The Failure of the War on Drugs:

Charting a New Course for the Commonwealth

REPORT OF THE
MASSACHUSETTS BAR ASSSOCIATION
DRUG POLICY TASK FORCE

David W. White Jr., ***Chair***

Our current policy mix is not working the way we want it to. The ease with which drugs can be obtained, the price, the number of people using drugs, the violence on the border all show that. We need to rethink our responses to the health effects, the economic impacts, the effect on crime. We need to rethink our approach to the supply and demand of drugs.

James Webb, U.S. Senator (Virginia), 2008.

ACKNOLWEDGEMENTS

The report of this Task Force is the work of a wide range of contributors who volunteered their considerable expertise, time and energy. The Task Force acknowledges the inspiration and guidance of attorney and state representative Roger Goodman of Washington State. The staff of the Massachusetts Bar Association supported the work of the Task Force in every way. The Task Force's work could not have been completed without the dedicated perseverance of its subcommittee chairs. The Task Force also thanks Matt Allen for data compilation and analysis. The Task Force also thanks Melissa Romaneck, Dorothy Weitzman and Roberta Leis for their valuable editorial assistance.

Contents

Executive Summary 1

Recommendations 2

Section I: Introduction 5

Section II: Prevention and Education: Saving Lives and Saving Dollars 7

Section III: Reforming Punitive Sentencing 13

Section IV: Treatment Works 22

Section V: Conclusions: A Diagnosis of Policy Flaws 29

Section VI: Recommendations: A New Direction 31

Notes 36

Committee Members 39

Appendix 40

Executive Summary to the Report of the Drug Policy Task Force of the Massachusetts Bar Association

It has become evident that the Commonwealth's policies with regard to drug education, drug treatment, and punishment for drug offenses are ineffective. The system is broken and it is badly in need of repair. Drug education programs fail to effectively educate the young and to reduce the likelihood of their using alcohol and drugs. Treatment opportunities are limited by lack of funding, and residents who could benefit from treatment are denied the opportunity. Many end up in jail or prison, where treatment is again limited. Incarceration is not an effective deterrent to most drug crimes, and the current sentencing system, including mandatory minimum sentences for many drug offenses, does not effectively reduce the likelihood of recidivism. The taxpayers of Massachusetts could get far greater value for their taxes with improved education and treatment. Changing policies from emphasis on incarceration to more encouragement for treatment would allow us to save money, reduce crime, and rebuild families and communities.

There are other considerations. There are presently over 25,000 individuals incarcerated in Massachusetts prison and county facilities. The prison population rose by 368% between 1980 and 2008, while the jail and house of correction population increased by 522% in the same period. The primary cause of this increase has been the growth in drug arrests. Corrections spending also continues to climb at a time when we cannot afford it. In FY 2009 the budget for corrections spending was greater than the budget for higher education. Prison and jail facilities are seriously overcrowded, but building more prisons and jails is simply not affordable.

Several other states have begun to re-examine harsh drug sentencing practices, and to explore the effectiveness of alternatives. California, Washington, Arizona, Maryland, New York and other states have altered sentencing policies for drug offenders. There are national calls for sentencing reforms, led by Senator Jim Webb of Virginia, who has called for better re-entry programs, and by the U.S. Attorney General, Eric Holder, and Gil Kerlikowske, the White House Drug Czar, who have called for an end for the term "War on Drugs" to emphasize that we are "not at war with people in this country."

Massachusetts cannot afford to maintain old policies of simply being tough on drug use, where those policies have proven to have failed. By re-shaping drug policies to make them less punitive, more effective and more cost-effective, enforcement can be devoted to policing violent crime, and to keeping our streets safer.

Full Task Force Recommendations

1. Short-term Recommendation: Legislative Reform – Amend Chapter 111E to Make Diversion to Treatment Effective and Available Statewide
2. Short-term Recommendation: Legislative Reform – Enact Drug Sentencing Reforms As Soon As Possible, Mitigating Mandatory Minimum Zone Sentencing and Ending Other Limits on Judicial Authority to Allow Treatment Instead of Excessive Punishment
3. Long-Term Recommendation: Culture Change – Educate Prosecutors, Defenders, Judges, Probation and Parole About the Benefits of Treatment and the Expectation of Relapse, and the Failure of Punishment to Reduce Recidivism
4. Long-Term Recommendation: Expand Treatment Resources, to Enable the Supply to Meet the Demand, Without Coercing Abstinence or Treatment for Non-abusive Use
5. Long-Term Recommendation: Rethink to Build Commitment to Systemic Changes. Expand the debate from the State House to the Town Hall and the kitchen table, respecting the central nervous system's capacity for intoxication, tolerating historic and cultural self-medication practices and conceding capitalism's superiority to anti-regulatory prohibitions.

Recommendations of the Task Force Prevention and Education Subcommittee

1. The governor, legislature and executive branch administration officials must lead in promoting environmental prevention strategies as a better, more cost-efficient means of addressing the state's problems related to alcohol and other drug use than the predominantly detention (criminal justice) based intervention of current prohibition policy.
2. Prevention experts must be included in reshaping policies on alcohol and other drugs to achieve improved safety and savings, and prevention measures must play a more prominent role keeping people out of the criminal justice system.
3. The Governor's Interagency Council on Substance Abuse and Prevention, chaired by the Lieutenant-Governor with representation from all state agencies concerned with substance use, should coordinate all prevention efforts and resources, and the Council should have the authority and staff resources necessary to do so.
4. Since science says that addiction is a brain disease, the state must be scientific in its policies, programs and messages about alcohol and drug addiction and related problems.
5. Alcohol, underage drinking and binge drinking should be the top priority for an environmental prevention agenda, with appropriately prioritized budgetary resources.
6. Prescription drug education is the second priority for a prevention agenda. We need cohesive policies and programs that educate the public about the dangers of misusing prescribed medications, monitor prescription drug prescribers, and emphasize safe storage -- since most prescriptions of abuse are obtained in the home or from relatives -- and proper disposal of unused medications.
7. The lessons learned from the state's Stop Smoking campaign can be translated to an alcohol and drug prevention campaign; successful model policies and programs that work include the promotion of smoking cessation through public awareness campaigns about the dangers of smoking, physicians encouraging patients to stop smoking, warning labels on packages, and raised taxes on tobacco products. We have significantly reduced the use of tobacco in Massachusetts by raising taxes, and thereby reduced the harm caused by tobacco, without arresting a single adult.
8. The state must more strongly enforce and insure fidelity to prevention policies, programs and strategies.

Recommendations of the Task Force Sentencing Subcommittee

Reform the Diversion to Treatment Law, G.L. c. 111E. To achieve the following recommendations, the Task Force urges enactment by the legislature and the Governor of of House Bill 1962, "An Act to Amend the Commonwealth's Drurg Treatment Program to Allow for the Diversion of Low-level Offenders Under Court Supervision."

1. Improve administrative arrangement. Lodge responsibility for disseminating information about available treatment centers and other aspects of diversion to the Bureau of Substance Abuse Services, not, as in current law to the "Department of Drug Dependence," an entity which doesn't exist.
2. Expand types of permitted evaluators. Change the law to allow an "addiction specialist" (a RN, LICSW, or other individual certified by the Bureau of Substance Abuse Services) to determine who is eligible for the program. Current law only allows a physician to evaluate defendants.
3. Expand current diversion eligibility provisions to apply to second time offenders as well as first time offenders, to acknowledge that relapse is an expected component of addiction recovery.
4. Mandate diversion. Expand current provisions so that diversion to treatment is mandated for first and second nonviolent offenders, if the offender chooses to try diversion instead of a disposition of his or her drug charges.

Reforms in School Zone and Other Mandatory Minimum Sentencing Laws, including G.L. c. 94C, § 32J.

5. Reduce size of school zones from 1,000 feet to 100 feet in school zone law, G.L. c. 94C, § 32J, (as in the current law for parks and playgrounds). The school zone statute makes no distinction for school year, school hours, or intent to sell to a student. This proposal was included in H. 5004, introduced by the Joint Committee of the Judiciary in July 2008.
6. Reduce sentence length for all school zone offenders. Current laws provide for sentences of 2 years to 15 years; revise G.L. c. 94C, so sentences would be set at 0 to 15 years for all offenders. This proposal would not weaken protection for children as other statutes impose stiff penalties for selling drugs to minors or using minors to make sales.
7. Eliminate mandatory sentences for all zone offenders. Under H. 5004, the mandatory minimum for first time offenders would have been eliminated. The Task Force supports this revision, but urges the repeal of mandatory minimums for all zone offenders.
8. Concurrent sentences. Allow school zone offender sentences to be served concurrently with other sentences. H. 5004 would have allowed first-time school zone offenders sentenced to incarceration to serve that time concurrently with another sentence. The Task Force supports this revision, but urges that all school zone offenders be allowed to serve a sentence concurrently with other sentences, in the discretion of the sentencing judge.

Reforms for All Drug Sentences, under c. 94C. Apply these changes retroactively, affording relief to prisoners currently serving harsh mandatory minimum drug sentences.

9. Eligibility for work release. Prisoners serving mandatory minimum drug sentences should be allowed to participate in work release programs.
10. Eligibility for parole. Reform drug sentencing laws to be consistent with current parole eligibility for non-mandatory sentences.

- For county (House of Correction) sentenced prisoners, establish parole eligibility after serving one-half of maximum sentence;
- For state (Dept. of Correction) sentenced sentences, establish parole eligibility after serving two-thirds of maximum sentence.

11. Eligibility for earned "good conduct" credit. Allow prisoners serving mandatory minimum drug sentences to participate in and receive deductions for educational, vocational, treatment or other programs that are approved for "good conduct" eligibility, like most other prisoners.
12. Restore suspended and split sentences. This proposal would apply to all offenses, but is particularly useful for drug offenders. It affords judges more discretion to impose effective sentences.

Recommendations of the Task Force Treatment Subcommittee

1. Invest in more treatment oriented system which includes more resources for treatment, less detention, fewer and shorter sentences for nonviolent drug offenders, requiring not only legislation but also "culture change" within the criminal justice system by its operatives. Defenders need education about more community-based or residential treatment alternatives to detention.
2. Implement the recently enacted 2008 Stat. c. 321, the Children's Mental Health Act. This law is directed at solving the chronic systemic problems of "stuck kids" trapped in juvenile detention or hospital emergency departments awaiting appropriate residential mental health services. This improvement in treatment service delivery should not only divert young potential abusers from becoming trapped in the criminal justice system, but also serve as a model for early diversion of adult nonviolent drug offenders.
3. Institute measures to purge the prisons and jails of offenders whose crimes did not threaten the public safety or violate the rights of other citizens, while making room for the violent who are a threat.
4. Re-calibrate the mix of bodies and funding allocated between detention and community-based treatment; treatment can and should be made available at a level that comes much closer to meeting the demand and need.
5. Ensure that the criminal justice system adheres to evidence-based principles and practices in criminal justice generally, designed to improve treatment outcomes and reduce recidivism.
6. Follow this priority ranking for treatment funding: first fund drug offenders' diversion to treatment before trial; then provide treatment for reintegrating ex-prisoners; then treatment for prisoners within 18 months of parole eligibility; and last fund treatment for prisoners farther from release, the least effective form of drug treatment. Because of their shorter sentences, treatment investment in county house of corrections prisoners should take higher priority than for prisoners in DOC custody who are not as close to parole eligibility.
7. Provide more offenders with professional social workers or substance abuse specialists who can provide confidential support disconnected from criminal justice supervisors, increasing the number of offenders who seek assistance at critical stress points, successfully access needed services, and make personal changes.
8. Support the 6 recommendations in Blueprint for the States: Policies to Improve the Ways States Organize and Deliver Alcohol and Drug Prevention and Treatment (www.jointogether.org/blueprint) including recommendation that calls for coalition, consumer and recovery leaders to be members of state policy task forces and interagency councils.

Section I

Introduction

Following a Symposium on Sentencing Reform, sponsored by the Massachusetts Bar Association (MBA) in October 2007, the MBA convened a Drug Policy Task Force, and reached out to a wide range of professionals, including lawyers, doctors, social workers, sheriffs, prosecutors, judges, treatment clinicians, educators and prevention specialists. In April 2008 the Task Force was asked to assess the Commonwealth's criminal justice system and its treatment of illegal drug users; to assess state drug policies for education, prevention and treatment; and, to offer recommendations for improvements.

The Task Force acknowledges the hard work of criminal justice and public safety officials, and their efforts protect the public, our property and our civil rights. The intent of this report is to make their work even more effective, by reducing drug addiction, by reducing the rate of crime, by helping to restore families and communities, and by saving the taxpayers' money. The report will, we hope, help enlighten public policy choices and spark new debate on drug policy.

The Task Force formed three subcommittees designed to provide three important perspectives on drug policy. This report includes the work of each of these subcommittees, compiled separately by each subcommittee but circulated among the entire Task Force for comment before final adoption by consensus (as has been the process for this entire report), as follows:

Education and Prevention (Section II);

Sentencing (Section III);

Treatment (Section IV).

Each section contains several recommendations for reform and new perspectives on the problems drug policy.

Section V sets out the Task Force's findings. The Task Force finds current policy cannot be sustained. The last section of this report presents four recommendations for reform (including legislative changes), and a series of questions for policy makers to consider as the Commonwealth continues to improve state drug policy.

In January 2009, the MBA House of Delegates (the governing body of the MBA), unanimously endorsed the legislative recommendations. In May 2009, the House of Delegates unanimously adopted and endorsed this report.

Overview of the Problem and Prospects for Solutions

While the Commonwealth has seen change in drug policy in the last twenty years, much of it has been counterproductive. Enactment of mandatory sentencing statutes and lengthening of parole eligibilities as part of the so-called "Truth in Sentencing" law has increased overcrowding of correctional facilities, and reduced opportunities for treatment and successful reintegration.

The recent downturn in the economy has brought a new urgency to examine the use of our diminishing economic resources as they are applied to crime and drug problems. The local impact of the global economic recession has resulted in plummeting state revenues starting in the fall of 2008 and likely to continue throughout this year and possibly 2010. The economic challenges the state's ability to sustain the expense of current policy which generates a growing prison population with little evidence of reductions in illegal drug use or access.

Drug policy has reached a crossroads and requires significant changes. These conclusions are shared by many states and the federal administration. The Task Force's primary finding is that the focus of drug policy must change from the "war on drugs," which has drastically increased prison populations, to a sustainable treatment and prevention model, with improved likelihood to achieve health, safety and savings.

It is now abundantly clear that harsh punishment for drug offenders swells state and county prison populations beyond their safe capacity, but does little, if anything to reduce drug use. Progress in reducing, much less ending, illegal drug use, abuse and addiction is hard to detect. Further, there is little, if any, discernible benefit in public safety and health for which this spending was intended.

In addition, families are burdened by imprisoned or addicted parents and children; neighborhoods are threatened by drug dealers and gangs; drug-related infectious diseases continue to spread among drug users in both neighborhoods and prisons. Scarce public resources, further depleted by the national economic crisis, are utilized for incarceration instead of prevention and treatment.

Surveys consistently demonstrate that the public is willing to explore alternatives to incarceration, particularly with non-violent drug offenders. The passage last fall of the state initiative to decriminalize marijuana also demonstrates the public's overwhelming willingness to change the focus of our drug policy away from punishment for nonviolent drug users. Our legislators are now considering several bills to reform drug policy which are recommended in this report.

A robust public debate should be welcomed and encouraged. We hope this report will add momentum to citizen and legislative consideration of significant reforms, for the benefit of our families, our neighborhoods and our economy.

Section II

Prevention and Education: Saving Lives, Saving Dollars

Report of the **Subcommittee** of the Massachusetts Bar Association Drug Policy Task Force **on Education and Prevention**; Chaired by Constance Peters, Vice President for Substance Abuse, Mental Health & Substance Abuse Corporations of Massachusetts, Inc. Sub-committee members included:

- Susan Aromaa, Join Together, Boston University School of Public Health
- Julia Hardy Cofield, National Association for the Advancement of Colored People
- Julie Cushing, Massachusetts Youth Program Director, SADD (Students Against Destructive Decisions) State Coordinator
- Steve Keel, Director of Prevention, DPH/Bureau of Substance Abuse Services
- Ken King, Suffolk Law School, Juvenile Justice Institute [now an Associate Justice of the state Juvenile Court]
- Roberta Leis, Join Together, Boston University School of Public Health
- Patricia Muldoon, League of Women Voters of Massachusetts
- Victoria Williams, City of Boston, Office of Civil Rights

This report has been adopted by the subcommittee and the Task Force, representing a consensus position of its members rather than the authorized representation of any organizational participant.

No disease is ever cured by punishing the patient – and punishment will not cure the disease of addiction.

Overview

According to the National Institute on Drug Abuse, addiction is a chronic, relapsing brain disease that is characterized by compulsive alcohol and drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs and alcohol can cause long lasting changes in the brain's structure and how it works. Addiction is similar to other diseases, such as heart disease. Both disrupt the normal, healthy functioning of the underlying organ and have serious harmful consequences, but they are *preventable, treatable, and if left untreated can last a lifetime*.[1]

Massachusetts continues to have among the highest rates of alcohol and other drug abuse in the nation across all age and cultural groups, inclusive of social and economic sectors. The principal issue facing our elected leaders today is whether the funding, policies and strategies used to address alcohol and other drug use should change, shifting from less frequent implementation of criminal penalties and detention to a more frequent employment of non-criminal prevention policies and programs; and, if so, what funding, policies and prevention strategies should be used.

This report presents a summary of the scope of the addiction problem in Massachusetts; an overview of prevention and education efforts relative to what works and what doesn't work; and a list of recommendations for how to proceed. It is important to note that no moral or political statement is being made in this report about the "non-harmful" use of substances, whether legal or illegal, but rather to focus on that use which results in behaviors that warrant a governmental response and the expenditure of scarce public resources (e.g., police, courts, prison beds, treatment services, emergency rooms, etc).

Indisputably, prevention is a crucial component of any responsible public policy aimed at minimizing the

harm done by alcohol and other drugs. Drug policies must recognize, however, that abstinence is not the socially dominant practice in American culture and that public health demands practical harm reduction targets rather than illusions of a drug-free society.

This subcommittee recommends an *environmental* approach to prevention efforts. Environmental strategies, which are described later in this report, are proven to be effective and have a greater impact with a larger percent of the population than individually-focused prevention efforts. They also are successful at delaying the onset of drug and alcohol use. The younger a person is when they first start to use drugs and alcohol, the more likely he or she will develop a lifetime problem; or stated conversely, the later the onset of first and regular use, the lower the risk for future problematic abuse.

Alcohol use should be the top priority for the state's environmental prevention agenda. Underage drinking kills four times as many youth as all illegal drugs combined,[2] and causes far more destruction to individuals, families, communities and public safety than tobacco or marijuana. It is critical to address the widespread apathy about alcohol and to change the belief that underage drinking is an acceptable *rite of passage* into adulthood or that it is not dangerous.

The governor, legislature and executive branch administration officials must lead in promoting the urgency and efficacy of prevention as a better and more cost-efficient means of addressing the state's many problems related to alcohol and other drugs.[3]

The Problem of Addiction in Massachusetts

Massachusetts continues to have among the highest rates of alcohol and other drug use in the nation across all age groups and cultural groups, inclusive of social and economic sectors.

