. (Nov. 7, 2014), https://www.asam.org/docs/default-source/advocacy/cmm-fact-sheet---11-07-14.pdf. *See generally* THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 540–46 (Am. Psychiatric Ass'n 5th ed., 2013) (regarding addiction generally).

70. *See Drug Abuse and Addiction: One of America's Most Challenging Public Health Problems*, NAT'L INST. ON DRUG ABUSE, https://archives.drugabuse.gov/publications/drug-abuse-addiction-one-americas-most-challenging-public-health-problems/addiction-chronic-disease (last visited Mar. 29, 2019).

71. *Id.*

72. *See* Hilary Smith Connery, *Medication-Assisted Treatment of Opioid Use Disorder: Review of the Evidence and Future Directions*, 23 HARV. REV. PSYCHIATRY 63, 66 (2015).

73. Janet Lubman Rathner, *Statin Medications Are Not a Blank Check for Eating Poorly*, LABORERS' HEALTH & SAFETY FUND OF N. AM., (July 2014), https://www.lhsfna.org/index.cfm/lifelines/july-2014/statin-medications-are-not-a-blank-check-for-eating-poorly.

chronic diseases, such as the lack of supervision by medical professionals, improper dosing of medication, lack of emotional and social support, and the fear of stigma. As a result of such commonplace factors, a well-planned OUD recovery program that includes behavioral treatment, access to an FDA-approved medication for OUD treatment, and wrap-around services (e.g., housing, Peer Support Specialists) provides the greatest chance to successfully address this chronic disease.

B. Medically Assisted Treatment: Methadone, Buprenorphine and Naltrexone

At the time of this Article's publication, the FDA has approved three different medications for treating OUD.[74] The first, methadone, is the most studied of the three and dates back to the wave of opioid addiction that washed across the country in the 1970s.[75] During that period, the United States faced an influx of opioid-related drug use, addiction, and crime. In response, the Nixon administration dramatically increased federal funding to stem the supply of illicit opioids—mainly heroin—entering the United States.[76] A fact less known is that the Nixon administration also provided funding for demand reduction.[77] In his June 1971 address to Congress, President Nixon argued that "[w]e must rehabilitate the drug user if we are to eliminate drug abuse and the antisocial activities that flow from drug abuse."[78] Consequently, the Nixon Administration funded the development of the methadone programs.[79]

Although methadone was initially developed by German scientists during World War II to handle a morphine shortage, researchers did not realize its therapeutic attributes for opioid addiction until the 1960s.[80] As a full opioid agonist[81] medication, methadone produces reactions in the brain similar to

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74. *Information about Medication-Assisted Treatment (MAT)*, FOOD & DRUG ADMIN., https://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm600092.htm (last updated Feb. 13, 2019).

75. *Soldiers, Hippies and Richard Nixon–An American History of Methadone*, CRC HEALTH, https://www.crchealth.com/addiction/heroin-addiction-treatment/heroin-detox/history_methadone (last visited Mar. 29, 2019) [hereinafter CRC HEALTH].

76. *Id.*

77. *See id.*

78. Richard M. Nixon, U.S. President, Special Message to the Congress on Drug Abuse Prevention and Control (June 17, 1971) (transcript available at https://library.cqpress.com/cqalmanac/document.php?id=cqal71-869-26707-1255187).

79. CRC HEALTH, *supra* note 75.

80. *See id.*

81. Agonist, partial-agonist and antagonist describe the strength of interaction between the medication and the affected brain-cells. Opioid agonist medications latch on to the opioid receptors stronger and therefore produce greater interaction with these receptors. *See* Jeffrey

other opioids. However, what sets it apart from heroin and other "short-acting" opioids is its longer half-life, which reduces withdrawal symptoms and cravings for opioids in chemically-dependent patients.[82] More importantly, researchers found methadone does not produce the same euphoric and tranquilizing effects as other opioids—when properly dosed—in OUD patients.[83] Collectively, these factors have been shown to reduce drug-seeking behavior in OUD patients and increase patients' engagement in productive lifestyles.[84] With almost fifty years of implementation, methadone treatment is one of the most researched approaches to treating opioid addiction. It is considered by the federal government—as well as the medical and treatment communities—to be the "gold standard" for OUD treatment.[85] Today, methadone maintenance treatment (MMT) programs dispense the medication to their patients daily in a liquid form to maximize its dosing effects on individual patients.[86] The programs also incorporate behavioral treatment, as federal and state regulations mandate that patients meet with treatment counselors and medical professionals before receiving the medication or continuing with an MMT program.[87]

In 2002, the FDA approved a second medication for OUD treatment, buprenorphine.[88] Recognized primarily by its brand names Subutex© and Suboxone©, it is a long-acting, but partial-agonist, opioid.[89] Since its approval, numerous studies have demonstrated the efficacy of buprenorphine as a medication for maintenance treatment in opioid-dependent individuals.[90] Similar to methadone, the long half-life of the medication helps curb opioid withdrawal symptoms, thereby mitigating the risks for relapse and overdose.[91]

Fudin, *Opioid Agonists, Partial Agonists, Antagonists: Oh My!*, PHARMACY TIMES (Jan. 6, 2018, 1:00 PM), https://www.pharmacytimes.com/contributor/jeffrey-fudin/2018/01/opioid-agonists-partial-agonists-antagonists-oh-my (discussing the different categories of opioids).

82. Marsch, *supra* note 63, at 515.

83. *Id.* at 515–16 (citations omitted).

84. *Id.* at 515.

85. Connery, *supra* note 72, at 63.

86. Justin J. Sanders et al., *Meaning and Methadone: A Model for Promoting Adherence in MMT, Based on Patients' Perceptions*, ADDICTION TREATMENT F. (Nov. 15, 2013), http://atforum.com/2013/11/meaning-and-methadone-a-model-for-promoting-adherence-in-mmt-based-on-patients-perceptions.

87. 42 C.F.R. § 8.12(f)(2) (2018); S.C. CODE ANN. REGS. § 61-4.1011 (Supp. 2018).

88. CTR. FOR SUBSTANCE ABUSE TREATMENT, CLINICAL GUIDELINES FOR THE USE OF BUPRENORPHINE IN THE TREATMENT OF OPIOID ADDICTION 2 (2004).

89. *See id.*

90. *E.g.*, Mattick, *supra* note 63, at 2.

91. *See* Xiaofan Li et al., *Buprenorphine Prescribing: To Expand or Not to Expand*, 22 J. PSYCHIATRIC PRAC. 183–92, at 3 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4852384.

However, unlike methadone, federal law caps buprenorphine prescribers at a certain number of patients, and authorization from the DEA is required to increase a prescriber's patient census.[92] "In 2000, Congress passed the Drug Abuse Treatment Act of 2000 (DATA 2000), which permitted qualified prescribers to obtain a waiver to treat opioid addiction with Schedule III-V medications."[93] The waiver allowed practitioners to engage in opioid-based treatment directly from their offices and "outside the traditional setting of the [MMT] programs."[94] In capping the number of patients, Congress expressed its concerns about abuse and diversion of buprenorphine that might be associated with increased accessibility and wider availability.[95] In 2006, Congress raised the limit to one hundred patients per prescriber, and did so once more in 2016 to a maximum of 275 patients for qualifying prescribers.[96] Unfortunately, even with the cap increases, the shortage in buprenorphine prescribers is quite noticeable. Recent studies point out that an estimated fifty-three percent of the counties in the United States do not have a single prescriber with a DEA DATA waiver.[97]

While the current push to make buprenorphine more available nationwide is in full swing, practitioners and OUD patients can also consider the FDA-approved naltrexone as a third option. Although developed in 1963 and patented in 1967, naltrexone did not receive FDA approval until 1984—and its approval only occurred after the National Institute on Drug Abuse (NIDA) stepped in and offered substantial funding to cover the costs of its clinical development.[98] Interestingly, NIDA originally developed naltrexone as medication to treat alcohol dependency. Research confirmed its efficacy in decreasing the amount and frequency of alcohol consumption in alcohol-

92. *Id.* at 4.

93. *Id.* Qualified prescribers include physicians, nurse practitioners (NPs) and physician assistants (PAs). *Qualify for Nurse Practitioners (NPs) and Physician Assistants (PAs) Waiver*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/training-materials-resources/qualify-np-pa-waivers (last updated Mar. 4, 2019).

94. Li et al., *supra* note 91, at 4.

95. *Cf. id.* at 8 (noting the authors' concerns of inevitable abuse).

96. *See Apply to Increase Patient Limits*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management/increase-patient-limits (last updated Feb. 9, 2017); *see also* 42 C.F.R. § 8.620 (2018).

97. Roger A. Rosenblatt et al., *Geographic and Specialty Distribution of US Physicians Trained to Treat Opioid Use Disorder*, 13 ANNALS OF FAM. MED. 23, 24 (2015).