- The Health Risk Behaviors of Massachusetts Youth Report, 2001 to 2007 found that in 2007:
    - 73 percent of all high school students had consumed alcohol
    - 46 percent were drinking alcohol currently
    - 28 percent binge drank
    - 20 percent began drinking alcohol prior to the age of 13.*
- Massachusetts continues to rank in the top fifth of all states for having the highest rates of past month use and illicit drug dependence among those aged 12 or older.[4]
- Massachusetts also ranks in the highest fifth of all states for past month use of an illicit drug other than marijuana, and past year use of cocaine (aged 12 or older).[5]
- 2006 mortality data from the state Department of Public Health shows deaths from overdoses of heroin and other opioids rose by more than seven percent per year from 2000-2006, and that 637 people died from opioid poisoning in 2006.

The younger a person is when they first start to use drugs and alcohol, the more likely he or she will develop a lifetime problem, and a significant number of Massachusetts high school students are starting to drink at a very early age.

Alcohol and Other Drug Prevention and Education

Prevention approaches have varied over the years in response to changing needs and conditions. At this time, prevention is conceptualized by experts in three general categories or strategies. According to the Institute of Medicine and the National Institute on Drug Abuse, these categories include:

Universal programs (e.g., mass media, school-based curricula) targeting the general population;

Selective programs (e.g., mentoring programs aimed at children with school performance or behavioral problems) targeting people at higher-than-average risk; and,

Indicated programs (e.g., parenting programs for parents with drug and/or alcohol problems) targeting people already using illegal substances or engaging in other high-risk behaviors (such as delinquency) to prevent chronic use.

Environmental Prevention

Environmental prevention models fall within the scope of universal programs. This subcommittee supports and recommends the environmental approach to prevention efforts. Environmental prevention approaches are managed at the regulatory or community level, and focus on *universal* interventions to deter alcohol and other drug consumption.

Environmental prevention strategies include a broad array of approaches designed to reduce problem behavior by changing the environment in which the behavior occurs, rather than changing the knowledge, attitudes, or behavioral intentions of individuals. Some categories of environmental strategies for alcohol include reducing alcohol availability, restricting marketing and promotion, increasing campus and municipal consumption and distribution enforcement, changing the normative environment through the media, and providing alcohol-free social, recreational, and vocational options.[6]

The most effective environmental prevention should occur at the regulatory and the community level. Environmental strategies have proven to be effective, and have a greater impact with a larger percent of the population, than individually-focused prevention efforts. Some environmental strategies that work include keeping alcohol and tobacco-promoting billboards away from schools and off public transportation. These strategies generate good outcomes and per capita value. Moreover, the cost of environmental programs and policies is minimal compared to the unaffordable per capita annual cost of imprisonment and small group lectures.

School-Based Prevention Education

Alcohol and other drug prohibition or bans may be viewed as the ultimate in environmental restrictions, but prohibition has generated unacceptable levels of unintended and counterproductive effects on individuals, families and community health and safety. Accordingly, we favor environmental prevention programming that allows for and includes a combination of more successful strategies and initiatives. For example, when considering how to prevent the use of the most prevalent and most dangerous drug of choice for youth – alcohol – people usually think of awareness programs that tell teens and their parents why underage drinking is bad. Such individual behavioral approaches may be common, but a more promising tactic is to work on changing the overall environment where problems take root, thereby protecting whole populations.[7]

We know that the following approaches to prevention ***do not*** work:

- **Scare tactics** — such as exaggerated presentations, testimonials from people whose own drug use got the best of them, or once-a-year presentations;
- **Punitive and so-called "zero tolerance" programs** — one-strike school-expulsion approaches[8]; and
- **Programs that make us feel good about crusading against drugs** — that wallow in public scorn against drugs but teach nothing new; that ignore human nature's natural tendency to engage irrationally in behaviors that are risky and adventuresome.

For example, the DARE program, the most successfully marketed program in the country, which has been taught in 5th grade for 10 weeks by a police officer in the classroom for more than 20 years, is not evidence-based. Evaluations show that DARE is not an effective program and never has met the requirements identified by the U.S. Department of Education for satisfactory drug-education performance. In several studies, students exposed to its "curriculum" fared no better and often worse than students receiving no drug education at all.[9]

Despite standards requiring such education in our schools, very little time is actually spent on alcohol and

other drug prevention education.[10] There are evidence-based programs that are effective in school environments but because they require time and resources that are unavailable, they are not for the most part being taught. What works in schools are modules that are integrated into other school curricula. There also is evidence that paying attention to high risk kids in schools is beneficial (e.g., as an "indicated" program).

Indisputably, prevention is a crucial component of any responsible public policy aimed at minimizing the harm done by alcohol and other drugs. If we can increase the age of first use among young people, we will create a healthier community, which will produce significant cost savings for the Commonwealth.

Given the penetration of alcohol and other drug use in our society, however, the goal of drug policy should be reducing risky alcohol and drug using behavior, especially among our youth, rather than seeking to convert the culture to abstinence. Alcohol and drug prohibition were and have been "noble" but failed experiments, demonstrating the benefit of practical rather than idealistic policies.

Prevention Programming in Massachusetts

Prevention services in Massachusetts are primarily funded by the federal government and currently include such programs as:

- Safe and Drug Free Schools and Communities — administered by the state Department of Elementary and Secondary Education, and awarded to most school systems in Massachusetts;
- Community Grants — administered by the state Executive Office of Public Safety (EOPS);
- Drug Free Communities Grants — awards made directly to communities by SAMHSA;
- Governor's Highway Safety grants — administered by EOPS;
- Purdue Pharma Lawsuit — one year of funding for prevention administered by the Department of the Attorney General; and
- Substance abuse prevention grants — $5.25 million funded by the SAMHSA's Substance Abuse Prevention and Treatment (SAPT) Block Grant, via the state Department of Public Health's Bureau of Substance Abuse Services.

While some of these funding streams support prevention and education efforts that are evidence-based, some do not. The health and safety of our children, families and neighborhoods and the investment of taxpayers, however, demand our attention and advocacy for more effective prevention and education efforts.

Alcohol: The Most Dangerous Drug

Alcohol's dominant role deserves critical attention. The National Institute on Alcohol Abuse and Alcoholism reports that children who begin drinking before the age of 15 are four times more likely to become dependent on alcohol during their lives. A recent study estimates that underage drinking alone costs the U.S. more than $62 billion a year and results in 3,200 deaths and 2.6 million other "harmful events."[11]

It bears repeating that *underage drinking kills four times as many youths as all illicit drugs combined*.[12] However, the federal government spends about 25 times more resources to prevent illicit-drug drug use than underage drinking.[13] The phenomenon of binge drinking is especially alarming and is a big problem with both high school students and college students.

Given the abundance of college students in Massachusetts, the primacy of alcohol as the state's most dangerous drug cannot escape our focus, compelling the conclusion that the state will get the most "bang" for the taxpayer's "buck" by investing in comprehensive environmental prevention measures. Environmental strategies have proven effective in reducing underage drinking: Limiting access to alcohol, implementing incentives to decrease availability, providing training to servers in bars and restaurants, establishing graduated driver licensing systems, and enforcing existing laws such as the minimum drinking age and social host laws.

Parents sometimes host drinking parties for underage youth in an attempt to protect their children by providing a supervised environment. In fact, adults are the most common source of alcohol for underage drinkers. Social host laws hold noncommercial servers of alcohol, such as homeowners or parents, liable when they provide alcohol to a minor or an obviously inebriated individual who later is involved in an accident that causes injury or death to a third party. A national study found that the prevention tactic of social host liability laws lowered the probability of binge drinking and drinking and driving among all drinkers.[14]

Criminal Penalties and Detention vs. Cost-Effective Non-Criminal Prevention Activities

This subcommittee agrees with Kenneth W. Robertson from the Division of Services Improvement, Center for Substance Abuse Treatment at SAMHSA. He says that to improve policy, Massachusetts should shift its spending from detention to prevention, treatment and pre-trial diversion for better safety and health outcomes. Robertson, an expert on substance abuse, urges that such a shift will reduce the incidence of relapse and recidivism for the same amount of money or far less than the cost of current policies which puts more resources in the criminal justice system (police, courts and prisons) than all other tactics for reducing drug abuse and adolescent use combined. He says, *"we simply cannot arrest our way out of the current level of abuse and drug harm; these health risks and our nation's current economic turbulence require less expensive and more effective programs."*

Prevention efforts provide a further profound benefit when compared to the criminal justice approach; they are race and color-blind. Environmental prevention strategies are superior to the criminal justice approach in that they not only reduce the incidence of harmful alcohol and other drug use, they do so without racially disparate impact. Shifting resources from criminal penalties to environmental prevention strategies can only improve the racial injustice resulting from our current emphasis on punitive law enforcement interventions.

The Subcommittee urges a significant shift of emphasis on public policies and spending from criminal penalties and detention to environmental prevention strategies. This shift presents little risk of worsening the current level of use and harm, but it is virtually certain to produce cost savings.

Recommendations

We respectfully submit the following recommendations for consideration:

1. The governor, legislature and executive branch administration officials must take the lead in promoting environmental prevention strategies as a better, more cost-efficient means of addressing the state's problems related to alcohol and other drug use than predominantly detention (criminal justice) based intervention.[15]
2. Prevention experts must be included in reshaping policies on alcohol and other drugs to achieve improved safety and savings, and prevention measures must play a more prominent role keeping people out of the criminal justice system.
3. The Governor's Interagency Council on Substance Abuse and Prevention, chaired by the Lieutenant-Governor with representation from all state agencies concerned with substance use, should coordinate all prevention efforts and resources, and the Council should have the authority and staff resources necessary to do so.
4. Since science says that addiction is a brain disease, the state must be scientific in its policies, programs and messages about alcohol and drug addiction and related problems, cautious not to muddle the concepts of use and abuse, or otherwise to engage in impractical aspirations and uncertainties.
5. Alcohol, underage drinking and binge drinking should be the top priority for an environmental prevention agenda. It is critical to address the widespread apathy about alcohol and the view that alcohol isn't a major problem, or the belief that underage drinking is an acceptable *rite of passage* into adulthood. The state should mount a regular and consistent public information campaign on this front. The state should coordinate alcohol prevention efforts with state and local law enforcement and licensing officials to

further reduce access to alcohol by minors.

6. Prescription drug education is the second priority for a prevention agenda. We need cohesive policies and programs that educate the public about the dangers of misusing prescribed medications, monitor prescription drug prescribers, and emphasize safe storage -- since most prescriptions of abuse are obtained in the home or from relatives -- and proper disposal of unused medications.
7. The lessons learned from the state's Stop Smoking campaign can be translated to an alcohol and drug prevention campaign; successful model policies and programs that work include the promotion of smoking cessation through public awareness campaigns about the dangers of smoking, physicians encouraging patients to stop smoking, warning labels on packages, and raised taxes on tobacco products. We have significantly reduced the use of tobacco in Massachusetts by raising taxes, and thereby reduced the harm caused by tobacco, without arresting a single adult.
8. The state must more strongly enforce and insure fidelity to prevention policies, programs and strategies.

The members of the Massachusetts Bar Association's Drug Policy Task Force Subcommittee on Prevention stand ready, able and willing to provide additional information, guidance and support to all efforts to develop and implement sound, science-based environmental strategies to better address the problem of alcohol and other drugs of abuse in Massachusetts.

Section III

Reforming Punitive Sentencing

Report of the Subcommittee of the Massachusetts Bar Association Drug Policy Task Force on Sentencing and Rehabilitation; Co-chairs Hon. Robert Ziemian, Boston Municipal Court; and Attorney Lee Gartenberg, Director of Inmate Legal Services for the Middlesex Sherriff's Office.

This report has been adopted by the subcommittee and the Task Force, representing a consensus position of its members. It does not necessarily reflect their individual views or that of the agencies or organizations they work for. We gratefully acknowledge the participation of Judge Ziemian, whose assistance in no way constitutes his specific endorsement of any particular finding or recommendation of this subcommittee or the Task Force. Subcommittee members include:

- Matt Allen, New England Policy Advocates (whose diligence in citation research was indispensable);
- Anthony Benedetti, General Counsel, Committee for Public Counsel Services;
- Andrea Cabral, Sheriff, Suffolk County;
- John Christian, City of Boston Public Health Commission;
- Barbara Dougan, Families Against Mandatory Minimums;
- Neil Hourihan, Salem attorney;
- Brandyn Keating, formerly with the Criminal Justice Policy Coalition and Gov. Patrick's Public Safety Working Group of his transition team;
- Paul McDevitt, Modern Assistance union health consultant;
- Neil McDevitt, McDevitt & Associates, Boston attorney;
- Joel Pentlarge, Criminal Justice Policy Coalition;
- Martin Rosenthal, Boston attorney and Co-Chair, Sentencing Reform Committee, Mass. Association of Criminal Defense Lawyers;
- Leslie Walker, Massachusetts Correctional Legal Services;

At the subcommittee's first meeting, the members expressed group support for a mission of seeking to improve outcomes for individuals, families and communities arising from criminal justice system interventions. Those interventions involve arrest, disposition (before and after trial) and reintegration from prison of illegal drug users and distributors. Improvement can come from change in legislation and administrative regulations. It can also come from culture change within the existing range of legal and executive discretion in the operation of police, prosecution, judicial dispositions, probation, prisons and parole. To better focus the subcommittee's work, we broke our work down into those three subdivisions: Culture Change, Data Collection and Legislation.

We view the rationale for this task force from the historical concern about effectively addressing the problem of drug abuse, its effect on public safety, and the systemic response to combating it. The convening of this task force reflects the need to re-examine the response to the problem and the desire to formulate effective, cost-efficient solutions that help ensure treatment of drug abusers and promote public safety.

The Criminal Justice System and Drug Policy

The missions of the criminal justice system as a tool of drug policy are to protect public safety, prevent crime caused by drug abuse and distribution, provide treatment to drug offenders, and prevent predatory crime resulting in harm to people and their property caused by drug abuse. This mission is accomplished by three functions: street policing, sentencing, and the societal reintegration of drug offenders. Our career experience

with the criminal justice system and our work as a subcommittee studying these three functions of that system, leads us to a series of observations concerning the success of the criminal justice system in achieving the goals of controlling and limiting the harm caused by drug use, improving re-entry success and reducing recidivism.

Enforcement

Drug-related arrests utilize substantial law enforcement resources. The extent is difficult to quantify. Despite the increased levels of arrest and incarceration to the point of overcrowding, the drug problem persists; not a dent has been made in drug use.

- In 1973, there were 328,670 arrests logged in the FBI's Uniform Crime Reports (UCR) for drug law violations in the U.S.; in 2004, 1,745,712, a more than five-fold increase. In 1997 more than 80% of drug arrests were for simple possession, 44% of those for marijuana.[16]
- The drug offender share of the U.S. jail population increased by 37% between 1996 and 2002.[17] Locally, the state prison population more than tripled between 1980 and 2002, with more than 20% of prisoners serving drug sentences as lead identified charges, and the overwhelming majority diagnosed as drug users.[18]
- According to the federal Drug Enforcement Administration of the U.S. Justice Department, 4 million people had used an illegal drug in 1965, 2% of the U.S. population; by 2005, this number had grown to 133 million, 46% of Americans.[19]
- By comparison during the same period, concerning the toxic drug, tobacco-delivered nicotine: In 2002, 26 percent of Americans were current cigarette smokers; now it is 24.2 percent, continuing a decades-long decline. The decline in current cigarette smoking for 12-to-17-year-olds is even more dramatic, from 13 percent to 9.8 percent. All without the risk or imposition of detention or career disabling CORI on tobacco users, a sanction deemed essential to curbing illegal drug use.[20]
- Nor has the explosion in arrests had any evident impact on supply: The United Nation Office for Drug Control and Crime Prevention reported that the mean purity level of heroin increased from 6% in 1987 to 37% in 1997, accompanied by a decrease in price.[21] Further, according to the Office of National Drug Control Policy's report, the price of a pure gram of heroin decreased from $2,000 in 1981 to $360 in 2003.[22]
- This flood of drug-related arrests has done little to further the criminal justice system's role in protecting public safety: In 1997, among state prisoners in the U.S., 58% had no history of violence or major drug activity, and 75% had prior criminal histories exclusively consisting of drug offenses.[23]

According to official state statistics, 20% of the people incarcerated in Massachusetts committed a drug-related crime.[24] We know that another 20% of defendants committed property crimes to support their drug habit.[25]

The distinction between predatory crime and non-predatory crime is a useful point for separating offenders deserving incarceration, with its attendant costs and reintegration difficulties, from offenders for whom such a punishment and expense would be deemed by most citizens to be disproportionate. Non-predators can be diverted from the criminal justice system long before their detention, with minimal risk to the public safety.

We acknowledge and applaud the efforts of the Commonwealth's eighteen drug courts in supervising drug-addicted defendants through treatment programs, as an alternative to incarceration. The availability of drug courts is still limited, and is not available to many defendants who have limited histories of drug abuse or criminal records. Those defendants deemed "too healthy" for drug court are subject to the nearly unlimited discretion of police and prosecutors. Some courts craft a disposition that avoids a criminal record for the offender, but many do not, resulting in harsher punishment for less offending defendants than offenders with longer records. Unfortunately many early offenders in the courts of the Commonwealth are more likely face a path to incarceration rather than diversion.

One solution to this "front end" problem is expansion of diversion programs that suspend criminal prosecution of nonviolent drug offenders while in treatment, with the prospect of dismissal upon the completion of treatment without a new arrest. The legislature created a statutory scheme to encourage the use of drug diversion programs in 1981 (G.L. c. 111E). Unfortunately diversion is under-utilized due to systemic obstacles including lack of treatment program funding and lack of prosecutorial enthusiasm.

Rep. Martin Walsh has introduced a bill, H. 1962 (this bill has also been introduced in the last two legislative sessions) to expand diversion access. In both sessions, the proposal languished after receiving favorable committee votes but failed to reach the floor of either the House or Senate. By reducing barriers and expanding treatment options, the Commonwealth can insure greater access to diversion that is less contingent on the economic means of defendants. Increased utilization of better diversion options promotes greater fairness in the system, improves safety by reducing recidivism, and saves money (see the report on diversion savings appended to this report).

Sanctions

For complex problems like reducing illegal drug use, legislation enacted without careful study too often fails to satisfy the urgent need for comprehensive analysis and evidence-based remedies. The "one size fits all" sanctions imposed under mandatory and "get tough" sentencing schemes go against the need for individual assessment and formulation of an individualized plan combining sanctions and treatment.

An example is the virtual midnight adoption (without committee hearings) of the last criminal justice package of laws in 1993, the "Truth in Sentencing" Act (1993 Stat. c. 432, amending G.L. c. 127, sec. 133 [parole] and c. 279 [sentencing], adding G.L. 211E).[26] That law abruptly increased penalties (by eliminating early parole terms) for the younger adults most amenable to rehabilitation, and instead emphasized longer sentences. Where increased punishment substitutes for real solutions to genuine problems, the results described below raise concerns about the current drug prohibition policy's impact on our universal objectives: justice, safety, fiscal responsibility and public health.