98. *See* NAT'L INST. ON DRUG ABUSE, NARCOTIC ANTAGONISTS: NALTREXONE PHARMACOCHEMISTRY AND SUSTAINED-RELEASE PREPARATIONS 8 (1981); JOSEPH WOUK, GOOGLE: LDN! HOW AN OVERLOOKED DRUG RELIEVES CANCER, MS, AND IMMUNE SYSTEM DISORDERS FOR A DOLLAR A DAY 78–79 (2008).

dependent patients.[99] In treating OUDs, naltrexone is approved for administration either as a daily oral dose in pill form or as a monthly intermuscular injection (Vivitrol©). Unlike the opioid-agonists methadone and buprenorphine, naltrexone is an opioid-antagonist medication. It attaches to the brain's opioid receptors and creates a barrier that blocks opioid molecules from attaching to the receptors.[100] Furthermore, as an opioid antagonist, naltrexone is not subject to misuse, diversion, or risks of overdose on its own. However, among the three FDA-approved medications, naltrexone has the most complicated process for induction into treatment. To avoid severe opioid withdrawal, candidates for naltrexone treatment must be free of all opioids prior to dosing, which can typically take seven to fourteen days.[101] Consequently, research indicates that prolonged symptoms of opioid withdrawal during washout do pose a higher risk for treatment dropout and relapse.[102]

C. The Choice

With all three FDA-approved medications available in some capacity to OUD patients across the country, the ultimate decision as to which is the appropriate medical therapy is made by and between the patient and the treating practitioner. This approach is consistent with decision-making processes associated with other chronic diseases. For example, treatment options for elevated cholesterol levels can range from simple dietary changes to intake of a daily dose of medication to surgery, any of which may be considered by patients pursuant to an informed decision-making process with their treating practitioners. OUD patients still face many obstacles that greatly diminish their access to MAT services, from the "shame" that frequently accompanies drug addiction to the inappropriate stigma that is associated with methadone treatment programs—or even the sheer unavailability of DATA-waivered buprenorphine prescribers. As will be discussed below, MAT

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99. Henry R. Kranzler & Jeffry Van Kirk, *Efficacy of Naltrexone and Acamprosate for Alcoholism Treatment: A Meta-Analysis*, 25 ALCOHOLISM: CLINICAL & EXPERIMENTAL RES., 1335, 1335 (2001) (first citing James C. Garbutt et al., *Pharmacological Treatment of Alcohol Dependence: A Review of the Evidence*, 281 J. AM. MED. ASS'N 1318, 1318–25 (1999); and then citing Henry R. Kranzler, *Pharmacotherapy of Alcoholism: Gaps in Knowledge and Opportunities for Research*, 35 ALCOHOL & ALCOHOLISM 537, 537–47 (2000)).

100. *How Vivitrol Works*, VIVITROL, https://www.vivitrol.com/opioid-dependence/how-vivitrol-works (last visited Mar. 29, 2019).

101. Connery, *supra* note 72, at 68.

102. Stacey C. Sigmon et al., *Opioid Detoxification and Naltrexone Induction Strategies: Recommendations for Clinical Practice*, 38 AM. J. DRUG & ALCOHOL ABUSE 187, 187 (2012) (footnotes omitted).

services accessibility is further complicated when the criminal justice system is involved.

V. MEDICALLY ASSISTED TREATMENT IN THE CRIMINAL JUSTICE SYSTEM

The criminal justice system in the United States has been late to incorporate MAT into the treatment of defendants with an underlying OUD. In 2013, the National Association of Drug Court Professionals (NADCP) found that nearly half of the country's drug courts do not use medications in their programs due to a lack of awareness or familiarity with MAT.[103] This result occurred even though the NADCP—several years prior—issued a unanimous resolution urging drug courts to learn the facts about MAT and obtain expert consultation from duly trained addiction psychiatrists or addiction physicians.[104] Furthermore, in its Adult Drug Court Best Practices Standards, the NADCP concludes that MAT can "significantly improve outcomes for" offenders, and "has been shown to significantly increase [opioid-dependent] inmates' engagement in treatment; reduce illicit [opioid] use; reduce rearrests, technical parole violations, and reincarceration rates; and reduce mortality and hepatitis C infections."[105] Of course, drug courts, as post-plea diversionary programs, represent only a minuscule fraction of cases in the criminal justice system as a whole. As a result, the fact remains that every year the vast majority of chemically dependent offenders pass through the criminal justice system without ever receiving treatment, let alone MAT.[106]

A. Drug Dependency and Crime

When it comes to chemically dependent offenders, the lack of proper treatment in the criminal justice system has a strong correlation to higher rates of incarceration. In 2017, the South Carolina Department of Corrections (SCDC) reported 20,951 individuals incarcerated in its facilities across the

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103. NAT'L ASS'N OF DRUG COURT PROF'LS, ADULT DRUG COURT BEST PRACTICE STANDARDS, at 44–45 (text rev. 2018) (citation omitted).

104. NAT. ASS'N OF DRUG COURT PROF'LS, RESOLUTION OF THE BOARD OF DIRECTORS ON THE AVAILABILITY OF MEDICALLY ASSISTED TREATMENT (M.A.T.) FOR ADDICTION IN DRUG COURTS (2010), https://ndcrc.org/wp-content/plugins/download-attachments/includes/download.php?id=3223.