- The Sentencing Project has reported that between 1980 and 1997, drug arrests tripled in the U.S. In 1997 four out of five drug arrests were for possession, with 44% of those arrests for marijuana offenses. Between 1980 and 1997, while drug offenders entering prisons skyrocketed, the proportion of state prison space housing violent offenders declined from 55% to 47%.[27]
- According to the U.S. Justice Department, drug offenders "represent the largest source of jail population growth," as prisoners jailed for drug crimes increased 37% from 1996 to 2002; 13% of those jailed for drug crimes were imprisoned for their first offense.[28]
- In 1986, 9% of state prisoners were drug offenders. By 1995 the drug prisoner percentage of all prisoners nearly tripled, to 23%. State prison data also shows that about a fourth of those initially imprisoned for nonviolent crimes are sentenced for a second time for committing a violent offense.[29]
- As of Sept. 1, 2008, the Massachusetts Department of Correction (DOC) had a population of 11,368, a 10 percent increase since 2005, breaking the record of 11,158 inmates set in 1999.[30]
- Between 1980 and 2002, the state prison population more than tripled, increasing from 2,754 to 9,150 inmates. The state per capita imprisonment rate more than tripled between 1980 and 1998, rising from 56 to 174 per 100,000 residents.[31]
- Over a fifth of state prisoners are imprisoned for drug crimes[32] with the prison population expected to increase 6% by 2011, over three times the expected population growth of 1.9%.[33] In the five years between 2003 and 2008 the population of DOC drug prisoners (73% of which are possession rather than distribution charges, *2001 FBI Crime statistics*, 2002) increased 32% from 1,975 to 2,610.[34]

- The DOC budget has grown significantly over the past decade, its costs having risen with the ascending prison population and during the temporary plateau in size between 1994 and 2003. DOC operating expenditures in 2003 totaled nearly $438 million, a 52% increase (adjusting for inflation, the growth in expenditures was 23% between 1994 and 2003) from $287 million in 1994.[35]
- As of January 1, 2008 there were 1,850 offenders in the DOC with a mandatory drug offense, representing 18% of the population.[36]

Current prohibition policy has resulted in a crisis of overcrowding in correctional facilities resulting in recent plans to double-bunk the state's largest maximum security prison.[37] Increased density of prisoners classified as "high risk" virtually assures constant violence-inducing tension in our prisons, raising the risk of harm to prisoners and staff. Overcrowding filters down throughout the system, from DOC to county Houses of Correction and jails. At present, every state and county prison, the capacities of which have been expanded within the last decade, is over-capacity.[38]

Mandatory Minimum Sentences

The exponential growth in our prison population amply attests to the increased frequency of incarceration and longer sentences used to control illegal drug use. Longer punishment carries greater risks of disproportionate justice. Nowhere is the incongruity between problem and solution more evident than in mandatory minimum sentencing laws ("mandatories"), also called "status" (based on the amount of drugs found) or "zone" (being within a thousand feet of a school or park) offenses.

With most other offenses, after conviction a judge may impose probation, a split sentence of time to be served followed by probation, or a sentence with a parole term specified by statute. Mandatories, however, if charged by a prosecutor and resulting in a conviction, prevent the judge from imposing probation or a sentence any shorter than the "mandatory minimum" term. Nor may the defendant be paroled or permitted to participate in off site treatment programs or reintegration programs prior to the expiration of the mandatory minimum term of incarceration. This sentencing scheme fails to adequately consider an individual's role in the case, prior criminal history or need for drug treatment. Even the shorter mandatories prevent county Houses of Correction from engaging nonviolent offenders in recidivism-reducing pre-release programs.

Although use, possession, or distribution of smaller amounts of drugs carry shorter sentences, many mandatories cost the state more than $700,000 in correctional expense for each 15-year sentence, even more annually as offenders age and incur health care problems which are exorbitantly expensive to treat in the prison environment.

The increase use of mandatory sentences has had no measurable effect on illegal drug access by adults or adolescents, evidenced by the rising drug purity at lower inflation-adjusted cost leading to ever-growing levels of drug overdoses and addiction (from 1981 to 1996, the inflation adjusted street price of cocaine has fallen by 66%, and the purity of street heroin has increased six-fold; U.S. Office of National Drug Control Policy, *National Drug Control Strategy 1998*, U.S. Government Printing Office, Washington, D.C.).

There have been other calls for the reform of mandatory sentences. In 2007, Massachusetts Lawyers Weekly's Board of Editors cited the support of Sentencing Commission Chair Robert Mulligan for reforming mandatories by returning discretion for tailored sentencing to judges and the Parole Board, rather than delegating the same discretion to prosecutors outside of public forums.

The Harshbarger Report also criticized mandatory minimum sentencing as having safety-disabling (recidivism-increasing) effects on reintegration, since such sentences bar 84% of state mandatory prisoners from pre- and work-release eligibility. Moreover, nearly all prisoners serving mandatory minimum sentences are released without the post-release supervision of parole.

Massachusetts's residents appear eager for reform, with survey results indicating 75% of residents believe that prisons should provide treatment, job training and education to offenders, and 88% oppose mandatories for drug

offenders.[39]

Many prominent citizens, groups and studies have reached the same conclusion. In 2003, the Greater Boston Civil Rights Coalition (comprised of more than 50 organizations) reported that drug mandatories had "achieved [n]either a decrease in the drug trade nor consistent sentencing. Instead, thousands of non-violent drug offenders have been incarcerated at enormous cost to taxpayers. The racial disparities... are nothing short of unconscionable...[and] documented in study after study. ... [Some] who originally favored such sentences, after recognizing the disastrous results, have changed their minds," including:

- U.S. Supreme Court Justices William Rehnquist (dec.), Anthony Kennedy, and Stephen Breyer;
- Criminologist John DiIulio, former head of Pres. Bush's Office Faith-Based and Community Initiatives;
- Former New York state senator John Dunne, who sponsored that state's drug mandatories;
- Ret. Gen. Barry McCaffrey, former Director of Pres. Clinton's National Drug Control Policy (aka, the federal "Drug Czar");
- Former Michigan Gov. William Milliken, who publicly acknowledged his mistake of signing into law harsh state drug mandatories;
- Attorney Eric Sterling, former Congressional staffer, who drafted the federal drug mandatories.

Many states already have repealed or reformed minimum mandatory sentences. Five years ago, *The New York Times* noted a national trend:

After two decades of passing ever tougher sentencing laws and prompting a prison building boom, state legislatures facing budget crises are beginning to rethink their costly approaches to crime. In the past year, about 25 states have passed laws eliminating some of the lengthy mandatory minimum sentences so popular in the 1980's and 1990's, restoring early release for parole and offering treatment instead of incarceration for some drug offenders. In the process, politicians across the political spectrum say they are discovering a new motto. Instead of being tough on crime, it is more effective to be smart on crime.[40]

The federal experience with mandatories reflects similar counterproductive results. The U.S. Sentencing Commission's 1991 "Special Report to Congress: Mandatory Minimum Penalties in the Federal Criminal Justice System," Summary (pp. i-iii), noted:

- Mandatory minimum sentences "... are wholly dependent upon defendants being charged and convicted of the specified offense ... . Since the power to determine the charge of conviction rests exclusively with the prosecution for the 85% of cases that do not go to trial, [mandatories] transfer sentencing power from the court to the prosecution ... . [Thus] disparity is reintroduced."
- Application of mandatories "appears to be related to the race of the defendant, where whites are more likely than non-whites to be sentenced below the applicable [mandatories].
- "While [mandatories] may increase severity, ... uneven application may dramatically reduce certainty. ... [T]his bifurcated pattern is likely to thwart [their] deterrent value ..."

Mandatory minimum sentencing, while constitutionally lawful, effectively grants sentencing discretion with the prosecutors, who have the authority to determine which charges to bring, and which to negotiate during plea bargains. Judicial discretion in sentencing is restricted by mandatory minimums, and judges cannot take into account mitigating factors which might suggest a lesser sentence or alternative sentence is appropriate.

School zone offenses illustrate some of the problems with mandatory minimum sentences. The "drug-free school-zone" law was proposed by Governor Dukakis in 1989 because, "We want kids to be able to go to school without running the gauntlet of drug pushers."[41] Massachusetts' zones are circles having radii of 1000 feet (about three city blocks) from schools and parks, covering our most populous cities with near-suffocating completeness.

In practice, in particular cities where poor and minority neighborhoods are clustered, the mandatory punishment's drug free zones may encompass entire cities, and offenders rarely realize they are within them

(*Comm. v. Lawrence*, 69 Mass. App.Ct. 596, 599-606 [2007] [citing in dissent the great "danger of abuse of prosecuting power," *Morrison v. Olson*, 487 U.S. 654, 728 (1988) (Scalia, J., dissenting)]).[42] The law creates an "urban effect," where city dwellers are punished more harshly than suburban or rural residents who commit the same offense, and where members of minorities are more likely to be arrested and convicted.

The laws are also simply ineffective. A 2001 report by Belmont Rep. William Brownsberger, on zone mandatory prosecutions in New Bedford, Springfield and Fall River, showed that less than 1% of the cases involved sales to minors, whom school zone laws were intended to protect.[43] The stereotype of drug dealers targeting children appears to have very little basis in fact, yet results in the imprisonment of some 300 people every year.[44] Thus, Massachusetts taxpayers are forced to incur exorbitant costs without perceptible abatement of the drug use and access in places that such sentences ostensibly were designed to achieve.

The overwhelming evidence locally and nationally is that, compared to treatment, enhanced (or ordinary) imprisonment simply doesn't work. We note treatment in prison is better than detention without treatment, but community-based treatment produces the best results (see the treatment subcommittee section of this report). Apart from the question of whether these sentencing laws are fair or even affordable, one has to ask if they are truly efficient. Since Congress and the states rushed to pass mandatory minimum sentencing more than two decades ago, a multitude of empirical studies have been conducted and uniformly conclude that mandatory minimum sentencing works no better in controlling drugs than other punitive measures, which is to say, hardly at all. A frequently cited 1997 study by the RAND Corporation estimated that treatment reduces drug-related crime fifteen times more than mandatories.[45]

Our study of sentencing as a tool against drug abuse finds grave concern with its cost, which the current economic crisis only exacerbates. We are disturbed by the legislative, law enforcement and judicial disregard of apparently consistent and public data about punishment's effectiveness in allocating the limited resources of taxpayers. Given the data on recidivism and relapse improvement derived from treatment as compared to detention, the cost comparisons are even more remarkable. A year of outpatient treatment usually runs as low as $2000, with residential treatment (being unusual and rarely longer than a month) costing about a third ($16,000) of the state prison's rate.[46] Also, see the 2003 statement of the Massachusetts Taxpayer Foundation in support of sentencing reform, citing "over $1.5 billion devoted to the [state's] criminal justice system ..." A 1% reduction in the recidivism rate for offenders would result in a DOC-only annual savings of nearly $4.3 million.[47]

The cost savings data from other states' switching their emphasis from detention to treatment is stunning. When California adopted reform by ballot initiative in 2000 (Proposition 36, also called the Substance Abuse Crime Prevention Act [SACPA]), the average treatment episode cost $3,300 as opposed to $34,150 per inmate per year.[48] SACPA saved over $173 million in its first year alone, decreased the drug offender prison population by over 27% in five years, and funded 526 new outpatient treatment centers in the state.[49] Reforms adopted by Arizona in 1996 and 2002 have produced savings of more than $10 million annually since 2000 and helped thousands access substance abuse treatment services.[50] In Maryland, the Correctional Options Program, a diversion policy passed in 1994, has saved an estimated $12.8 million in annual operating costs and contributed to prison population reductions saving more than $50 million in construction costs.[51]

The cost of a incarceration (both human and financial), the improved results from far less expensive treatment alternatives, and the number of states undertaking major shifts from detention to treatment, all suggest that Massachusetts should rise to the challenge of re-assessing its drug policies. Members of the legislature should no longer fear public backlash—they should be leaders in wise policy reassessment, leading the way to productive and cost-effective reforms. We are certain their constituents would applaud those efforts.

The Racial Results of Drug Arrests and Sentencing

This subject is a subset of the "sanctions" topic, but its findings are so harmful to criminal justice and democracy in a multi-racial society generally as to merit our special attention. Beyond the un-affordability and health-ineffectiveness of drug sentencing is its blatant racial impact, particularly with mandatories. Despite minority composition of the state population at 20% and evidence that drug use rates among white, black, and

Latino racial groups are nearly identical,[52] 75% of mandatory minimum offenders are racial minority members.[53]

- "Within the category of drug offenses the racial composition of convicted defendants also varied... 56.9% of defendants convicted of possession offenses were white and 42.2% were racial/ethnic minorities; ... 25.4% of defendants convicted of mandatory distribution offenses were white and 74.6% were racial/ethnic minorities."[54] A Northeastern University study of drug charges in the Dorchester district court found that minority defendants were four times likely to be charged with drug dealing than white defendants, even when controlling for similar amounts of drugs.[55]
- In the 1998 federal *Household Survey*, 72% of American illegal-drug users were white, 15% were black and 10% were Latino, yet blacks constituted 37% of drug violation arrests and 58% of the state drug prisoners (with Latinos making up 21%). [56]
- Among persons convicted of drug felonies in state courts, whites were less likely than blacks to be sent to prison. 33% of convicted white defendants received a prison sentence, while 51% of black defendants received prison sentences.[57]

We know too many judges, prosecutors, defenders and police officers whose good faith we respect (even when we disagree) to accuse individuals or groups of personal bias. To the extent racial discrimination exists within the criminal justice system, we suspect it reflects a frequency no more and no less than the incidence of such attitudes in the general population. Given the glaring nature of the foregoing data, however, we cannot omit this focus on an unacceptable and unintended consequence of current policy. This issue needs to be addressed to compel the conscious mitigation of these disturbingly disparate racial impacts.

Reintegration

The last point in the criminal justice system where drug policy drives prison and jail populations is in reintegration: deciding who to let go, when, and with what strings and impediments attached. Too often this last part of the system creates a vicious circle, since ex-offenders have a high rate of re-offense. Nationally, more than half of released offenders are back in prison within three years, either for a new crime or for violating the terms of their release. [58]

Reintegration while on parole or probation for a suspended sentence carries risks additional to detention. Typical requirements for a drug-offending probationer or parolee include random urine tests, appointments with a supervising officer, and steady housing and employment. Many people, without presenting an immediate risk of harm to others, have difficulties meeting that regimen, but remain good candidates for parole or probation since their conduct is not threatening others.

Due to a parolee's (or probationer's) liberty being so fragile, the peculiar phenomenon of "maxing out" has emerged. Many inmates when offered early release with parole now turn it down, knowing that a technical violation short of a new crime can send them back behind bars for many more years. They have learned not to take that risk. Urine testing, in the case of less expensive commonly used kits, results in nearly half false-negatives and half false-positives. It often indicates marijuana use as long as a month after a single use, while failing to show more recent heroin or cocaine intoxication. Some ubiquitous methods of testing could indicate merely shaking hands with a user or even only touching something she touched, rather than personal use. For too many ex-prisoners, parole becomes a trap rather than a bridge. Nationally, parole revocation for all offenses constitutes a third of prison admissions annually. [59]

Subcommittee members note the filing of H. 5004 in the last week of the 2007-2008 legislative year, which (among other sentencing-related topics) proposed some useful reforms to mandatory minimum sentences. This bill also created the potential for an increase in prison population, however, by requiring mandatory post-release supervision for most new ex-prisoners. We question the value of extending post-release revocation authority instead of granting parole eligibility to mandatory-sentenced prisoners. We also challenge the wisdom of increasing funding for post-release supervision *without providing equal if not greater access to and funding for pretrial diversion* of nonviolent drug offenders. The return on treatment investment has proven to be far greater

before than after detention.

The unintended consequences of CORI, which frustrate reintegration

Another issue with reintegration is the Criminal Offender Record Information law (CORI), which creates additional barriers to successful reintegration following release. CORI was adopted in 1972 for the purpose of improving prisoner reintegration by keeping off the public record the returning citizen's criminal history. Contrary to that purpose, however, CORI pushes some offenders back to criminal conduct by preventing their access to housing and jobs. The system has inaccuracies which can be difficult to correct. Data is often misunderstood by the potential providers of services to former offenders. Access to the state criminal record system has increased 300% since 1998, from 400,000 to 1.5 million requests annually.[60]

CORI data now is widely used to prevent potential employment and bar families from living together due to punitive public housing regulations. CORI records routinely block loans, college admission and eligibility to become a guardian or foster parent, even for the most rehabilitated minor offender. Employment, education and housing are essential to living a productive, crime-free life, yet CORI too often obstructs a better life and the community's safety from recidivists.[61]

The data confirms the importance of and need for CORI reform. The recidivism rate for drug offenders released from Massachusetts's prisons is 37%.[62] Reducing recidivism is one of the most effective ways of reducing crime. At the point of reentry the factors that have the biggest impact on reducing recidivism are employment and housing.[63] An estimated 2.8 million people in Massachusetts have a CORI record.[64] Each year 60,000 people are convicted of new crimes, resulting in additional CORI.[65] There are now 10,000 organizations certified to receive CORI for either employment or housing screening.[66] The Criminal History Systems Board received over 1.5 million requests for CORI in 2007.[67]

Research on recidivism has found that if an individual has not re-offended after three years for a misdemeanor or seven years for a felony, the chances of that individual offending again are no greater than chances of someone with no criminal record offending.[68] But, employers will avoid hiring anyone with a criminal record.[69] Many programs for public and subsidized housing exclude anyone with a drug conviction.[70]

In 2006, the Massachusetts Bar Association made the following recommendations for improving CORI's impact on state safety and savings:

Access

- Establish clear and separate levels of CORI access: comprehensive access of entire record for law enforcement, and limited access (containing only convictions and pending cases) for all non-law enforcement entities;
- Limit conviction information provided to all non-law enforcement entities only to findings or guilty verdicts of an adult offense or an adjudication as a youthful offender, and include only the crime of conviction not the original charge;
- Establish an educational program for recipients of CORI reports concerning the nature and purpose of the law and the proper use of information provided;
- Develop a process to ensure within a reasonable time that all CORI reports are formatted in a way to make them comprehensible and prepared in plain English, especially reports for prospective employers and schools;

Accuracy

- Establish a verification process to ensure that the CORI is accurately attributed to the proper person, such as by the use of fingerprints;

- Simplify the process to permit the correction of erroneous CORI by establishing an administrative procedure (similar to the process used to correct a credit report);
- Place the burden of proof, that a record is accurate, on the Commonwealth in an action to correct an erroneous CORI, following a *prima facie* showing by the offender that a particular record may be inaccurate;
- Ensure that all CORI reports (including those available to law enforcement) contain an accurate record of the offense of conviction not just the initial charge, by establishing a uniform system for entering information and a process of verification of the entry;
- Create a process to purge information concerning cases where charges of a crime or complaints of delinquency have been dismissed or the defendant (or juvenile) has been found not guilty (or not delinquent), because the defendant was mistakenly identified or the alleged crime never occurred;

Sealing Old Records

Reduce the length of time before a record can be sealed, but allow law enforcement access to the sealed record.

Section IV

Treatment Works

Report of the Subcommittee on Treatment of the Massachusetts Bar Association Drug Policy Task Force; Co-chairs Luis Sanchez, M.D. of the Massachusetts Medical Society and Attorney Len Engel from the Crime & Justice Institute. This report has been adopted by the subcommittee and the Task Force, representing a consensus position of its members rather than the authorized representation of any organizational participant. The subcommittee members include:

- Tim Burke LICSW, Addiction Treatment Center of New England;
- Norma Finkelstein, Institute for Health and Recovery;
- Maryanne Frangules, Massachusetts Organization for Addiction Recovery;
- Joe Kelleher, Hope House;
- David Matteodo, Massachusetts Association of Behavior Health Systems;
- John McGahan, Gavin Foundation;
- Anita Myer, Ed.D., Boston Neurofeedback Center; and,
- Leah Randolph, Human Resources Development Institute.

The Treatment Subcommittee (whose membership includes only one lawyer) welcomes this opportunity to restate fundamentals of treatment generally. We also express the strong consensus of opinion among clinicians in supporting drug abusers' efforts to achieve stability, improvement and personal autonomy, while keeping in mind society's need to protect public health and safety. We understand the mission of this subcommittee to be the examination of current state drug control policy from our professional perspectives, and to recommend policy reforms to enhance safety and savings while improving the quality of life for families and neighborhoods. We offer these observations from our unique perch at the intersection of the treatment and criminal justice systems.