105. NAT'L ASS'N OF DRUG COURT PROF'LS, *supra* note 103, at 44 (citations omitted).

106. NAT'L INSTS. OF HEALTH, ADDICTION AND THE CRIMINAL JUSTICE SYSTEM 1 (2010) (citations omitted), https://report.nih.gov/nihfactsheets/Pdfs/AddictionandtheCriminalJusticeSystem(NIDA).pdf.

state, consisting of 19,491 males and 1,460 females.[107] In its latest census, the SCDC showed that one-third of the male population (7,122) and over half of the female population (753) were classified as chemically dependent.[108] A further analysis of these figures demonstrates that approximately sixty-four percent of the chemically dependent inmates currently serve sentences for major crimes, such as murders, burglaries, and armed robberies.[109] This correlation provides strong evidence that drug dependency plays a major role in criminal behavior and recidivism. It also highlights the need for states to explore ways to provide evidence-based treatment to chemically dependent offenders when they intersect with the criminal justice system.[110]

B. The Sequential Intercept Model

There are five points of intersection in the criminal justice system where treatment for chemically dependent offenders can make a difference: deflection, pre-plea diversion, post-plea diversion, post-conviction, and post-release. These structural points are part of what is known as the Sequential Intercept Model (SIM). The SIM is a conceptual model that was developed in 2006 by Mark R. Munets, M.D., and Patricia A. Griffin, Ph.D., in collaboration with the federal Substance Abuse and Mental Health Services Administration (SAMHSA).[111] The SIM envisions these points of "interception" as opportunities for intervention to prevent chemically dependent individuals from entering or penetrating deeper into the criminal justice system.[112] The interception itself has:

> several objectives, [such as] preventing initial involvement in the criminal justice system, decreasing admissions to jail, engaging individuals in treatment as soon as possible, minimizing time spent moving through the criminal justice system, linking individuals to

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107. Statistical data on file with the Author.

108. Statistical data on file with the Author.

109. Statistical data on file with the Author.

110. Matthias Pierce et al., *Insights into the Link Between Drug Use and Criminality: Lifetime Offending of Criminally-Active Opiate Users*, 179 DRUG & ALCOHOL DEPENDENCE, 309, 314, (2017) (citation omitted).

111. Mark R. Munetz & Patricia A. Griffin, *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*, 57 PSYCHIATRIC SERVS. 544, 544 (2006).

112. *Id.*

community treatment upon release from incarceration, and decreasing the rate of return to the criminal justice system.[113]

Recognizing its benefits, a growing number of correctional and law enforcement agencies, as well as prosecutorial entities across South Carolina, have begun taking notice of the SIM and have steadily increased efforts to make OUD treatment more accessible at the various points of intersection.

C. The First Intercept: Deflection

Of the five intercept points, the first one involves deflection from the criminal justice system altogether, leading to an early intervention and access to treatment. In essence, deflection aims to divert chemically dependent offenders from arrest, and with the help of law enforcement, direct them to community-based services without the need to leverage the court through adjudication.[114] The Law Enforcement Assisted Diversion (LEAD) program is a great example of a successful deflection model. Originally launched in 2011 in Seattle, Washington, the program is currently implemented in several other jurisdictions across the country.[115] The program teaches law enforcement officers how to exercise their discretionary arresting authority at the point of contact with chemically dependent offenders for the purpose of diverting them to community-based treatments or harm-reduction interventions. This is especially prevalent in cases involving legal violations that are driven by unmet behavioral health needs.[116] In a 2017 study of the program, researchers confirmed significant positive outcomes in LEAD participants with respect to housing, employment, and income—these outcomes ultimately resulted in a thirty-three percent reduction in recidivism.[117] Although law enforcement agencies in South Carolina have yet to implement a LEAD-model program, the Mount Pleasant Police Department did develop—and is currently implementing—an opioid-based deflection

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113. *Id.* at 545 (citations omitted).

114. *See* Substance Abuse and Mental Health Services Administration, *Justice Intervention: Bringing Services to Scale Discussion Guide*, RECOVERY MONTH (Dec. 18, 2017), https://recoverymonth.gov/sites/default/files/roadtorecovery/r2r2018-july-discussion-guide-508.pdf.

115. *See What is LEAD?*, LEAD NAT'L SUPPORT BUREAU, https://www.leadbureau.org/about-lead (last visited Mar. 29, 2019); *About the Bureau*, LEAD NAT'L SUPPORT BUREAU, https://www.leadbureau.org/about-the-bureau (last visited Mar. 29, 2019).

116. *What is LEAD?*, *supra* note 115.

117. Seema L. Clifasefi et al., *Seattle's Law Enforcement Assisted Diversion (LEAD) Program: Within-Subjects Changes on Housing, Employment, and Income/Benefits Outcomes and Associations with Recidivism*, 63 CRIME & DELINQUENCY 429, 429–30 (2017).

program called First Step. The program began operation in July 2018, and it aims to prevent opioid-related overdoses by connecting opioid users and their families with MAT and behavioral treatments.[118]

D. The Second Intercept: Pre-Plea Diversion

While the first intercept operates outside the reach of the court system, the second, third, and fourth intercepts are all well within the system—and as a result—are more complex to implement. Part of the complexity is due to an unavoidable gap in time from the moment of arrest to the disposition of the criminal case. During this gap, the prosecution is ethically discharging its duties in administering justice via the gathering of case materials and evidence from the arresting agency, reviewing these files in their entirety, turning them over to the defense through the discovery process, contacting the victims, discussing any legal challenges that the defense advances, and finally, formulating the appropriate plea offer. However, from a treatment perspective, this gap in time—created by the unavoidable process of processing a case through our legal system—is counterproductive when addressing opioid-dependent individuals. Defendants who are not able to post bond remain incarcerated at local detention centers, where they are not only forced into abstinence, but are also unable to receive the medically adequate treatment to address their underlying substance use disorder. To complicate matters even more, opioid-dependent offenders who remain incarcerated for longer periods of time—while remaining abstinent—experience a significant decrease in their opioid tolerance.[119] As a result, once these individuals are released back into society, they are at an increased risk of drug-related death—especially in the first two to four weeks following release.[120] However, defendants who are able to post bond are no better positioned to address their underlying OUD. Concerned defense counsel cannot petition the court for

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118. Angie Jackson, *Amid Opioid Crisis, Mount Pleasant Police First in SC to Launch Recovery-Focused Program*, POST & COURIER (Aug. 5, 2018), https://www.postandcourier.com/news/amid-opioid-crisis-mount-pleasant-police-first-in-sc-to/article_0b5a869c-861b-11e8-8709-b7b231fe8d4e.html.

119. Elizabeth L. C. Merrall et al., *Meta-Analysis of Drug-Related Deaths Soon After Release from Prison*, 105 ADDICTION 1545, 1545 (2010).

120. Sheila M. Bird & Sharon J. Hutchinson, *Male Drugs-Related Death in the Fortnight After Release from Prison: Scotland, 1996–99*, 98 ADDICTION 185, 185 (2003) (citing S.R. Seaman et al., *Mortality from Overdose Among Injecting Drug Users Recently Released from Prison: Database Linkage Study*, 316 BRITISH MED. J. 426, 428 (1998)).

drug treatment without their clients' consent.[121] As a result, with the absence of judicial authority to order chemically dependent defendants into treatment until the time of a plea, they remain at a higher risk of drug overdoses and recidivism regardless of their ability to post bail.

The second SIM intercept, pre-plea diversion, provides an opportunity to increase access to treatment notwithstanding the aforementioned time gap. Although many judicial circuits in the state already operate diversionary programs, such as Pre-Trial Intervention, Alcohol Education Programs, and Traffic Education Programs,[122] the reality is that none of these programs is adequately equipped to address the complex nature of drug addiction. To bridge this gap, DAODAS formulated the Medication-Assisted Treatment Court (MATC) program in 2017.[123] By drawing on knowledge and experience from both the worlds of the judicial system and drug addiction treatment, the program capitalizes on the judicial time gap. The MATC provides opioid-dependent defendants with access to treatment, and it does so with minimal interruption of the judicial process of pending criminal cases.

MATC commences upon arrest; therefore, it is essential to identify the appropriate participants prior to setting bond. Since defendants' right to bond in criminal matters is embedded in the United States Constitution, the South Carolina Constitution, and the South Carolina Code of Laws, arresting agencies and intake personnel at the detention centers must work quickly and efficiently to screen defendants' appropriateness for the program prior to the defendants' departure from incarceration.[124] In some cases, the presence of opioid dependency is evident from the charges pending against the defendant, such as possession of heroin or drug paraphernalia.[125] In other cases, it can be ascertained from the officers' engagement with individuals they know—or

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121. *See generally* MODEL RULES OF PROF'L CONDUCT r. 1.4 (a)(2) (AM. BAR ASS'N 2018) ("A lawyer shall . . . reasonably consult with the client about the means by which the client's objectives are to be accomplished.").

122. S.C. COMM'N ON PROSECUTION COORDINATION, DIVERSION PROGRAMS OFFERED BY THE OFFICES OF SOLICITOR BY CIRCUIT AND COUNTY (2018), https://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee/AgencyWebpages/ProsecutionCoordination/Diversion%20programs%20offered%20by%20the%20Circuit%20Solicitors'%20Offices%20(as%20of%20July%202018).pdf.