First, a clarification on the use of the phrase 'substance abuse' as opposed to the 'non-harmful' use of such substances. We use the phrase 'substance abuse' to describe the use of legal or illegal substances to the point of or in a manner that causes or creates a likely risk of serious harm to oneself or harm to others. We do not do adopt this distinction to make a political or moral statement about the 'non-harmful' use of illegal substances, but to distinguish between behavior that may warrant expensive and scarce residential or outpatient resources. Second, we emphasize the verities about treatment with which every policy-maker — indeed, every informed citizen — should be familiar. These indisputable conclusions are drawn from decades of observation and hundreds of studies, many by federal and state agencies.

- Evidence-based substance abuse treatment results in clinically significant reductions in alcohol, other drug use and crime, and in improvement of individual health and social function[71]
- Drug treatment reduces drug use by 40 to 60 percent and significantly decreases criminal activity during and after treatment[72]
- Treating drug offenders with substance abuse problems reduces recidivism and creates citizens who contribute to the community
- Outpatient treatment costs one-tenth the cost of incarceration[73]
- No single treatment mode or set of protocols works for every person who needs help; multiple and/or sequential systems may be required
- Treatment is most effective in the context of a support system that may involve family, community and employment opportunity, rather than punishment
- Treatment for incarcerated individuals must begin during the period of incarceration and should

be accompanied by evidence-based programs that address other criminogenic (re-offending) risk factors

- Evidence-based treatment for ex-inmates must continue after release from incarceration and be coordinated with the treatment protocol implemented in the correctional system.

The lesson of these reports and findings, and our consistent professional experience can be summed up in two words: *Treatment works*. That lesson is neither new nor controversial. Drug courts, a growing national phenomenon receiving federal, state and philanthropic support, bloom from that recognition (an April 2009 report by the nationally recognized Washington, D.C. Sentencing Project, however, raises questions about drug courts' abstinence-coercive impact on non-abusive drug users' punishment for nonviolent conduct). The Commonwealth's many public and private substance abuse agencies and organizations labor valiantly every day in vivid demonstration of treatment's efficacy. The power of treatment, as a tool in the state strategy against substance abuse is as reliable as any other proven tactic in state policy to reduce drug harm and is a necessity in a multi-pronged approach to reduce the affects of substance abuse.

As professionals and providers, we move between two worlds. One world is populated with people being treated for their drug problems; the other is populated by similar people in treatment for similar drug problems, but who at the same time are incarcerated.

We have spent many hours in jails and prisons and have few illusions about the magnitude of the problem facing individuals, families and communities, the scarcity of resources devoted to treatment under current policy or the importance of treatment to reduce the harm caused by drug abuse (as distinguished from non-abusive use). We have seen the people who populate these facilities. Most drug offenders are not invidious drug dealers, but ordinary men and women who did something more stupid than dangerous, driven by illness, financial desperation, and who lacked the financial means to extricate themselves by access to affordable substance abuse treatment or superior legal defense.

Our patients' responsibility for being detained, as a symptom of the illness we treat, is not for our determination. We question as clinicians, taxpayers and neighbors of drug users, however, why our patients are detained while their families suffer and their (and our) neighbors watch new dealers fight to supply an unchecked demand for their product. Most drug offenders are not violent people from whom society needs protection. With treatment, vocational training and modest start-up housing assistance, they could live autonomously or return to their families. Why we "lock them up and throw away the key" likely lies in anthropology rather than thoughtful policy development and research, and reflects a prevailing public scorn for some drugs and their users rather than a reasoned position.

While often forced to coexist, punishment and treatment are not a natural match. Punishment complicates treatment; in the allocation of finite taxpayer-supported government resources, imprisonment drives treatment out. A policy enabling more resources for treatment necessarily includes less detention and fewer and shorter sentences for nonviolent drug offenders.

A more treatment-oriented system requires not only legislation but also "culture change" within the criminal justice system by its operatives. Defenders need education about more community-based or residential treatment alternatives to detention. Prosecutors need to view successful treatment in the community as an objective when formulating dispositional recommendations. Judges should consider more pretrial diversion and sentencing alternatives to detention. Probation and parole officers need to recognize that relapse is part of the rehabilitation process and that revocation should be a last resort reserved for interdicting a likelihood of serious and harmful criminal behavior.

The legislature and Governor already recognize the value of treatment and early intervention with children, as demonstrated by their courage and wisdom in enacting 2008 Stat. c. 321, the Children's Mental Health Act. This law is directed at solving the chronic systemic problems of "stuck kids" trapped in juvenile detention or hospital emergency departments awaiting appropriate residential mental health services. This improvement in treatment service delivery should not only divert young potential abusers from becoming trapped in the criminal justice

system, but also serve as a model for early diversion of nonviolent drug offenders. We know of few better tactics in the state's intervention strategy with high risk, drug abusers for improving public safety and the financial costs.

Accordingly, we wholeheartedly support measures to purge the prisons and jails of offenders whose crimes did not threaten the public safety or violate the rights of other citizens, while making room for the violent who are a threat. For our neighbors and family members who have a drug problem, given the substantial savings attendant to reducing prison populations where the per capita annual cost of one prisoner's detention would fund community-based treatment for as many as ten abusers needing care, treatment can and should be made available at a level that comes much closer to meeting the demand and need.

We have other observations to offer, but they pale in significance to the need to re-calibrate the mix of bodies and funding allocated between detention and community-based treatment. Absent a significant change in our incarceration practices, the Commonwealth must ensure that the criminal justice system adheres to principles and practices designed to improve treatment outcomes and reduce recidivism. The ideal treatment system applies evidence-based principles within criminal justice generally and corrections specifically, to prepare ex-offenders for community reintegration with maximum stability and financial autonomy. Better outcomes for patients and detainees result from better case management, with more skilled and valued managers trained in teamwork and conflict resolution. Even for sentenced prisoners, outstanding treatment results became common at the low-security Longwood correctional program, lamentably closed despite its success by prior "tough-on-crime" state administrations.

Evidence-based principles require a process of identification, intervention and follow-up for our neighbors at risk of continued substance-abuse and criminal activity. The research is clear what should be in place for the population most at risk of continued criminal justice involvement.

- **Risk and Needs Assessments** Substance abuse and co-occurring disorders are a predictor of criminal activity. Substance abusing offenders are not a homogeneous group; they have different natures and severities of substance abuse. In fact, nearly one-third of offenders exhibit no substance abuse problems and require only prevention-oriented intervention. Validated risk/needs assessments should be used to identify offenders' substance abuse severity and relationship to criminal behavior.
- **Intervention.** When we know which offenders are at highest risk of continued substance abuse and criminal activity, we should target programs proven to reduce these risks. Whether in the correctional setting or in the community, interventions must be available to this population and programs that begin in the corrections system must continue into the community under a similar case management plan. See Appendix A for a list of evidence-based corrections programs proven to reduce recidivism from the Washington State Institute of Public Policy.
- **Supervision.** Whether released to the community from incarceration or the court, the supervision of offenders in the community should be based on the risk the offender poses to re-offend. This triage requires that lower risk offenders have minimal supervision, and that higher risk offenders receive increased supervision. Offenders with ongoing substance abuse needs (presenting a likely risk of serious harm, beyond mere use) must be supervised with continued programs. The research is clear that supervision without interventions neither reduces recidivism nor curbs substance abuse.[74]
- **Intermediate Sanctions.** Relapse is a fact of life in recovery and the person's involvement in the criminal justice system does not alter this fact. Community supervision must recognize that noncompliance with parole or probation conditions that is not criminal should not necessarily result in person's return to incarceration. Intermediate sanctions in community supervision have been shown to be more effective in responding the needs of the person and are far more cost effective.[75]
- **Community Integration.** Offenders with substance abuse problems often face many other

barriers that limit their stability once back in the community. Housing, employment, mental health issues, and family problems make reintegration difficult for people with substance abuse problems. As indicated above, interventions to address substance abuse must be available in the community, but there must also be a well-organized web of services and community connections in order to enhance the chances of success.

- **Data Collection and Outcome Measures**. To know whether what we are doing works, we must be able to evaluate against what we expect the results to be. The adage "what gets measured gets done" is vital to positive treatment outcomes and the continued effectiveness of proven programs. Thus, practitioners and administrators must collect the key data that supports the application of treatment protocols and this information must be evaluated against the initial objectives and anticipated outcomes. As important, in this time of economic crisis, where human and social service financial support is extremely limited, treatment providers and system administrators must be able to show that what they are doing is having a positive effect on the targeted population and the general public.

The relative efficacy and efficiency of treatment compared to detention should drive funding decisions for both tactics in the strategy for reducing drug harm. Priority for funding first should support nonviolent drug offenders' diversion to treatment before trial; then treatment for reintegrating ex-prisoners, treatment for prisoners within 18 months of parole eligibility; and last for the least effective form of drug treatment, for prisoners farther from release. Careful planning and targeted funding among the foregoing priorities, rather than undifferentiated incremental increases on existing prison and criminal justice budgets, will deliver far greater returns on investment for individual health, family strength, neighborhood safety and taxpayers.

For prisoner treatment, the special cases of county house of correction prisoners (whose confinement averages less than a year, and whose population matches the size of state prison system) deserves priority over the state Department of Correction and its inmates, whose average incarceration period exceeds five years. County prisoners' quick eligibility for bracelet pre-release (recently reinvigorated by the Supreme Judicial Court's decision in *Comm. v. Donohue*, 452 Mass. 256 [2008]) makes their treatment investment far more valuable than longer term state prisoners.

Treatment becomes more effective using comprehensive intake assessments containing physical and mental health, vocation and education, and family components. Corrections officials in Massachusetts have made significant progress in the past few years in the application of evidence-based principles for preparing offenders for release through effective service targeting the indices of criminal behavior such as substance abuse. Hampden, Essex and Suffolk sheriffs' departments have taken significant steps toward addressing the underlying causes of criminal behavior while preparing offenders for release. By generating meaningful treatment plans and programs that begin in jail, follow the prisoner after sentencing and continue contact after release, this quality and range of individually-tailored programming produces measurable recidivism reductions.

Best of all treatment modalities, however, is the diversion of nonviolent users to treatment that avoids detention altogether. For probationers and parolees, successful supervision can be supported by providing offenders clinical social workers or substance abuse specialists. These clinicians, unlike law enforcement supervisors from the Probation Department or the state Parole Board, owe their clients a duty of confidentiality except for the duty to disclose an imminent risk of serious bodily harm (G.L. c. 112, sec. 135A[c]). With confidential support disconnected from a supervisors' revocation authority, offenders in crisis would be encouraged to seek assistance at critical stress points without fear that their candor would motivate preventive detention as too often occurs under current conditions of supervision.

Beyond the elevation of treatment funding within the allocation of state budget resources and a policy that requires the exhaustion of treatment opportunities for the nonviolent before resort to detention, different people respond better to differing treatment modalities that reflect gender, racial, national origin, age, faith and abuse drug familiarity. It bears repeating that fundamental to increasing successful recovery outcomes is the recognition that relapse is the expected course of any illness, a condition that deserves patience rather than

punishment if unaccompanied by violence or a likelihood of serious harm. We further emphasize the need for funding a continuum of care that recognizes the far greater efficacy (in terms of safety and savings) of community-based treatment as compared to treatment in detention.

The appreciation of these benefits can be emphasized by data collection and reports that track outcomes from these policy and funding re-calibrations. Our experience with the federal Government Performance Results Act (enacted in 1993 and amending among other laws, 31 U.S.C., by adding sec. 1115 *et seq*.) supports its application to state-funded programs. This useful federal law requires federally-funded social service agencies to track outcomes for their service consumers to assure program productivity (or identify the lack thereof) and is a model for monitoring the efficacy of state funded treatment programs.

Although we understand that CORI reform is discussed in the sentencing subcommittee's report, we must stress its importance to successful treatment outcomes. The personal autonomy impaired by drug abuse and repaired by treatment also requires the financial autonomy of stable employment. Current CORI policy disables recovery, particularly for older workers. We trust that the CORI law can be improved without jeopardizing public safety, to ensure that drug offenders can obtain jobs with dignity instead of the dead-end menial labors to which CORI now limits them.

Unfortunately, budget decisions under current policy have poorly served the common objectives of personal health, support for stressed families, community safety and taxpayer savings. As the corrections budget has consistently accelerated increasing $300 million since 1998[76], substance abuse services have not kept pace, for both the state (Department of Public Health's Bureau of Substance Abuse Services) and federal (Medicaid) funders. Worse, until the implementation of universal health insurance, the rolls of the uninsured were swelling, leaving a dangerous excess in abuse service demand while affordable treatment access declined. Our experience consistently demonstrates that the earlier and more often community-based treatment is available, the less expensive and more effective the state intervention is in reducing drug abuse.

One potential legislative remedy for the under-capacity of treatment is 2009 H. 1948 (by Reps. Rushing and Balser, amending G.L. c. 111E [the Public Health Drug Rehabilitation Act] at sec. 5), entitled "An act increasing public safety by increasing access to addiction treatment." This bill would "establish a program of assistance for the treatment of all substance dependent persons who are not otherwise eligible for assistance under any other program, and who lack private health insurance coverage or have health insurance coverage which does not cover all necessary treatment ..." This investment would repay itself in savings, growing multiples of its original costs in lowered emergency room and detention expenses for individuals, and reducing the abuser population generally while delivering improved community safety and family cohesion.

Last, but certainly not least, a fundamental flaw in the formulation of drug policy has been the omission from past studies and task forces of perhaps the most important perspective of all the stakeholders in drug policy: The user/consumer. The absence of the consumer perspective from state mental health policy formulation is an error long since and vigorously corrected. See the Department of Mental Health's "Do It Your Way" initiative, calling "attention to the rights of individuals with serious mental illness to participate in advance care planning in order to make their medical and psychiatric health care preferences known" (www.promotingexcellence.org).

Similar recognition, of the treatment consumer's role in shaping state policy and individual interventions, is as critical to current and former drug abusers and their families as has been the prominent role of people with mental illness and its survivors with the state Department of Mental Health. We acknowledge and welcome the participation in our subcommittee of a representative of the Massachusetts Organization of Addiction Recovery (MOAR), and conclude this report with another user group's admonition to all government drug policy-makers:

"Nothing About Us Without Us."

Appendix A

Adult Corrections: What Works?

Example of how to read the table: an analysis of 56 adult drug court evaluations indicates that drug courts achieve, on average, a statistically significant 10.7 percent reduction in the recidivism rates of program participants compared with a treatment-as-usual group.

Programs for Drug-Involved Offenders	
Adult drug courts	**-10.7%** (56)
In-prison "therapeutic communities" with community aftercare	**-6.9%** (6)
In-prison "therapeutic communities" without community aftercare	**-5.3%** (7)
Cognitive-behavioral drug treatment in prison	**-6.8%** (8)
Drug treatment in the community	**-12.4%** (5)
Drug treatment in jail	**-6.0%** (9)
Programs for Offenders with Co-Occurring Disorders	
Jail diversion (pre- and post-booking programs)	**0.0%** (11)
Programs for the General Offender Population	
General and specific cognitive-behavioral treatment programs	**-8.2%** (25)
Programs for Domestic Violence Offenders	
Education/cognitive-behavioral treatment	**0.0%** (9)
Programs for Sex Offenders	
Psychotherapy for sex offenders	**0.0%** (3)
Cognitive-behavioral treatment in prison	**-14.9%** (5)
Cognitive-behavioral treatment for low-risk offenders on probation	**-31.2%** (6)
Behavioral therapy for sex offenders	**0.0%** (2)
Intermediate Sanctions	
Intensive supervision: surveillance-oriented programs	**0.0%** (24)
Intensive supervision: treatment-oriented programs	**-21.9%** (10)
Adult boot camps	**0.0%** (22)
Electronic monitoring	**0.0%** (12)
Restorative justice programs for lower-risk adult offenders	**0.0%** (6)

Work and Education Programs for the General Offender Population

Correctional industries programs in prison	**-7.8%** (4)
Basic adult education programs in prison	**-5.1%** (7)
Employment training and job assistance in the community	**-4.8%** (16)
Vocational education in prison	**-12.6%** (3)

Program Areas in Need of Additional Research & Development

(The following types of programs require additional research before it can be concluded that they do or do not reduce adult recidivism rates)

Case management in the community for drug offenders	**0.0%** (12)
"Therapeutic community" programs for mentally ill offenders	**-27.4%** (2)
Faith-based programs	**0.0%** (5)
Domestic violence courts	**0.0%** (2)
Intensive supervision of sex offenders in the community	**0.0%** (4)
Mixed treatment of sex offenders in the community	**0.0%** (2)
Medical treatment of sex offenders	**0.0%** (1)
COSA (Faith-based supervision of sex offenders)	**-31.6%** (1)
Regular parole supervision vs. no parole supervision	**0.0%** (1)
Day fines (compared to standard probation)	**0.0%** (1)

Work release programs	**-5.6% (4)**

Section V

Conclusions: A Diagnosis of the Policy Flaws

Society tries to control drugs and drug users in three principal ways: By imposing harsh criminal sanctions on people who possess or trade in certain drugs; by discouraging young people from using them in the first place through parental influence, education and public health approaches; and, by providing treatment programs to people who have substance abuse problems. Enforcing criminal sanctions claims the vast majority of the total drug control budget. As more monetary and human resources are invested in the detention approach with no evident health or safety benefit, the Commonwealth faces the uncomfortable question of staying the course or trying a different approach. Can sustaining or intensifying punishment reasonably be expected to produce better protection of health, safety and property? The Task Force concludes current drug policies are obsolete and offer no expectation of improvement.

By obsolescence the Task Force does not mean that the machinery of the drug war is antiquated. Federal and state police enjoy the latest science in surveillance and detection technologies. What appears to the Task Force as obsolete in state drug policy is the *idea* of using the criminal justice system to control what people consume. Prohibition may have seemed reasonable to our ancestors during the last century, when America was a vastly different place. Too much has changed, however, since the passage of the Harrison Narcotics Act in 1914 which criminalized opiates and coca, since the Marihuana Tax Act of 1937 which led to marijuana criminalization, and even since the modern drug war was proclaimed a generation ago. The most important change is the diminishing ability of the government to keep up with the vexing fiscal burden that a permanent war on drugs requires, as dramatically worsened by the deepening global economic recession.

The signs of obsolescence are manifest. Some are obvious, others less so. They include the following components, appearing to us to be beyond reasonable dispute:

1. Increased arrests have not diminished illegal drug use

Despite the best efforts and expanded capacities of police, courts and prisons, the use of illegal drugs has not been diminished. Current drug policy's primary reliance on incarceration has proven to be ineffective as a method of preventing drug use. The SAMHSA report cited by the Education and Prevention Subcommittee indicates that 537,000 people committed the crime of illicit drug possession in Massachusetts at least once a month in 2006. The monthly rate means at least 6,444,000 drug law violations that year, a number that simply overwhelms the enforcement systems currently in place.

The arrest statistics cited by the Sentencing Subcommittee report from the FBI Uniform Crime Statistics, however, indicate that fewer than one-third of one-percent (17,729 people) of the people committing drug offenses in Massachusetts were arrested for drug crimes in 2006. The overwhelming preponderance of drug users avoid detection. This data demonstrates that even a dramatic increase in punishment and its resulting enormous expense in potentially doubling the arrest rate still would reach less than 1% of illegal drug use.