123. S.C. Dep't of Alcohol and Other Drug Abuse Services, South Carolina's Medication-Assisted Treatment Court Project (unpublished proposal) (on file with author).

124. *See* U.S. CONST. amend. VIII; S.C. CONST. art. 1, § 15; S.C. CODE ANN. § 17-15-10 (Supp. 2018) ("Person charged with noncapital offense may be released on his own recognizance").

125. S.C. CODE ANN. § 44-53-370(c) (2018) (prohibiting intentional or knowing possession of a controlled substance unless obtained directly via prescription); *Id.* § 44-53-391 ("It shall be unlawful for any person to advertise for sale, manufacture, possess, sell or deliver or to possess with the intent to deliver, or sell paraphernalia.").

recognize—as chemically dependent. However, neither of these methods is sufficient to identify the vast majority of opioid-dependent individuals who trickle through the criminal justice system. To standardize the identification process, MATC utilizes the evidence-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) model. Developed by professionals at the Institute of Medicine, SBIRT provides a simple and reliable method for community-based screening for health risk behaviors, which includes substance use.[126] Through a series of short but carefully crafted questions, intake personnel can identify and flag arrestees with OUD and initiate the process for their inclusion in MATC.

A positive screen is followed by notification of a Peer Support Specialist (PSS). A PSS is a man or woman who has experienced the challenges and successes of the earlier stages of substance use and recovery. The importance of having a PSS involved with arrested individuals at a point of incarceration—and throughout the program—cannot be understated. Research recognizes that "[p]eople who have common life experiences also have a unique capacity to help one another based on a shared affiliation and a deep understanding that go beyond what exists in their other relationships."[127] Additionally, well-qualified and vetted peers can "offer their experience, strength, and hope, which allows for a natural evolution of personal growth, wellness promotion, and recovery."[128] Following notification from the detention center, the PSS—along with a drug treatment counselor—meets with a defendant at the detention center, explains the purpose and goals of MATC, and conducts a comprehensive assessment to determine the defendant's level of addiction and proper course of treatment. If a defendant is diagnosed as appropriate for MATC, the counselor notifies the bond court prior to the setting of bond.

When determining bond amounts for MATC-appropriate defendants, bond courts do not deviate from the outlined statutorily-defined criteria.[129]

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126. *SBIRT: Screening, Brief Intervention, and Referral to Treatment*, SAMSHA-HRSA CTR. FOR INTEGRATED HEALTH SOLUTIONS, https://www.integration.samhsa.gov/clinical-practice/sbirt (last visited Mar. 29, 2019).

127. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEPT. OF HEALTH & HUMAN SERVS., PUB. SMA-11-4633, CONSUMER OPERATED SERVICES: THE EVIDENCE 7 (2011) (citation omitted).

128. *Id.* (citation omitted).

129. As previously stated, in South Carolina, any "[p]erson charged with a non-capital offense may be released on his own recognizance." § 17-15-10. In cases where personal recognizance does not reasonably ensure the appearance of the person, or where the person poses a danger to the community or an individual, the court may impose additional conditions on the release. These may include requiring the person to post a surety bond, restrictions on travel, or

Instead, they suspend the original personal recognizance bond in favor of participation in MATC. This substitution of bonds allows defendants to be quickly released in order to commence treatment, and safeguards against penalizing defendants if they "fail out" of the program. Non-compliant MATC defendants are returned to the detention center for imposition of the original bond without risking bond revocation altogether. Compliant defendants enjoy access to MAT as well as behavioral treatment from qualified service providers. MATC participants also have increased access to ancillary services, such as housing solutions, transportation to and from court, and employment assistance. By incorporating the behavioral, medical, and wrap-around services in a single program, MATC desires to increase defendants' compliance with the court and reduce the likelihood of overdoses and recidivism. Inevitably, at the disposition of their criminal charges, MATC participants can accumulate several months of recovery and avoid recidivism. They are primed for success either in a drug court program—or alternatively—are able to use MATC involvement as a mitigating factor in traditional plea and sentencing.

The success of a program such as MATC hinges entirely on its stakeholders' ability to synergistically communicate and collaborate among themselves. Unlike deflection programs—which require fewer entities to deploy—MATC is multi-layered and encompasses numerous stakeholders at various times throughout the lifespan of the criminal case. These stakeholders include magistrate and general sessions judges, solicitors and assistant solicitors, public defenders, law enforcement agencies, county detention centers, behavioral health treatment providers, physicians, nurse practitioners, methadone maintenance programs, housing organizations, peer-support services, and other at-large community partnerships. Consequently, rapid communication and fostering trust among participating entities is challenging. In addressing this concern, MATC singles out three primary stakeholders who are responsible for the day-to-day effective flow of accurate information on the participants: the solicitor's office, the treatment service provider, and the PSS. Alternatively, anecdotal stakeholders, such as bond courts or housing organizations, are consulted as needed and draw upon the information supplied by the primary stakeholders.