2. Disparate Racial Impact

The impacts of the enforcement of the current drug laws have a significant disparate racial impact. The Task Force does not accuse anyone within the criminal justice system of racism, but the results are unmistakable. Such injustice, regardless of a lack of intent, is intolerable.

3. Harsh Economic Effects

An undeniable side-effect of the current system of enforcement of drug laws is the lasting stigma of a criminal record. Individuals processed through the criminal justice system have a criminal history kept by the Criminal Offender Record Information (CORI) system. A CORI record impedes job opportunities, housing, and education loans. These obstacles directly conflict with the economic interest of individuals, families and the Commonwealth.

In Massachusetts 2.3 million of our 6.5 million people are in the CORI database, and over 1.5 million new CORI reports are produced every year. Some reports have errors, which can be difficult and time-consuming

to correct. CORI records are not subject to verification through identifying information, such as fingerprints. "CORI was never intended to turn every offense into a life sentence," Governor Patrick observed in a press release in 2008, yet current policy permits it to do exactly that. Economic damage is inflicted in many other, less obvious ways.[77] Prisoners do not pay child support, victim restitution, or taxes. Not surprisingly, a 2001 study in Massachusetts found that fully three-quarters of the state's prison population were delinquent with child support payments.

4. Recidivism

The extraordinary recidivism rate in Massachusetts — half of all inmates released are back behind bars within three years — demonstrates some of the failings of the present system of incarceration and rehabilitation. In addition to failing to rehabilitate, educate or train inmates, incarceration itself has a negative impact on many initially nonviolent people. Department of Corrections data show that about a fourth of those initially imprisoned for nonviolent crimes are sentenced for a second time for committing a violent offense. Whatever else this data reflects, this pattern highlights the possibility that prison serves to transmit violent habits and values rather than to reduce them."[78]

Section VI

Recommendations: A New Direction

This Task Force is not the first convened to assess state drug policy. It is not likely to be the last, nor should it be. The purpose of state drug control policy to protect public safety and reduce the harm caused by drug abuse. If current drug prohibition policy is failing its purpose by the wide margin detailed in the foregoing subcommittee reports, it requires careful scrutiny and the attention of our fellow citizens and our state's elected leaders.

Notwithstanding the best efforts of the criminal justice system, the state's present drug policy shows no prospect of delivering abstinence or even near-abstinence from illegal drug use. To pursue that goal by upgrading the machinery of detection, prosecution, and punishment — repeatedly deploying more police, breaching the privacy of more people, hiring more prosecutors, and building more courtrooms and prisons, is economically impractical and unaffordable.

States around the country are reaching that same conclusion, and seeking meaningful and sustainable reforms that reduce the use of criminal punishment for nonviolent drug users. As this report is being adopted, New York is ending mandatory minimum sentences for drug use and distribution by repealing its infamous "Rockefeller" sentencing laws, choosing to emphasize treatment instead of punishment and judicial discretion over prosecutorial plea bargaining.

The Task Force offers recommendations for the short and longer terms. Our first two recommendations address the most acute problems, requiring statutory change. For longer term drug policy improvements, the last three recommendations suggest careful diagnosis and rehabilitation planning using a practical perspective of limited budgets and accountability based on the evidence-based outcomes of reforms, rather than moral aspirations.

1. Short-term Recommendation: Reform Chapter 111E to Make Diversion to Treatment Effective and Available Statewide

One immediate problem facing the Commonwealth is prisoner overpopulation and ex-prisoner reintegration impairment. There is no funding available for further prison expansion, and a way to reduce prison populations without harm to neighborhoods must be found. To begin to accomplish that objective, diversion to treatment (suspension of criminal charges for drug offenders, access to treatment and the dismissal of charges on the completion of the treatment period without involuntary discharge from the treatment program) must be expanded statewide and available over prosecutorial objection.

To make diversion in Massachusetts effective, several reforms are crucial:

- Change c. 111E so that information about available treatment centers and other aspects of diversion is disseminated by the Bureau of Substance Abuse Services, rather than the "Department of Drug Dependence," which doesn't exist.
- Change the law to allow an "addiction specialist" (a RN, LICSW, or other individual certified by the Bureau of Substance Abuse Services) to determine who is eligible for the program. Current law only allows a physician to evaluate defendants; many courts are unwilling to pay for this expensive service provider's examination.
- Expand current diversion eligibility provisions to apply to second time offenders as well as first time offenders, to acknowledge that relapse is an expected component of addiction recovery.
- Expand current provisions so that treatment for first and second nonviolent offenders is mandated if the offender chooses to try diversion instead of a disposition of his or her drug charges. This option will ensure that the program is used uniformly across all jurisdictions, allowing better evaluation of the impact of diversion policies in the future.

Potential Impact: An effective, uniform diversion program could save the Commonwealth millions. The

average cost of housing an individual in the county jail for a year is $39,000 (DOC's annual cost is more than $47,000), while the cost of the average treatment episode is well under $7,000 per patient last year.

In FY 2006, there were 1,880 individuals sentenced to incarceration for simple possession. After excluding those arrested with a "violent or repetitive record" or a "serious violent record," 1,426 offenders remain. The average sentence of these offenders is about four months.

Even if we include probation costs of about $500 per arrestee, the state could save approximately $8.7 million in annual corrections costs alone if drug offenders were diverted to treatment rather than being sentenced to jail.

Many studies of diversion programs show that when the long term effects of treatment are included in a fiscal analysis, including increased tax revenue from the wages of treated offenders and a decrease in crime, savings are much greater.

2. Short-term Recommendation: **Enact Drug Sentencing Reforms As Soon Possible**

Beyond diversion of offenders to treatment instead of punitive detention, sentencing, reforms are needed for new drug offenders and current drug prisoners.

Proposals # 1 – 4 concern the state's school zone law, G.L. c. 94C, § 32J.

Proposal # 1: Reduce size of school zones: Reduce the size of drug-free school zones from 1,000 feet to 100 feet (the same as for parks and playgrounds). The school zone statute makes no distinction for school year, school hours, or intent to sell to a student. The school zone impacts urban residents disproportionately, due to the number of schools scattered through the cities, and also disproportionately impacts minorities. A 2008 report on school zone prosecutions in Hampden County showed that urban residents were five times more likely than suburban or rural residents to be arrested under this law. According to a study done by Representative William Brownsberger (Belmont), only approximately one percent of the school zone convictions involve sales of drugs to students. This proposal was included in H. 5004 in 2008.

Proposal # 2 Reduce sentences for all zone offenders: Current sentencing laws provide for sentences of 2 years to 15 years. Currently under the school zone statute, each year approximately 300 offenders are sentenced to at least two years of incarceration for school zone violations. The mandatory minimum is two years to be served, without eligibility for parole or work release. The 2008 report, mentioned above, found that a total of 727 prisoners were serving time for school zone offenses. H. 5004 would have reduced the sentence of first time zone offenders to 0 to 2 years. In addition to supporting the reduction to this level, the Task Force supports revising the current sentencing laws for 2 to 15 years to 0 to 15 years for all offenders. NOTE: This proposal would not weaken protection for children as we still have statutes that impose stiff penalties for selling drugs to minors or using minors to make sales.

Proposal # 3 Eliminate mandatory sentences for all zone offenders. Under H. 5004, the mandatory minimum for first time offenders would have been eliminated. The Task Force supports this revision, but urges the repeal of mandatory minimums for all zone offenders.

Proposal # 4 Allow concurrent sentences for zone offenders: Under existing law, sentences for school zone offenders can not be served concurrently with other sentences. This extra punishment is inconsistent with most other sentencing provisions. H. 5004 would have allowed first-time school zone offenders sentenced to incarceration to serve that time concurrently with another sentence. The Task Force supports this revision, and also urges that any school zone offender be allowed to a sentence concurrently with other sentences, in the discretion of the sentencing judge.

Proposals # 5-7 concern all drug offenses under c. 94C and would treat drug offenders like most other

prisoners. These proposals would also apply retroactively, affording some relief to those who are currently serving harsh mandatory minimum drug sentences. Drug offenders currently are barred from pre-release programs, parole, and earned "good time" credit for participating in educational and vocational programs. As the Harshbarger Commission stated in 2004, "Quite simply, based on what we now know about reducing re-offense, this is a recipe for recidivism rather than a recipe for effective risk reduction."

Proposal # 5 Expand eligibility for work release: Prisoners serving mandatory minimum drug sentences should be allowed to participate in work release programs.

Proposal # 6 Expand eligibility for parole: Over the last several legislative sessions, Sen. Creem has filed bills that would allow prisoners serving mandatory minimum drug sentences to be eligible for parole after serving two-thirds of the minimum sentence. We took her proposal one step further, so that it is consistent with current parole policy for non-mandatory sentences.

- For county (House of Correction) sentenced prisoners, establish parole eligibility after serving one-half of minimum sentence;
- For state (Dept. of Correction) sentenced sentences, establish parole eligibility after serving two-thirds of maximum sentence.

Proposal # 7 Expand eligibility for earned "good conduct" credit: Allow prisoners serving mandatory minimum drug sentences to participate in and receive sentence credits for educational, vocational, treatment or other programs that are approved for "good conduct" eligibility, like most other prisoners.

Proposal # 8 Restore suspended and split sentences: This proposal would apply to all offenses, but is particularly useful for drug offenders. It affords judges more discretion to impose effective sentences.

Notes: It should be mentioned in conjunction with this proposal that the Massachusetts Bar Association has previously proposed legislation that would amend G.L. c. 279, §3 to give judges flexibility in imposing a sanction when a probationer, who was subject to a suspended sentence, is surrendered. In Comm. v. Holmgren*, 421 Mass. 224, (1995), the court held that the only options a judge has are either to reprobate with a modification of conditions or to impose the full suspended sentence.*

The Task Force endorses the concept of expanded supervision of inmates upon release from incarceration. Provisions already exist in Massachusetts for post-incarceration supervision. One method is parole, but parole must be made possible for the inmate through appropriate sentencing, including restoring parole for drug offenders; and, by restoring suspended and split sentences, the probation system can also be utilized. Accordingly, the Task Force opposes new legislation for post-incarceration supervision which would merely or primarily increase incarceration time, including either by revocations of release or by adding conditional release after harsh mandatory jail sentences . Adequate post-incarceration supervision can and must be achieved through appropriate sentencing reforms, i.e. expanded probation and parole, and does not require new, budget-busting programs further exacerbating counterproductive overcrowding of prisons and houses of corrections. Post-incarceration supervision can be "smart on crime," but only if prison-population-neutral.

In support of these reforms, the Task Force files a separate report with this report, entitled "Drug Crimes and Incarceration Rates in the Commonwealth, Trends and Proposed Reforms," produced by the Sentencing Subcommittee principally through the talented work of its members, Suffolk County Sheriff Andrea Cabral, and Matt Allen of New England Policy Associates.

3. Long-Term Recommendation: Culture Change

The current drug laws prefer punishment over treatment in addressing addiction and nonabusive drug use. Aside from needing more flexibility in responses to drug abuse (and distinguishing between non-abusive use and harmful abuse), decision-makers who formulate solutions and responses need to be more creative. This group

includes prosecutors, defense lawyers, judges, probation officers, corrections administrators and parole officials.

From the beginning of a defendant's involvement in the criminal justice system at the time of arrest and arraignment, until discharge from custody or supervision, greater creativity is needed to develop community-based treatment programs and formulate modes of sanction and supervision that encourage the success of safely remaining on the street. The system at each level should cultivate and deliver more effective supervision and provide better treatment options that avoid re-incarceration unless necessary to protect public safety. Greater creativity and innovation should be encouraged and utilized.

4. Long-Term Recommendation: Expand Treatment Resources

Growing access to treatment seems difficult to accomplish in a time of a weakening economy. Massachusetts' development of a universal health care system, however, has enhanced the availability of resources. By treating substance abuse as a public health problem (which the new state and federal laws requiring parity in physical and mental health insurance coverage implies), the universal health care system and the expertise of public health professionals, treatment systems and agencies can work with court resources to assess, refer, and provide services to people whose drug abuse is better treated than punished. For example, each court can have a public health liaison whose specific purpose is to ensure effective utilization of resources in the health system. Economies of scale can be realized by coordinating health care resources throughout the justice system.

5. Long-Term Recommendation: Rethinking to Build Commitment to Systemic Changes

The model of how we address the drug problem in the criminal justice system needs to change. The legislature should enact legislation encouraging the formulation of a treatment plan for offenders with disabling addictions at the time of arraignment, similar to treatment programming for people with chronic mental illness. Additionally, the statutory scheme in Chapter 94C which regulates and sanctions the use of controlled substances should be amended to eliminate statutory provisions mandating length of sentence, restricting access to treatment and re-entry programs, and limiting the availability of probation and parole.

To support this rethinking, this report concludes by offering some questions aimed at sparking reconsideration of long-accepted notions of the current drug prohibition policy and its unaffordable failure to improve health and safety. The Task Force believes these questions have been ignored in the crafting and enforcement of current policy, and must be confronted if that policy and its results are to improve; thus we deem them Necessary Questions. Until these questions are asked, debated and sufficiently answered, state drug prohibition policy risks remaining mired in an obsolescent past and unsustainable present.

Additional Questions for Continued Policy Debate

1. Is it realistic to think that continuing to pour vast resources into detection, enforcement, and prosecution, and making punishment harsher, ever will achieve improvement (much less "success") in the struggle against illegal drug use? If we were successful, how many people would be incarcerated, and at what cost to taxpayers?
2. If tobacco consumption can be reduced by 50% through public health measures, social influence, and tax policy, without arresting anyone, can we find a way to used similar policies to reduce the use of other drugs and alcohol?
3. How should we be improving our treatment of alcoholism, which affects a far greater number of people than drug abuse? Should we be increasing our focus on treating alcoholism?
4. Does it make sense to ignore the ubiquity of drugs or the implausibility that all children will remain abstinent as and when they grow up? How do we adjust our educational programming to achieve the greatest reduction in this potential harm?
5. Have mandatory minimum penalties actually benefited the zones and vulnerable zone inhabitants

intended for protection?

6. Can we learn from the drug policies of certain European nations, which have focused on non-punitive regulatory models and harm reduction?
7. Would violent crime be more likely to increase or decrease if addiction were treated as a public health rather than a criminal matter? Should the law recognize the differences among drug use, drug abuse and drug use that creates a likelihood of significant harm to others?

Notes

1. *Drugs, Brains and Behavior: The Science of Addiction*, National Institute on Drug Abuse, National Institutes of Health, US Department of Health and Human Services, February, 2007

2. *Research Summary*, *Pacific Institute on Research and Education*, Join Together, Boston University School of Public Health, July 5, 2006

3. *Blueprint For The States: Policies To Improve The Ways States Organize And Deliver Alcohol And Drug Prevention And Treatment,: Findings and Recommendations of a National Policy Panel,* Join Together 2006, authors, David Rosenbloom, Roberta Leis, Payal Shah and Robert Ambrogi.

4. *State Estimates of Substance Use from the 2005-2006 National Surveys on Drug Use and Health*, Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 2008

5. *Ibid*.

6. Join Together, Boston University School of Public Health, http://www.higheredcenter.org/instruments/glossary.html

7. Join Together, Boston University School of Public Health, http://www.jointogether.org/news/yourturn/commentary/2006/fight-teen-drinking-from-the.html

8. Del Elliot, Director of the Center for the Study and Prevention of Violence at the University of Colorado at Boulder states that "Many after-the-fact punitive reactions focus on deterrents rather than causes of the problem. Serious violence continues because the underlying problems are never addressed." See also 2001 *Youth Violence: A Report of the Surgeon General:* "Programs which remove youth from their peers and group together young people with problem behavior, result in increased problem behavior because the novices learn from the more practiced youth."

9. *Project DARE: No Effects at 10-Year Follow-Up,* Donald R. Lynam, Richard Milich, Rick Zimmerman, Scott P. Novak, T. K. Logan, Catherine Martin, Carl Leukefeld, and Richard Clayton, University of Kentucky, Journal of Consulting and Clinical Psychology, 1999, Vol. 67, No. 4, 590-59

10. *Prevention Education in America's Schools: Findings and Recommendations from a survey of Educators,* Join Together2007, authors, Pamela Anderson, Susan Aromaa and David Rosenbloom

11. *Research Summary, Pacific Institute on Research and Education,* Join Together, Boston University School of Public Health, July 5, 2006

12. *Ibid*.

13. *Ibid*.

14. *Preventing Underage Drinking: Using Getting To Outcomes with the SAMHSA Strategic Prevention Framework to Achieve Results,* Pamela Imm, Matthew Chinman, Abraham Wandersman, David Rosenbloom, Sarah Guckenburg, Roberta Leis, Rand Corporation, 2007

15. *Blueprint For The States: Policies To Improve The Ways States Organize And Deliver Alcohol And Drug Prevention And Treatment,: Findings and Recommendations of a National Policy Panel,* Join Together 2006, authors, David Rosenbloom, Roberta Leis, Payal Shah and Robert Ambrogi.

16. Vincent Schiraldi, Barry Holman and Philip Beatty. "*Poor Prescription: the costs of imprisoning drug offenders in the United States*," Justice Policy Institute: July 2000. P. 3. http://www.drugpolicy.org/docUploads/PoorPrescription.pdf

17. U.S. Department of Justice, Bureau of Justice Statistics. "*Special Report: Profile of Jail Inmates, 2002*." July, 2004. http://www.ojp.usdoj.gov/bjs/pub/pdf/pji02.pdf

18. Lisa Brooks, Amy Solomon, Sinead Keegan, Rhiana Kohl, and Lori Lahue. "*Prisoner Reentry in MA*." Urban Institute, Justice Policy Center: March 2005. 1,11. http://www.urban.org/UploadedPDF/411167_Prisoner_Reentry_MA.pdf

19. Department of Health and Human Services. "*Results from the 2005 National Survey on Drug Use and Health: National Findings*". SAMSHA: September 2006.

20. Department of Health and Human Services. "*Results on the 2006 National Survey on Drug Use and Health: National Findings*". SAMHSA: September 2007.

21. United Nations Office for Drug Control and Crime Prevention, *Global Illicit Drug Trends* 1999 (New York, NY: UNODCCP, 1999), p. 86.

22. Office of National Drug Control Policy. "The Price and Purity of Illicit Drugs: 1981 Through the Second Quarter of 2003". November, 2004. http://www.whitehousedrugpolicy.gov/publications/price_purity/.

23. Ryan King and Marc Mauer. "Distorted Priorites: Drug Offenders in State Prisons." The Sentencing Project: September 2002. 2.

24. Lisa Brooks, Amy Solomon, Sinead Keegan, Rhiana Kohl, and Lori Lahue. "Prisoner Reentry in MA." Urban Institute, Justice Policy Center: March 2005. 1, 11. http://www.urban.org/UploadedPDF/411167_Prisoner_Reentry_MA.pdf

25. Mass. Dept. of Public Health. Bureau of Substance Abuse Services. Winter Newsletter, 2007.

26. *Commonwealth vs. Marc Brown*. SJC-08211. April 4, 2000-June 21, 2000. http://caselaw.lp.findlaw.com/scripts/getcase.pl?court=ma&vol=sjcslip/8211&invol=1.

27. Vincent Schiraldi, *supra,* p. 3.

28. King Country Bar Association. "*Effective Drug Control: Toward A New Legal Framework: A State-Level Regulation as a Workable Alternative to the 'War on Drugs*.'" King County Bar Association: 2005. 248.