Funding is another major obstacle to developing and implementing a pilot program such as MATC. In September 2018, the United States Bureau of Justice Assistance awarded DAODAS a competitive grant to establish the first

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placing the person on electronic monitoring. *See id.* § 17-15-10(A)(1)–(4) (stating the judge has discretion to impose any condition he or she deems "reasonably necessary").

MATC program in York County.[130] The grant, which totals $900,000 over a period of three years, aims to divert at least thirty defendants annually into treatment from the point of incarceration.[131] The project is a collaboration between DAODAS, the Sixteenth Judicial Circuit Solicitor's Office, the York County Sheriff's Office, Keystone Substance Abuse Services (treatment service provider), Rock Hill Treatment Specialists (methadone maintenance program), Oxford Houses, Peer Support Specialists trained by Faces and Voices of Recovery, as well as a research component to be conducted by Dr. Duane Neff and Dr. Jessica Yang with Winthrop University's Department of Social Work.[132] The pilot program's goal is to implement a successful and practical MATC model that can be duplicated elsewhere in South Carolina. Moreover, if successful, MATC's blueprints can extend beyond opioids to provide meaningful alternatives to incarceration for chemically dependent individuals, irrespective of MAT.

E. The Third Intercept: Post-Plea Diversion

While MATC addresses gaps in access to treatment from the point of arrest to disposition, the third sequential intercept, post-plea diversion, strives to address similar gaps in post-disposition programs, such as drug courts. The genesis of drug courts is intimately tied to the exponential growth in drug caseloads in the 1980s. "As a centerpiece of the so-called 'war on drugs,' elected officials across the nation backed efforts to arrest, prosecute, and imprison persons possessing or selling illegal drugs. As a result, arrests for drug-related violations represent the largest single category of police activity, particularly in the nation's major urban areas."[133] Since the creation of the first drug court in Dade County, Florida, in 1989, more research has been published on the effects of drug courts on the criminal justice system than virtually all other criminal programs combined.[134] According to the NADCP, the United States boasts over 2,700 drug courts, and the model is implemented in at least thirteen other countries.[135] In South Carolina, fifteen out of the sixteen judicial circuits operate drug courts. However, although the NADCP

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130. *See* U.S. BUREAU OF JUSTICE ASSISTANCE, SOUTH CAROLINA'S MEDICATION-ASSISTED TREATMENT COURT PROJECT, https://external.ojp.usdoj.gov/selector/awardDetail?awardNumber=2018-AR-BX-K028&fiscalYear=2018&applicationNumber=2018-H2059-SC-AR&programOffice=BJA&po=BJA (last visited Feb. 14, 2019).

131. *See id.*

132. *See id.*

133. DAVID W. NEUBAUER & HENRY F. FRADELLA, AMERICA'S COURTS AND THE CRIMINAL JUSTICE SYSTEM 97 (13th ed).

134. NAT'L ASS'N OF DRUG COURT PROF'LS, *supra* note 103, at vi.

135. *Id.*

adopted the position that drug courts should explore the benefits of MAT, only one judicial circuit—in collaboration with DAODAS—has elected to do so.

Due to the fact that drug courts in South Carolina have been slow to harness the benefits of MAT, the House Opioid Abuse Prevention Study Committee recommended in its report that the General Assembly allocate funding to support MAT-based diversion programs.[136] In the 2018 legislative session, the General Assembly followed this recommendation and provided funding in *proviso*. The *proviso* tasks DAODAS to collaborate with a judicial circuit solicitor's office to establish a program that will provide both behavioral and medical treatment, consultations with Peer Support Specialists, and continued supervision of participants.[137] In late 2018, DAODAS partnered with the Sixteenth Judicial Circuit Solicitor's Office in York County to establish a first-of-its-kind MAT-based drug court in South Carolina.[138] The court treats ten participants with ranging levels of opioid dependency for a minimum of eighteen months. It is supervised by the Honorable Lee S. Alford, who also presides over the Circuit's primary drug court program. The program incorporates intensive outpatient treatment, to include all three FDA-approved medications, which are provided by Keystone Substance Abuse Services (York County's alcohol and drug abuse authority) and a local methadone maintenance program. Similar to MATC, this MAT-based drug court program is augmented with ancillary support services (e.g., peer support, housing, transportation) to ensure maximum compliance, low recidivism, and prevention of drug-related overdoses. From a research perspective, implementing both MATC and the MAT-based drug court as successive programs in the same county provides a unique opportunity to measure a continuum of care within the criminal justice system and its effects on criminal behavior.