29. Haney and Zimbardo, "The Past and Future of U.S. Prison Policy," *American Psychologist,* July 1998.

30. Laura Crimaldi. "State Sets Record High for Inmates". *Boston Herald*, September 7, 2008.

31. Lisa Brooks, *supra,* p. 1.

32. Brooks, p. 11.

33. Len Engel. "*Promoting Public Safety Through Successful Community Transition: Toward an Evidence Based System of Offender Reentry.*" Crime and Justice Insitute: May, 2008. 6.

34. R. Mclaughlin, Pamela J., and Rhiana Kohl. "January 1, 2008: *Inmate Statistics*." Massachusetts Department of Correction Research and Planning Division: 2008. 16.

35. Scott Harshbargar (Chair), "*The Commonwealth of Massachusetts Governor's Commission on Corrections Refor*m," June 30, 2004. 2.

36. Massachusetts Department of Correction, "January 1, 2008 *Inmate Population*," 2008.

37. Laura Crimaldi, "No room to stir," *Boston Herald*, September 7, 2008.

38. Massachusetts Department of Correction, "*3rd Quarter 2008 Overcrowding Report*," 2008.

39. Len Engel, *supra,* 6.

40. Butterfield, "With Cash Tight, States Reassess Long Jail Terms," *New York Times*, November 10, 2003, p 1.

41. Jo-Ann Moriarity, "Drug Free Zones Facing Review," *Springfield Republica*n, July 26, 2008.

42. See also Aleks Kajstura, Peter Wagner, and William Goldberg, "*The Geography of Punishment: How Huge Sentencing Enhancement Zones Harm Communities, Fail to Protect Children,"* Prison Policy Initiative, July 2008. (http://www.prisonpolicy.org/zones/report.html).

43. William Brownsberger, Susan Arommaa. "*An Empirical Study of the School Zone Law in Three Cities in Massachusetts*," Join Together and the Boston University School of Public Health. July 2, 2001.

44. Massachusetts Sentencing Commission, "*Survey of Sentencing Practices FY 2005*" and "*Survey of Sentencing Practices FY 2006*," 2005, 2006.

45. Jonathan P. Caulkins, C. Peter Rydell, William L. Schwabe and James Chiesa, *Mandatory Minimum Drug Sentences: Throwing Away the Key or the Taxpayers' Money.* Rand. 1997.

46. Peter Elikann, *The Tough on Crime Myth,* 1996.

47. Engel, ii.

48. Doug McVay, Vincent Schrialdi, Jason Ziedenberg. "*Treatment or Incarceration? National and State Findings on the Efficacy and Cost Savings of Drug Treatment Versus Imprisonment*." Justice Policy Institute. January, 2005.

49. Scott Ehlers and Jazon Ziedenberg. "*Proposition 36: Five Years Later.*" Justice Policy Institute, April 2006. p. 2, 15.

50. Arizona Supreme Court, Office of the Courts, Adult Probation Services Division. "*Drug Treatment and Education Fund: Report Detailing 2001-2004.*" p. 5.

51. Doug McVay, *supra,* 13.

52. Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health, "*Illicit Drug Use, by Race/ Ethnicity in Metropolitan and Non-metropolitan Counties: 2004-2005.*" June 21, 2007.

53. Massachusetts Sentencing Commission, "Survey of Sentencing Practices FY 2006," 2007, pg. 53

54. *Ibid.*

55. Aleks Kajstura, *supra,* p 6.

56. Substance Abuse and Mental Health Services Administration, *National Household Survey on Drug Abuse: Summary Report 1998* [1999], p. 13; Bureau of Justice Statistics, *Sourcebook of Criminal Justice Statistics 1998* [U.S. Dept. of Justice, August 1999], p. 343, Table 4.10, p. 435, Table 5.48, and p. 505, Table 6.52; Beck and Mumola, Bureau of Justice Statistics, *Prisoners in 1998* [U.S. Dept. of Justice, August 1999], p. 10, Table 16; Beck and Harrison, Bureau of Justice Statistics [U.S. Dept. of Justice, August 2001], p. 11, Table 16.

57. Durose and Langan, Bureau of Justice Statistics, *State Court Sentencing of Convicted Felons, 1998,* Statistical Tables U.S. Dept. of Justice, December 2001, Table 25.

58. Langan and Levin, "*Recidivism of Presoners Rleased in 1994"*, U.S. Department of Justice, Bureau of Justice Statistics, Washington. D.C., June 2002.

59. Ryan King, *supra,* 6.

60. Engel, 12.

61. Yakov Kronrod and the EPOCA members. "Petition to Reform Massachusetts' CORI Laws". http://www.petitiononline.com/corilaws/petition.html

62. Rhiana Kohl, et al., *Massachusetts Recidivism Study: A Closer Look at Releases and Returns to Prison,* the Urban Institute Justice Policy Institute and the Massachusetts Department of Correction, April 2008; available at http://cjpc.org/Recidivism.pdf, see page 20, table 4. Recidivism for the purposes of this report is defined as re-incarceration within three years. For all prisoners released by the DOC in 2002 the recidivism rate was 39%. See page 10 and table 4.

63. Ginger Martin and Cheryl Roberts, *From Incarceration to Community A Roadmap to Improving Prisoner Reentry and System Accountability in Massachusetts*, Crime and Justice Institute, June 2004 available at http://www.crjustice.org/reentryrpt.pdf

64. MA Sentencing Commission, *Survey of Sentencing Practices, FY 2004,* Boston, MA April 2005.

65. *Ibid*.

66. Report of the Task Force on CORI Employer Guidelines, *CORI: Opening Doors of Opportunity, A Workforce and Public Safety Imperative*, the Boston Foundation and the Crime and Justice Institute, 2007, at page 11; available at http://www.crjustice.org/cji/cori_may2007.pdf.

67. *Ibid*., at p. 13.

68. Governor's Ex-Offender Task Force, Preliminary Report, Tallahassee, FL December 31, 2005; *CORI: Opening the Door of Opportunity*, p. 22; and, Governor Patrick's testimony to the Joint Committee on the Judiciary on March 18, 2008, page 8, http://cjpc.org/2008webpostings/Governor%20PatrickCORI%20Testimony.pdf.

69. Employers Group Research Services, *Employers of Ex-Offenders: A Survey of Employers' Policies and Practices.* SFWORKS. (April 12, 2002). See also: Len Engel, *Promoting Public Safety Through Successful Community Transition, Toward an Evidence-Based System of Offender Reentry,* the Crime and Justice Institute and Community Resources for Justice, May 2008, page 12.

70. Legal Action Center, *Housing Laws Affecting Individuals with Criminal Convictions.* (2000).

71. Belenko, Patapis, French, "*Economic Benefits of Drug Treatment: A Critical Review of the Evidence for Policy Makers*," February, 2005, Treatment Research Institute, University of :Pennsylvania

72. *Treatment*, Office of National Drug Control Policy, Washington, D.C.

73. Massachusetts Information Related to *Blueprint for the States* Recommendations, Join Together (Boston Univ. School of Public Health) 2006.

74. Petersilia, Turner, "Intensive Probation and Parole." *Crime and Justice: A Review of Research*, edited by Michael Tonry. Chicago, Illinois: University of Chicago Press. (1993)

75. Clear, Harris, Baird, "Probationer Violations and Officer Response." *Journal of Criminal Justice.* 20:1-12, (1992)

76. Engel, "*Promoting Public Safety through Successful Community Transition: Toward an Evidence-Based System of Offender Reentry*" citing FY 1998 and 200FY 2008 Massachusetts Final Budget data from the Massachusetts General Court website. (2008)

77. Thoennes, Dr. Nancy, *Child Support Profile: Massachusetts Incarcerated and Paroled Parent*, Center for Policy Research (Denver, CO: May 2002)

78. Haney and Zimbardo, "The Past and Future of U.S. Prison Policy: Twenty-five Years After the Stanford Prison Experiment," American Psychologist, Vo. 53, No. 7 (July 1998), p. 721.

The Massachusetts Bar Association Drug Policy Task Force was formed in the spring of 2007 to study Massachusetts sentencing mandates and incarceration policies concerning drug addiction and related crimes. Its mission is the following:

- To assess education and prevention programs for their adequacy and effectiveness
- To assess treatment programs for their availability and adequacy
- To examine the manner in which drug-related crimes are treated in the criminal justice system
- To make appropriate recommendations to improve these three policy issues

- David W. White, Jr., Chair; Massachusetts Bar Association Past President; Partner, Breakstone, White & Gluck PC, Boston
- Michael D. Cutler, Assistant Chair; Law Office of Michael D. Cutler, Brookline
- Matt Allen, New England Policy Advocates
- Susan Aromaa, Join Together, Boston University School of Public Health
- Anthony Benedetti, General Counsel, Committee for Public Counsel Services;
- Tim Burke LICSW, Addiction Treatment Center of New England
- Andrea Cabral, Sheriff, Suffolk County;
- John Christian, City of Boston Public Health Commission
- Julia Hardy Cofield, National Association for the Advancement of Colored People
- Julie Cushing, Massachusetts Youth Program Director, SADD (Students Against Destructive Decisions) State Coordinator
- Barbara Dougan, Families Against Mandatory Minimums;
- Lee Gartenberg, Director of Inmate Legal Services for the Middlesex Sherriff's Office
- Len Engel, Crime & Justice Institute
- Norma Finkelstein, Institute for Health and Recovery;
- Maryanne Frangules, Massachusetts Organization for Addiction Recovery;
- Neil Hourihan, Salem attorney Steve Keel, Director of Prevention, DPH/Bureau of Substance Abuse Services
- Brandyn Keating, formerly with the Criminal Justice Policy Coalition and Gov. Patrick's Public Safety Working Group of his transition team
- Joe Kelleher, Hope House;
- Ken King, Suffolk Law School, Juvenile Justice Institute [now an Associate Justice of the state Juvenile Court]
- Roberta Leis, Join Together, Boston University School of Public Health
- David Matteodo, Massachusetts Association of Behavior Health Systems
- Neil McDevitt, McDevitt & Associates, Boston attorney;
- Paul McDevitt, Modern Assistance union health consultant
- John McGahan, Gavin Foundation;
- Patricia Muldoon, League of Women Voters of Massachusetts
- Anita Myer, Ed.D., Boston Neurofeedback Center
- Joel Pentlarge, Criminal Justice Policy Coalition;
- Constance Peters, Vice President for Substance Abuse, Mental Health & Substance Abuse Corporations of Massachusetts, Inc.
- Leah Randolph, Human Resources Development Institute
- Martin Rosenthal, Boston attorney and Co-Chair, Sentencing Reform Committee, Mass. Association of Criminal Defense Lawyers
- Luis Sanchez, M.D. of the Massachusetts Medical Society
- Leslie Walker, Massachusetts Correctional Legal Services Victoria Williams, City of Boston, Office of Civil Rights
- Hon. Robert Ziemian, Boston Municipal Court

Drug Crimes and Incarceration Rates in the Commonwealth

Trends and Proposed Reforms

Massachusetts Bar Association
Drug Policy Task Force

April 29, 2009

Data Sub-Committee

Matt Allen, New England Policy Advocates
Andrea Cabral, Suffolk County Sheriff
Patti Muldoon, League of Women Voters
Leslie Walker, Massachusetts Correctional Legal Services

Introduction

Corrections spending is skyrocketing in Massachusetts as incarceration rates climb. In the FY 2009 budget total corrections allocations amount to over $1 billion.[2] With overcrowding becoming an increasing problem in the Commonwealth's county correctional facilities and the annual per prisoner cost of incarceration in the state prison system approaching $48,000 annually, policy makers and advocates have begun to examine sentencing alternatives for non-violent offenders.

Research Questions:

• How many drug offenders are sentenced to incarceration annually?

• What are the rates of incarceration for possession, distribution, trafficking, and other crimes, respectively?

• What is the racial break down of these offenders?

• What are the fiscal savings that might be realized through diversion of low-level offenders to treatment?

• What are the fiscal savings that might be realized through mandatory minimum reform?

Summary of Findings

• Over 25,000 individuals are currentlyincarcerated in Massachusett's prisons and county facilities. The prison population rose by 368% between 1980 and 2008, while the jail and house of correction population increased by 522% in the same period.[1]

• The proportion of drug offenders representing new commitments to houses of correction and state prisons rose from 6.5% in 1980 to 23% in 2006.

• From 1994 to 2006, the proportion of offenders sentenced to incarceration for possession for personal use compared to the total number of drug offenders sentenced to incarceration rose from 30% to 39%.

• In 2006 minorities comprised 20% of the state's population, but 54% of those convicted of drug crimes and 74.6% of those sentenced to incarceration under mandatory minimum statutes for drug crimes.

• School zone violations represent the largest category of mandatory minimum violations, making up 31.5% of all new commitments to houses of correction and state prisons for mandatory offenses in 2006.

• Diverting simple possession offenders to treatment instead of incarceration could result in more than $8 million in annual savings to the state.

• Mandatory minimum sentencing reform (parole at 2/3 of sentence for offenders in state prison and 1/2 of sentence for offenders in county correctional facilities.) could generate over $17.7 million in annual savings.

The Massachusetts Bar Association Drug Policy Task Force (DPTF) was convened in 2008 under the leadership of the Massachusetts Bar President David White. The Task Force consists of lawyers, advocates, treatment providers, legislators, and concerned citizens from across the Commonwealth. The group is charged with examining existing drug policies and suggesting reforms intended to reduce addiction, save money, and increase public safety.

To inform their policy recommendations, the Task Force members examined over 95 reports compiled by state agencies between 1980 and 2008.

Simple Possession: Possession of a small amount of drugs for personal use.

Possession with Intent to Distribute: Possession of a larger amount of drugs, but not enough for a trafficking charge.

Mandatory Minimum Drug Charges: These charges carry mandatory prison time. They may be trafficking charges (determined by the weight of the drug) or enhanced possession with intent charges, such as possession with intent to distribute drugs in a school zone.

Jail: where prisoners awaiting trial are held within a county correctional facility.

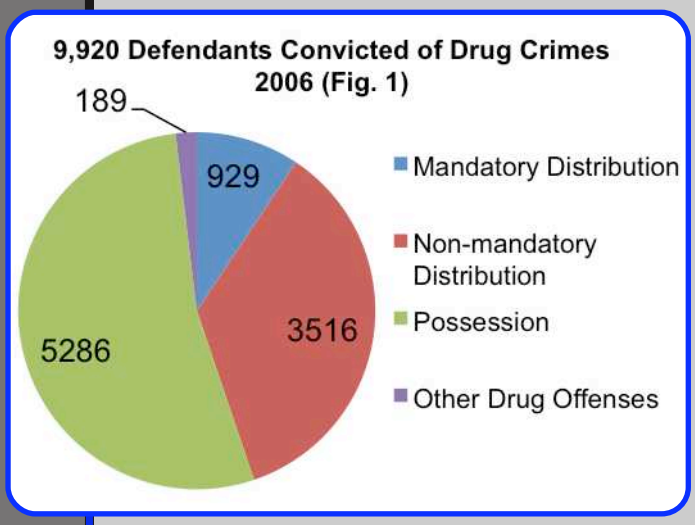
House of Correction (HOC): also within a county correctional facility, HOCs are where offenders who have been sentenced are incarcerated

State Prison: Where prisoners serving terms over 2.5 years are incarcerated.

What are Drug Offenses?

Possession offenses include possession of a small amount of drugs for personal use, possession of a hypodermic needle (no longer a criminal offense) and similar conduct. People arrested for possession with intent to distribute generally have a small amount of drugs, often packaged to suggest an intent to sell or distribute. Individuals may also be charged with possession with intent to distribute if they are caught distributing drugs, but in quantities not large enough to be charged with trafficking. Mandatory minimum drug crimes are the result of sentencing policies that were enacted in the late 1980s and 1990s. These crimes include trafficking, subsequent possession with intent to distribute charges, possession with intent to distribute in a school zone (within one-thousand feet of a school or headstart facility or within 100 feet of a park or playground), and distribution to a minor. First offense possession with intent to distribute specific drugs, such as PCP, cocaine, or methamphetamine, may also require a mandatory minimum sentence. Other drug crimes that do not fit neatly into these categories include driving under the influence, conspiracy to violate the Controlled Substance Act, and attempting to acquire drugs with a fake prescription.

Offenders serving time for lower-level drug crimes, such as simple possession, tend to be incarcerated in county correctional facilities (houses of correction). Offenders serving sentences longer than 2.5 years serve time in state prisons.



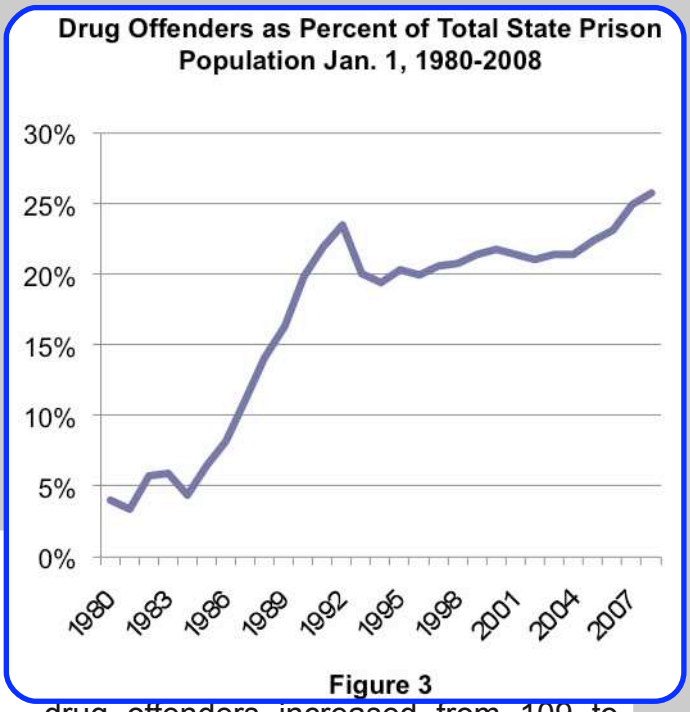


Figure 3

There were 9,920 defendants convicted of drug crimes in 2006. Fifty-three percent of all drug convictions were for possession offenses. Mandatory minimum distribution convictions (including trafficking) were 9% of all convictions for drug crimes.[3] (Fig. 1)

Snapshot of the State Prison Population

The State prison population increased from 2,754 in 1980 to 10,132 in 2008 - an increase of 368%. The amount of drug offenders increased from 109 to 2,610 in the same period - an increase of 2,394%. (Fig. 2)[4]

The practice of incarcerating drug offenders has a significantly contributed to the increase in the Massachusetts prison population. Drug offenders made up just 4% of the state prison population in 1980, but over 25% of the population in 2008. (Fig. 3)[5]

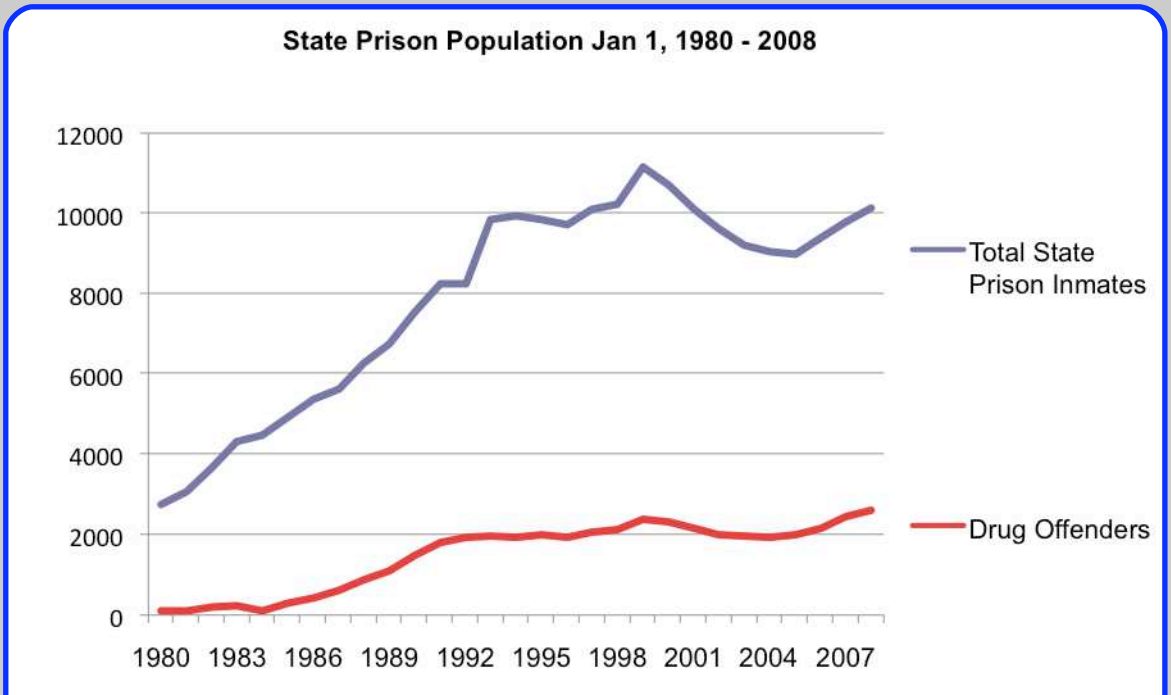


Figure 2

New Commitments to the HOCs and State Prisons

The previous charts were based on a snapshot of the state prison population that is always in flux, as prisoners are admitted and released on a daily basis. The annual DOC "Court Commitments" Reports present a comprehensive view of the population of offenders moving through the courts and into prison and county houses of correction.[6]

There were 6,675 total new commitments in 1980: 5,441 to the HOC and 1,234 to the state prisons. Of those cases, 432 were committed with a drug charge as their lead offense. By 2006 there were 20,858 new commitments: 17,722 to the HOC and 3,136 to the State Prisons. Of those, 4,794 were sentenced with a drug offense as their lead charge. (Fig. 4)

In 1980, only 6.5% of new commitments to the HOC and prisons had a drug crime as their lead charge. By 2006 that proportion had increased almost four times to 23%. (Fig. 5) In the state prisons alone, drug offenders represented over 34% of all new commitments.