F. The Fourth and Fifth Intercepts: Post-Conviction and Post-Release

Apart from engagement in pending criminal cases, DAODAS also recognizes the need to address drug dependency and relapse prevention in a

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136. S.C. H.R. OPIOID ABUSE PREVENTION STUDY COMM., FINDINGS AND RECOMMENDATIONS 23–24 (2018), https://www.scstatehouse.gov/CommitteeInfo/HouseOpioidAbusePreventionStudyCommittee/House%20Opioid%20Abuse%20Prevention%20Study%20Committee%20Final%20Report%202018.pdf.

137. H.R. 4950, 122nd Gen. Assemb. 1st Spec. Sess. (S.C. 2018).

138. Press Release, S.C. Dep't Alcohol & Other Drug Abuse Servs., DAODAS Pilots New Medication-Assisted Treatment Court Concept in York County (Mar. 3, 2019), http://www.daodas.sc.gov/wp-content/uploads/2019/03/Medication-Assisted-Treatment-Court-19-174B.pdf.

corrections setting. The fourth and fifth intercepts of the SIM, post-conviction and post-release, contemplate opportunities to increase access to treatment for incarcerated individuals or those who leave corrections. As discussed *supra*, incarcerated populations are especially susceptible to relapse and drug-related overdoses in post-release. Hence, the benefits of increasing drug treatment in corrections, especially MAT, are tremendous. Data from a recent study in Rhode Island that examined the benefits of providing MAT in corrections facilities demonstrated almost a sixty-one percent decrease in post-incarceration deaths.[139] Additionally, Rhode Island saw an overall twelve percent reduction in overdose deaths in the state's general population in the post-implementation period.[140] In South Carolina, SCDC has consistently shown interest in expanding access to evidence-based practices and developing programs for its incarcerated population.

In November 2017, DAODAS and SCDC started a small-scale pilot project to provide the opioid-antagonist Vivitrol© to inmates prior to their discharge from SCDC.[141] Similar to the program in Rhode Island, the aim of the South Carolina project is to reduce drug-related mortality rates in the post-release population. Additionally, the project helps inmates transition back into the community by connecting them with local treatment providers. At the heart of the project are two DAODAS Peer Support Specialists who work with both male and female inmates at various correctional facilities. Enrollment in the program is voluntary and is irrespective of receiving Vivitrol©. To date, the Peer Support Specialists have worked with over 270 inmates to maximize their access to treatment while transitioning back into communities across the state.[142] Out of this group, sixteen have elected to receive Vivitrol© prior to release. The Peer Support Specialists follow up with participants at thirty, sixty, ninety, and 180 days post-release to evaluate their engagement in treatment, housing, and employment. The results are promising. Out of the sixteen who received Vivitrol© prior to release, thirteen have secured transitional housing, and twelve are gainfully employed. The vast majority are still engaged in treatment and—more importantly—none has suffered a drug-

139. Traci C. Green et al., *Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System*, 75 J. AM. MED. ASS'N PSYCHIATRY 405, 406 (2018).

140. *Id.* at 405–06.

141. Andrew Brown, *South Carolina Prisons Attempting Trial Run For New Opioid Treatment Drug*, POST & COURIER (Sep. 4, 2017), https://www.postandcourier.com/news/south-carolina-prisons-attempting-trial-run-for-new-opioid-treatment/article_3b559298-8c1a-11e7-978d-174ab60d0b25.html.

142. S.C. DEPT. OF ALCOHOL & OTHER DRUG ABUSE SERVS., BUDGET REQUEST FISCAL YEAR 2018–2019 (Jan. 23, 2018).

related overdose.[143] Both SCDC and DAODAS are in the process of expanding the program to reach a wider range of the incarcerated population.

VI. CONCLUSION

For too long, misinformation, judgment, and prejudice took the lead in treating drug dependency in the United States. As evidenced by the raging opioid-related public health crisis impacting the nation, years of heavy criminal penalties for drug crimes and mass incarceration have yielded very few results in reducing drug addiction or in making communities safer. If anything, the monstrous size of this epidemic exposed how drug use has infiltrated the American way of life with utter disregard for race or socio-economic status. It brought to light not only the shame and stigma of drug use, but also the insidious greed of those who profited from it. This Article's highlighted programs demonstrate not only the untapped opportunities for drug addiction treatment within the criminal justice system, but also the need to shift resources and reexamine the current prevailing criminal justice mindset in South Carolina.

143. *See generally* Harold Blackwell, *MAT Program Weekly Client Tracker Log–Weekending*, Nov. 16, 2018 (showing no record of overdoses) (on file with author).

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