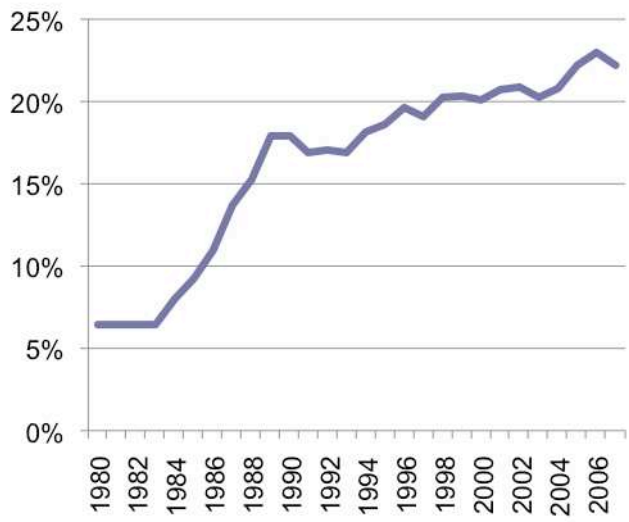


Figure 5

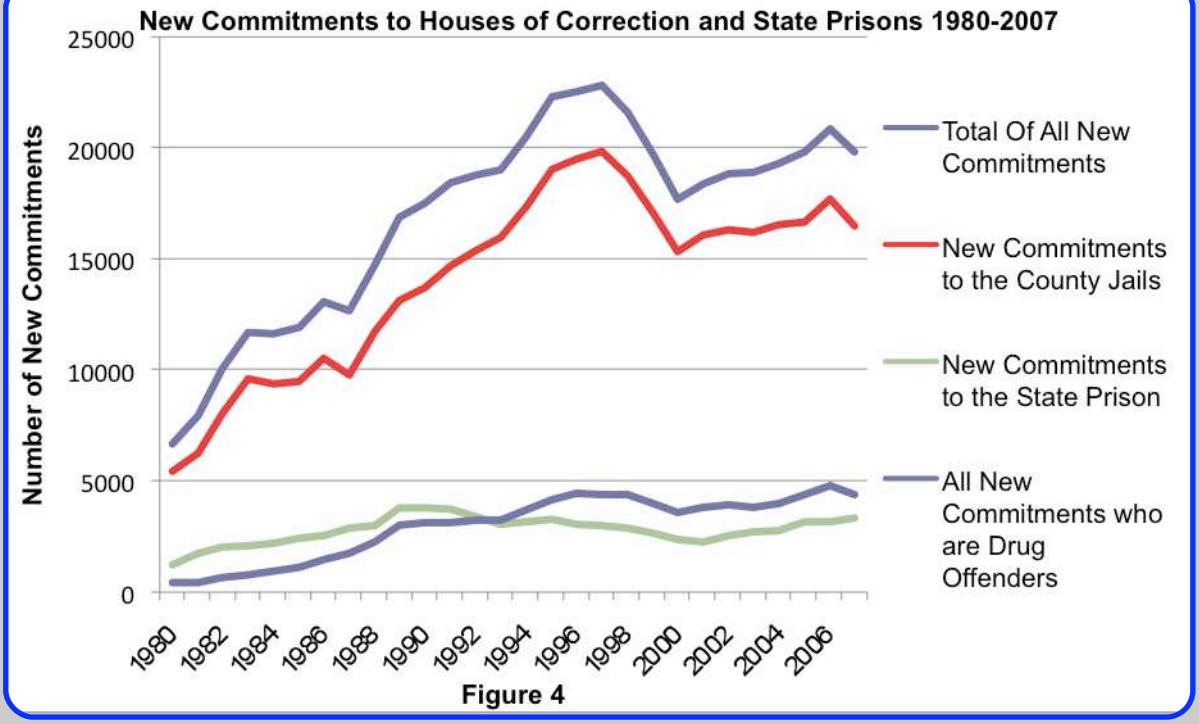


Figure 4

Race and Drug Crimes

Researchers have long noted that minorities are convicted and incarcerated at higher levels than whites, and that these disparities are amplified in the area of drug crimes. The "Survey of Sentencing Practices" reports released by the Massachusetts Sentencing Commission demonstrate the racially discriminatory sentencing impact on defendants convicted of drug crimes in Massachusetts. Racial disparities increase with the severity of the type of drug offense. Racial disparities between the general population and the population of convicted defendants are great for possession offenders but even greater for mandatory minimum drug offenders (all of whom serve state prison or county corrections time).

In 2006 the racial composition of Massachusetts was 80% white, 6.9% black, 7.9% Hispanic, and 5.2% other races (see column to the right in fig. 6). In contrast, the racial composition of those convicted of possession offenses was 56.9% white, 19.7% black, 20.7% Hispanic, 1.9% other races, and 0.8% unknown.

By far, the greatest racial disparities are shown for mandatory minimum offenders. Minorities composed 74.5% of all offenders sentenced for mandatory drug crimes in 2006. (Fig. 6)

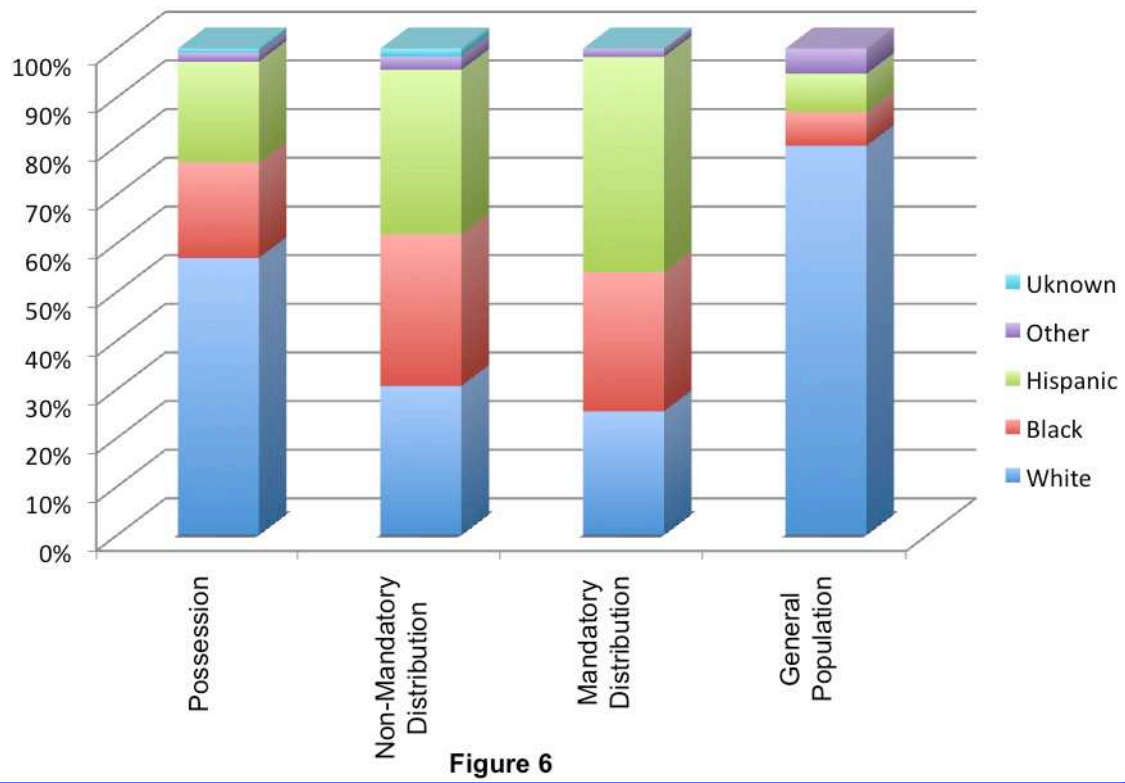


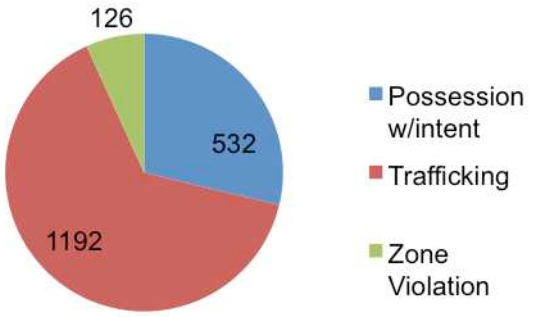
Figure 6

Fiscal Analysis: Early Parole for Mandatory Minimum Offenders

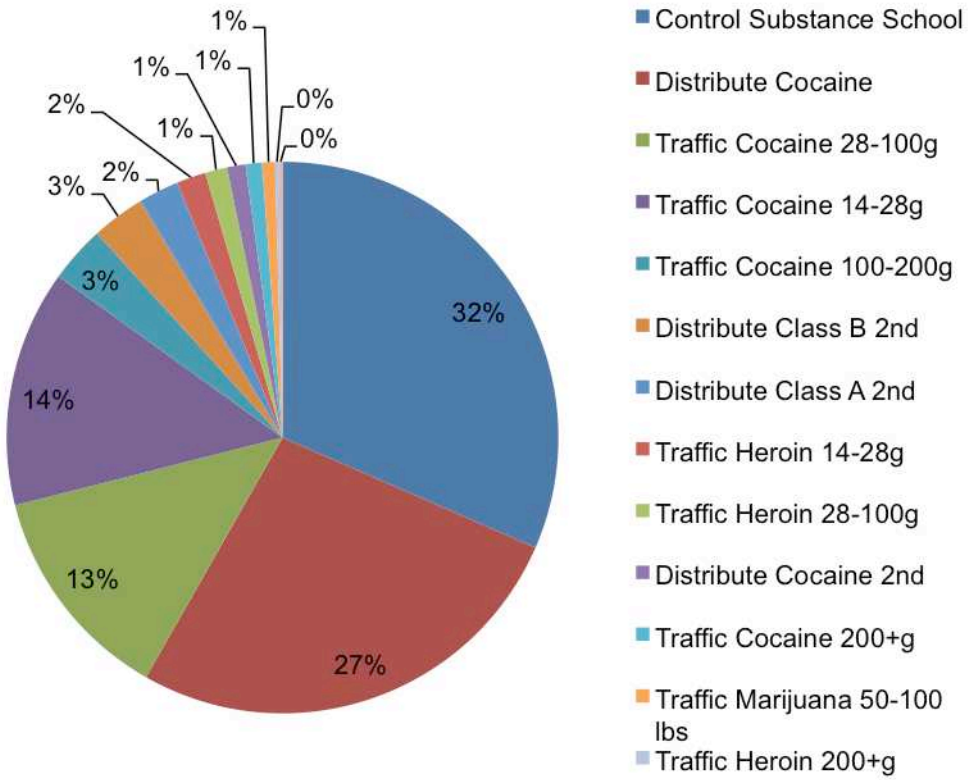
Mandatory minimum sentencing accelerated the increase of drug offenders in the state prisons. On January 1, 1998, there were 1,399 offenders serving mandatory minimum sentences in the state prisons. Ten years later that figure had increased to 1,850. In addition to drug offenders serving mandatory minimum sentences in the state prisons, over 250 school zone offenders are admitted annually to county houses of correction.[7]

Although school zone offenders make up a small portion of the population of the state prisons at any given time (Fig. 7), school zone offenses are by far the largest single contributor to new drug mandatory minimum commitments to prisons and houses of correction. There were 293 school zone convictions as the governing offense in 2006 sentences. These prisoners were 31.5% of all offenders imprisoned with a lead charge of a mandatory drug crime.[8] (Fig. 8, trafficking offenses are determined by the weight of the drug in grams.)

1,850 Mandatory Minimum Drug Offenders in State Prisons Jan 1, 2008 (Fig. 7)



Break-up of 929 Offenders Sentenced with a Lead Charge of a Mandatory Drug Crime in FY 2006 (fig. 8)



One proposed mandatory minimum sentencing reform would allow non-violent mandatory minimum drug offenders to become eligible for parole after serving 2/3 of their state prison sentence (or ½ their sentence for offenders serving time in county HOCs). Savings to the state resulting from a decrease in correctional costs are offset by an increase in parole costs. Such a reform could result in over $17.7 million in annual savings. (Fig. 9)

To determine this figure we used Sentencing Commission data on mandatory minimum offenders and maximum sentences from 1994 – 2006. It is important to note that mandatory minimum reforms should be enacted retroactively to generate significant savings. For instance, an offender sentenced to a 15 year mandatory minimum in 1994 would be eligible for parole after serving 2/3 (or 10 years) of their sentence; therefore savings would not begin to accrue until 2004. Savings (incarceration costs minus parole costs) would then accrue until 2009, at which point the offender would have been released had the individual served his or her full term.

This analysis is based on current parole rates of 61% for eligible offenders serving time in the state prisons, and a 72% for offenders in the HOC.[9] The actual number of individuals eligible for parole may be much higher since these figures are based on all offenders serving their maximum non-mandatory sentence. Were some of these offenders to serve only their minimum non-mandatory sentence, the number of inmates eligible for parole would be higher in any given year.

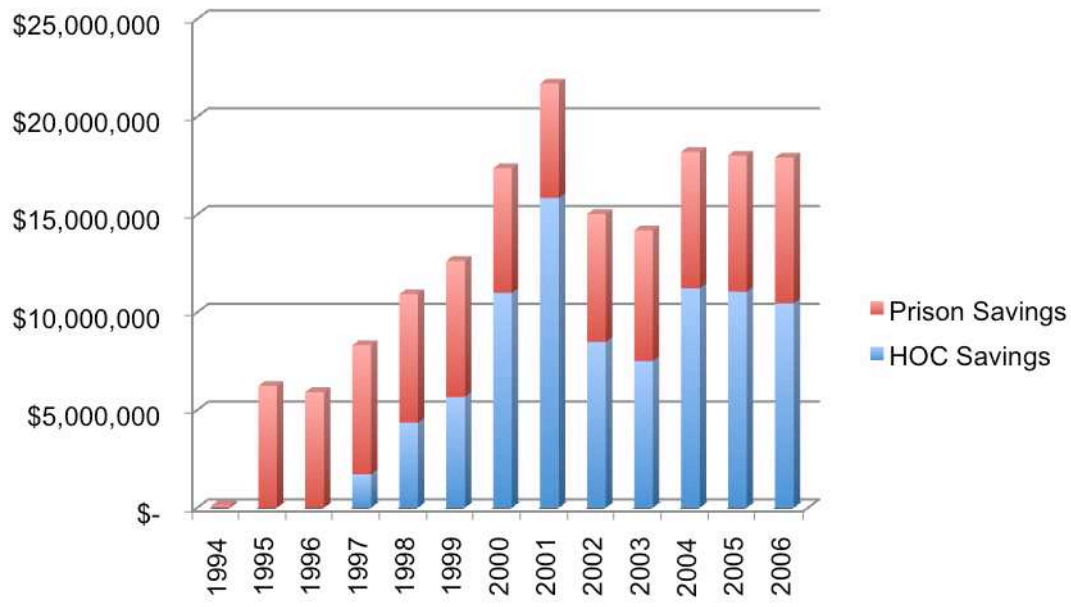


Figure 9

Fiscal Analysis: Diversion to Treatment

Another cost-saving sentencing reform examined by the DPTF is pre-trial diversion to treatment for low-level drug offenders. Diversion enables drug possession offenders to have the option of enrolling in substance abuse treatment rather than risking a prison sentence and criminal record.

Diversion generates savings to the state resulting from decreased correctional costs offset by an increase in probation and treatment costs. For example, an offender sentenced to incarceration in a county correctional facility for 3.6 months in 2006 would cost taxpayers $11,042. Were the same offender sentenced instead to substance abuse treatment and a year of probation, the state would save $3,991. (Fig. 10)

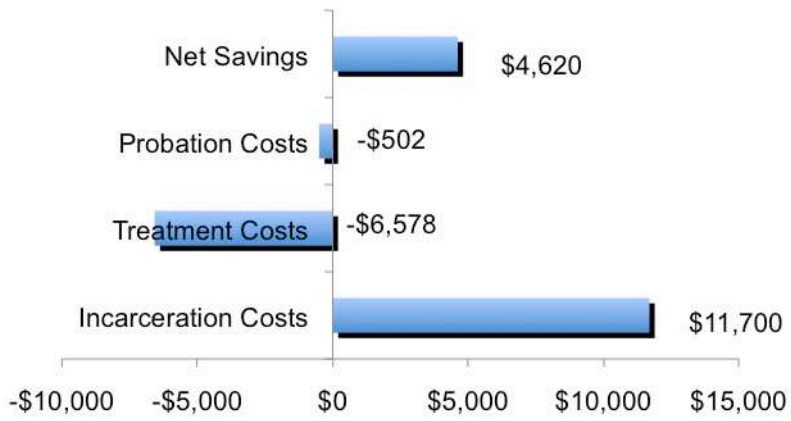


Figure 10

Potential savings from diversion to treatment in Massachusetts are compelling as the Commonwealth is confronting shortfalls across the budget. The potential for savings in 2006 considers the diversion of 1,426 possession offenders with non-violent criminal histories, resulting in avoided HOC costs of $18,109,567. After treatment and probation costs of $10,053,993, the net savings to the state would be about $8,055,574. (Fig. 11) This figure does not include additional savings which could be generated by a reduction in crime, increased tax revenues due to offenders not losing employment, and future correctional savings as drug abusers who receive treatment are less likely to re-offend.

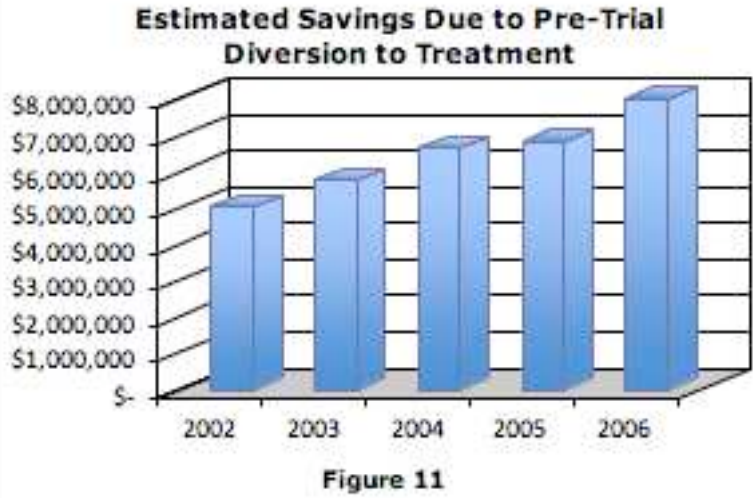


Figure 11

Conclusion

Considering the current fiscal crisis, policy makers in the Commonwealth cannot afford to ignore sensible sentencing reform for drug offenders that would reduce the significant overcrowding of our state prisons and county houses of correction. Mandatory minimum sentencing reform and pre-trial diversion to treatment could result in over $25.7 million in annual savings to the state.

When considering potential savings from sentencing reforms, advocates and researchers often attempt identify corrections savings in relation to the movement of individual offenders, as we have done in this report. Such analyses examine the relative risks and benefits of state spending on alternatives to incarceration. The diversion of one individual offender from a county correctional facility to treatment actually has an imperceptible effect on the corrections budget. Effective reforms must affect a large enough population of convicted defendants to result in a reduction of correctional staff, reduced use of utilities, less spending on health care and pharmaceuticals, the avoidance of new prison construction and lower recidivism rates. A decrease in overcrowding might also allow Sheriffs to transfer prisoners between facilities in order to place them in the most appropriate re-entry, job-training, and rehabilitation programs, contributing to the development of improved and more effective correctional practices, and ultimately decreasing recidivism. For a more detailed discussion of incarceration costs in the State Prisons our Houses of Correction, refer to the methodology section of this report.

New prison construction is unavoidable in Massachusetts without sentencing reform. In the third quarter of 2008, county correctional facilities operated at an average of 161% of their designed capacity (the Essex facility alone was at 264% of its design capacity). State prisons are operating at 144% of their designed capacity.[10]

According to Department of Correction Commissioner Harold W. Clarke, “The message to policy makers is we have very limited resources to continue to incarcerate at the rate we’re doing now.”[11] Massachusetts policy makers need to institute sentencing reform for non-violent drug offenders now, to save prison and jail space for individuals who represent a greater risk to public safety than nonviolent drug users.

We thank Stephanie Geary from the Parole Board, the Massachusetts Department of Corrections, Linda Holt from the Sentencing Commission, Laura Lempicki from the Probation Department, Task Force member Anthony Benedetti from the Committee for Public Counsel Services, interns Sarita Subbaro and Michael Coyne, and all others who contributed to this report.

Methodology

We analyzed data from over 95 reports issued from the Department of Correction (DOC) and the Massachusetts Sentencing Commission.

The data gathered here came from two primary sources: the Department of Correction and the Massachusetts Sentencing Commission. Additional information was gathered from representatives of the Department of Correction, the Probation Department, the Parole Board, and the Suffolk County House of Correction. DOC reports analyzed from 1980 to 2007 include "New Commitments to the Massachusetts Department of Correction" and "New Commitments to Massachusetts County Correctional Facilities".

The DOC reports "January 1 Inmate Statistics" were also analyzed from 1980 to 2008. The Strategic Planning and Research department of the DOC provided additional information on incarceration costs and incarceration rates. Data from the Sentencing Commission's "Survey of Sentencing Practices" reports was analyzed from Fiscal Year 1994 to FY 2006 as well.

January 1 Inmate Statistics

The DOC reports "January 1 Inmate Statistics" present a snapshot of the population of the State Prisons.

The Task Force examined these annual reports since 1980 to understand the long-term trends of incarceration rates for drug crimes. Reports before 1999 included only sentenced inmates in DOC facilities, while the 1999 report and those subsequently released also include DOC inmates serving time in Houses of Correction, other states' correctional facilities, or the Federal Bureau of Prisons.

New Commitments

The DOC reports "New Commitments to MA DOC" are annual statistical descriptions of individuals committed by the courts to the DOC for criminal offenses. The reports do not include DOC prisoners awaiting trial or parole or probation violators that are not being returned on a new sentence. If an individual was committed to a DOC facility more than once in a given year, each court commitment for that individual is counted separately. Given that DOC sentences are all 2.5 years or longer, repeated commitments for an individual in a given year are few.

The DOC reports "New Court Commitments to Massachusetts County Correctional Facilities" are annual statistical descriptions of individuals committed to Massachusetts County Facilities (Houses of Correction). All new court commitments and those individuals who began serving a new sentence during the year are included in the reports. If an individual was committed more than once during a given year, each court commitment was counted separately. Sentences to the Houses of Correction are for 2.5 years or less.

Sentencing Commission

The Massachusetts Sentencing Commission began issuing reports in 1994. Sentencing Commission data includes all criminal cases that were resolved in the Commonwealth's courts in a given fiscal year. These reports are the most detailed information available on sentencing practices across the state, including information about the criminal

histories of offenders, maximum sentences, and minimum sentences. The Sentencing Commission did not issue a report in 2001.

There are some discrepancies between DOC data and Sentencing Commission data, largely attributable to the different reporting periods used by the two agencies; DOC data is reported by calendar year, while the Sentencing Commission reports are made by fiscal year. The "New Commitments to County Correctional Facilities" reports also may undercount certain drug offenders in comparison due to inconsistencies in how the governing charge is determined by various counties.

Mandatory Minimum Sentencing Reform

To determine the individuals who would be eligible for early parole, we used sentencing information from the Sentencing Commission, available from 1994 to 2006. We used 2002 data for 2001, which is unavailable. We examined the sentences of all mandatory minimum drug offenders, including the sentences imposed for underlying charges. The Sentencing Commission lists sentences for both maximum and minimum sentences imposed on an individual. Where an individual is sentenced only for a mandatory minimum drug crime, the maximum and minimum sentences are the same. In cases where as sentence was imposed in addition to the mandatory minimum charge, there may be a difference of several months or even a few years between the minimum and potential maximum sentence. For the purposes of this analysis, we assumed each offender would serve 100% of their non-mandatory maximum sentence and 2/3 of their mandatory minimum sentence before being eligible for parole. For offenders sentenced to incarceration at the HOC, parole would be available after an offender has served their maximum underlying sentence and ½ of the mandatory minimum sentence.

For instance, in 2003 there were 100 offenders convicted of trafficking 14-28 grams of cocaine which carries a 36 month mandatory minimum sentence. The mean maximum sentence for these offenders was 43.6 months, 7.6 months longer than the mandatory minimum alone. If one of these offenders was paroled after serving 2/3 of their mandatory minimum sentence and all of the 7.6 month additional sentence, the complete sentence served would be 31.6 months (a 7.6 month underlying sentence plus 24 months). Savings associated with these offenders would result from the one year not served if they were paroled early. Savings would begin to accrue in late 2005, after the underlying sentence and 2/3 of the mandatory minimum sentence were served, and continue to accrue for one year- the

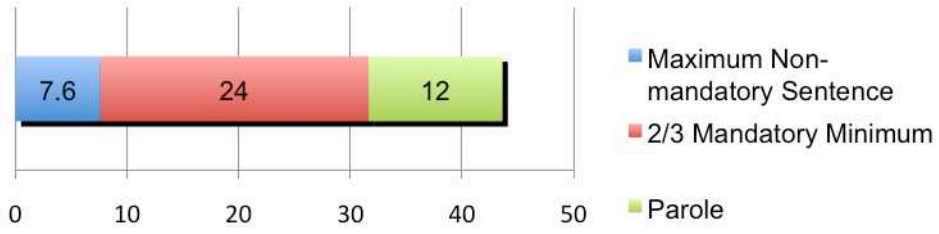


Figure 12

remaining 1/3 if the sentence that is being served on parole rather than in prison. Savings would be offset by parole costs of a year. In the chart below the portion of the sentence marked parole represents the part of the sentence which would be served on parole and therefore generate correctional savings. (Fig. 12)

Not all offenders would be good candidates for parole; current parole rates are about 61% for those incarcerated in the state prisons and about 72% for those incarcerated in the county HOCs.[12]

Costs in this analysis are based on "The Commonwealth of Massachusetts Governor's Commission on Corrections Reform" (chaired by former state Attorney General Scott Harshbarger), which identified the annual cost of imprisonment of one individual in a state facility at $43,000 and annual parole costs at $4,000.[13] Since the Harshbarger Report was published in 2004, we applied inflation rates retroactively to estimate incarceration and parole costs between 1990 and 2004. According to the DOC the current annual costs of incarceration for one individual was $47,679 in 2008. To determine estimated DOC costs for 2005, 2006, and 2007 we adjusted backwards for inflation from 2008. The Parole board cites $5,000 as the current cost of supervising one parolee for a year; we used this figure for 2005-2007. For HOC costs we used the estimated statewide average of $38,000 per individual annually in 2007 and adjusted backwards for inflation. This figure is an estimate of a statewide average for costs of incarceration in the HOCs. Individual facilities may have different figures; it is likely Suffolk County HOC's costs are slightly higher than the statewide average, for instance.

Diversion to Treatment

The first step at calculating potential savings due to diversion to treatment reforms is to identify the population that would be eligible for such a proposal. Successful programs in other states have targeted "first or second time low-level nonviolent offenders". Generally, this category can be interpreted to mean drug offenders charged with possession, as long as they are not involved in a concurrent violent offense, any crime involving a minor, or sale of narcotics. To estimate the savings that could be realized in the Commonwealth through such a program, we looked at Sentencing Commission figures for the incarceration rates of low-level offenders.

To ensure that our estimate is conservative and based on offenders most likely to benefit from treatment and who would not present a threat to the community if they were not incarcerated, we excluded any possession offenders who had a "violent or repetitive record" or a "serious violent record", as defined by the Sentencing Commission. Our final calculations included only new commitments sentenced with a lead charge of simple possession or being in the presence of an illegal narcotic and having a criminal history of A, B, or C (no/minor record, moderate record, or serious record).

Most diversion programs include probation supervision as well as treatment; in our analysis we included a year of probation as an additional cost. Presently a year of probation supervision for one individual costs about $502. All costs and savings were based on the most recent data available, and adjusted backwards for inflation.

Because there is a range of substance abuse treatment in the community, there is also a range of costs associated with treatment. The Substance Abuse and Mental Health Services Administration (SAMHSA) published in 2004 a survey of 2,395 treatment facilities to identify typical costs for residential care, outpatient treatment, and outpatient treatment with methadone. SAMSHA found the available service costs to range from $1,433 for outpatient services to $3,840 for non-hospital residential treatment to $7,415 for outpatient methadone treatment. An average of these costs puts the average treatment episode at $4,229.33.[14]

More recently, researchers at the University of Miami attempted to define an accurate cost of substance abuse treatment specifically for use in policy discussions. The 2008 study identified ten different treatment modalities ranging from $407 per episode for screening and brief intervention to $21,404 for inpatient treatment in a therapeutic community (an average treatment episode of 33 weeks). The average of all relevant modalities (not including irrelevant modalities such as treatment in prison or adolescent residential treatment) examined in this paper is $6577.71 (in 2006 dollars), with the average treatment episode amounting to 27 weeks.[15] In our analysis of the potential benefit of a diversion program in the Commonwealth we used $6577.71 as the potential cost of treatment. The true cost of treatment under such a program would likely be closer to $3,000, however, which is more typical of an outpatient treatment program. Potential state savings were calculated according to the cost of confining an individual to a house of correction, which cost about $100/ day or $38,000 a year in 2007. Adjusted backwards for inflation annual incarceration costs would amount to about $36,807 in 2006.

Savings associated with each offender depend on the length of their sentence. For instance, in 2006 there were 132 new commitments to the HOCs of offenders with a lead charge of possession class B narcotics and a criminal history defined as “no/ minor record”. The average sentence for this group of individuals was 3.6 months. To calculate the savings associated with diverting one such individual to treatment, we took the HOC costs of incarcerating an individual, subtracted treatment and probation costs, and arrived at a figure for potential saving. Two to 3% of convicted drug offenders reported by the Sentencing Commission have no sentence recorded; in these cases we assumed that such offenders were sentenced to the same average time as other offenders with the same lead charge and criminal history.

Given this criteria, we identified 1152 candidates for a diversion program who were incarcerated at the county level in 2002. Using Sentencing Commission data for the average sentence for these individuals, we are able to calculate the total time incarcerated for all individuals as 4452.4 months (just under four months for each offender). If these individuals were diverted to treatment instead of being incarcerated at the HOC, the state could have saved about $5,017,932 in 2002.

Diversion of 1426 offenders in 2006 would amount to $8,055,574 in savings.

Sentencing Reform and Correctional Savings

Mandatory minimum reform and diversion to treatment have been enacted in many States, and have generated significant savings across the country. Determining an accurate picture of the potential savings that can be realized from these reforms presents many challenges to researchers. In the analyses above, we examine savings in terms of the average DOC or HOC costs necessary to incarcerate one offender annually, based on the total budgets of the DOC and the HOCs divided by the number of incarcerated offenders.

As noted in the conclusion of this report, the moving one offender out of prison or a house of correction actually results in little savings, since one offender has little impact on the overall operating costs of the prison or house of correction. Food costs will vary according to the population in the institutions, but such food costs are an almost insignificant part of the corrections budget. Other "variable costs" that can be reduced through the diversion or early parole of an individual offender are pharmaceutical costs, medical care, and transportation, for instance. Many services are provided to prisons and HOCs by third parties which operate on a per diem basis while other contracts are priced at a flat rate.

According to the DOC, the cost of incarcerating a prisoner for a year is about $48,000: $39,000 of this is fixed costs, with the remaining $9,000 being variable costs. If an offender is released for a year or diverted from state prison, the correctional savings of $9,000 is guaranteed. The fixed costs associated with hospital operation, utilities, and staffing, will not change with movement of one offender out of State Prison.[16]

Therefore, in order to generate significant savings, reforms must move enough prisoners out of prisons or HOCs to reduce fixed costs such as staffing and utilities, or to avoid future prison and correctional facility construction. Due to the complexity of with service providers' contracts, the varying nature of prisons and HOCs across the state, and as different policies between Sheriff's departments, it is difficult to pinpoint how many offenders would have to be affected by these sentencing reforms in order to generate significant savings. Nonetheless, data recently collected from the Suffolk County House of Correction offers some insight into this phenomenon.

Research completed by staff at the Suffolk County HOC indicates that the moving 100 drug involved offenders out of the House of Correction could produce significant savings in fees to service providers, utilities, and staffing. According to research assembled by Sheriff Cabral, monthly savings associated by movement of these offenders would be about $12,059 in per diem costs to an independent contractor, $7,200 in pharmacy costs, $14,000 in laboratory and x-rays fees, and $24,500 on use of other medical services. These savings to annual savings of $693,108 in avoided spending on medical service contracts alone for the movement of only 100 offenders.

Avoided prison and HOC construction costs are difficult to predict, as is the impact of decreased incarcerated populations on staffing expenses and other costs. Anecdotal evidence from Suffolk County HOC, however, illustrates that some costs can be flexible. Due to

budget cuts, several prisoner units at the HOC were closed in January and February, resulting avoided staffing and overtime costs of $132,825 in January and $110,550 in February. Estimates indicate that closing only one unit could save about $1,375 in staffing and overtime daily- resulting in savings of $501,875 annually. Diverting only 100 HOC prisoners could allow for the permanent or semi-permanent closure of one or two units, resulting in significant annual savings. Additional savings could be realized in other areas as well, such as a reduction in meals (at $3.97 a day, moving of 100 offenders out of the HOC for a year would result in savings of over $144,000) and reduced transportation costs (Suffolk County HOC transported inmates from the HOC to courts, hospitals and other institutions almost 33,000 times in 2008).[17]

While the DOC indicates that $9,000 in variable costs are guaranteed for each offender moved out of the State Prisons, lessons from Suffolk HOC indicate that sentencing reform does have the potential to also decrease other operating costs.

End Notes

1. "New Commitments to Massachusetts County Correctional Facilities," and "January 1 Population Statistics," Massachusetts Department of Correctin, 1980 and 2008.
2. Commonwealth Budget for FY 2009, Chapter 182 if the acts of 2008.
3. “Survey of Sentencing Practices FY 2006,” Massachusetts Sentencing Commission.
4. Figure 1, from “Jan. 1 Population Statistics”, Massachusetts Department of Correction, 1980 – 2008.
5. Ibid.
6. "New Commitments To Massachusetts County Correctional Facilities” and “Court Commitments to the Massachusetts Department of Correction,” Massachusetts Department of Correction, 1980 – 2007.
7. “January 1, Population Statistics,” Massachusetts Department of Correction, 2008.
8. “Survey of Sentencing Practices FY 2006,” Massachusetts Sentencing Commission.
9. “2007 Annual Statistics Report,” Massachusetts Parole Board.
10. “2008 Third Quarter Report”, Massachusetts Department of Correction.
11. Crimaldi, Laura.
12. “2007 Annual Statistics Report,” Massachusetts Parole Board.
13. Harshbargar, Scott. "The Commonwealth of Massachusetts Governor's Commission on Corrections Reform."
14. SAMHSA, "The DASIS Report."
15. French et al., “The Economic Costs of Substance Abuse Treatment."
16. Conversations with Paul Heroux, DOC, April 2009.
17. Memo from Sheriff Cabral, April 2009.

Works Cited

Crimaldi, Laura. "Chief: 'Angry' Felons to be Freed: Swamped Prisons Seek Work-Release Programs," Boston Herald, October 12, 2008.

French, Michael T., Ioana Popovici, Lauren Tapsell. "The Economic Costs of Substance Abuse Treatment: Updated Estimates and Cost Bands for Program Assessment and Reimbursement," Journal of Substance Abuse Treatment, 2008.

Harshbarger, Scott (Chair), "The Commonwealth of Massachusetts Governor's Commission on Corrections Reform," June 30, 2004.

Massachusetts Department of Correction, "Court Commitments to the Massachusetts Department of Correction, 1980 - 2007," 1980 - 2007.

Massachusetts Department of Correction, "Jan. 1 Population Statisitics, 1980 - 2008," 1980 - 2008.

Massachusetts Department of Correction, "New Commitments to County Correctional Facilities 1980 - 2007," 1980 - 2007.

Massachusetts Parole Board. "2007 Annual Statistical Report."

Massachusetts Sentencing Commission, "Survey of Sentencing Practices FY 1994 - FY 2006," 1999 - 2007.

McLaughlin, Pamela. "2008 Third Quarter Report," Research and Planning Division, Massachusetts Department of Correction. 2008.

Office of Applied Studies. "The DASIS Report: Alcohol and Drug Services Cost Study," Substance Abuse and Mental Health Services Administration. June 18, 2004.