Mayor's Copy

City of Grand Rapids

Mayor's Task Force on Drug Policy Reform

Final Report

March, 1998

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Mayor's Task Force on Drug Policy Reform

Executive Summary

On January 9, 1997, Mayor John Logie called for "a round table of experts in medicine, treatment, law enforcement, and drug policy" to enter into serious debate about drug and alcohol enforcement, treatment and prevention with the objective of evaluating current and future policies for the City of Grand Rapids.

The Mayor's charge to the Task Force was structured around seven key questions. A brief summary of Task Force recommendations follows each.

1. **Should we eliminate mandatory sentencing and restore judicial discretion in the sentencing of drug offenders?**

Task Force Recommendation: Repeal mandatory sentencing; reserve serious penalties for sales to minors or where violence occurs in the drug trade.

2. **Should there be a drug court, modeled after the one established in Dade County, Florida, which could require convicted addicts to go through a treatment program?**

Task Force Recommendation: Establish a drug court; Provide education throughout justice system to ensure identification of Alcohol and Other Drug (AOD) abusers; expand intake testing for alcohol and other drugs; recommend/offer treatment to offenders who test positive for alcohol and others drugs at the time of arrest and during incarceration.

3. **Should there be an increased emphasis on "alternative to incarceration" programs and sentencing relief for nonviolent offenders?**

Task Force Recommendation: Develop a residential treatment program for incarcerated offenders, establish a minimum security facility; ensure that existing residential programs provide sufficient capacity for the necessary support and structure associated with strictly supervised aftercare programs; provide treatment programs for substance addicted inmates; identify offenders who should be directed away from prison into an alternative programs via the drug court system; expand existing educational programs provided to individuals during their incarcerations.

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4. **What changes in criminal justice priorities need to be made to focus on major traffickers and violent crime?**

Task Force Recommendation: Repeal mandatory sentencing; restore judicial discretion to the sentencing process; re-establish the priorities of the criminal justice system to focus on major traffickers; reserve the most serious penalties for sales to minors or where violence occurs in the drug trade; provide sentencing alternatives to non-violent offenders to reintegrate them into society; increase the percentage of minorities on the police force to match the demographics of the community; expand community officers' interaction with residents; increase the taxes on alcohol, beer and wine to finance prevention and treatment programs.

5. **Should our local government be allowed to set up tightly controlled needle programs to slow the transmission of HIV?**

Task Force Recommendation: Implement a Harm Reduction program for needle exchange; establish a fixed site to provide testing and health care services; include a component for mobile outreach to ensure contact in targeted areas.

6. **Should trained health professionals be allowed to give drugs to addicts as part of a treatment and detoxification program?**

Task Force Recommendation: Allow physicians to dispense or prescribe maintenance drugs to addicts; increase recognition for the specialty practice of addictions medicine; transfer aspects of the drug problem from the law enforcement/penal system to the public health system.

7. **What can be done to repair a system that has us on the brink of losing millions of young people to illiteracy, crime, jail and death?**

Task Force Recommendation: Prevention is the single most important intervention. The community must develop a public health approach to the problems associated with high rates of drug abuse and addiction. This must clearly emphasize prevention at the elementary school, high school and adult levels: a comprehensive prevention program must extend across all domains, utilizing widespread community collaboration and partnerships.

The supporting background and complete recommendations are set forth in Summary of Task Force Recommendations.

Mayor's Task Force on Drug Policy Reform

On January 9, 1997, Mayor John Logie offered his State of the City address to the residents of Grand Rapids. Many of his comments focused on the current practice of the criminal justice system in dealing with drug related crime.

He stated that "one definition of insanity is continuing to do the same thing again and again, yet expecting different results. Apply that logic to these questions:

1. Have we won the war on drugs?
2. Are our current strategies winning the war on drugs?
3. Will doing more of the same allow us to win in the future?

Obviously the answer to all three is 'no'."

"Given the failure [of drug policy] to achieve meaningful progress at any other level...there is a role for local government to play.... The time has come for our cities to be laboratories to test changes in drug policies..." The Mayor added that "while illegal drug use must continue to be a crime, drug addiction must be recognized as a disease, and we must begin to develop a "public health" strategy to deal with it".

The Mayor called for "a round table of experts in medicine, treatment, law enforcement, and drug policy, who will begin to develop and recommend programs," and identified the initial list of issues to be considered:

1. Should we eliminate mandatory sentencing and restore judicial discretion in the sentencing of drug offenders?

2. What changes in criminal justice priorities need to be made to focus on major traffickers and violent crime?

3. Should there be a Drug Court, modeled after the one established in Dade County, Florida, which could require convicted addicts to go through a treatment program?

4. Should there be an increased emphasis on "alternative to incarceration" programs and sentencing relief for nonviolent offenders?

5. Should our local government be allowed to set up tightly controlled needle programs to slow the transmission of HIV?

6. Should trained health professionals be allowed to give drugs to addicts as part of a treatment and detoxification program?

Mayor Logie added that something must be done to repair a system that has us on the brink of losing millions of young people to illiteracy, crime, jail and death.

In closing, the Mayor stated "it is time to recognize that we will never be able to prosecute our way out of drug-related crime...for two reasons: 1) the volume of drug related crime far exceeds the prosecuting capacity of the criminal justice system, and 2) prison over-crowding has become pandemic. He added "Grand Rapids is a conservative city...I do not want to change that. In fact, I want to build on that strength. If we can create a basis of support for this kind of change in our community we can become a beacon of light in a nation that is now darkened by trite slogans and failed policies. Together we can make this happen, but it needs serious debate and discussion. Are you willing to try? Will those of you willing and able to contribute please step forward?"

Nearly 100 volunteers responded to the Mayor's challenge to enter into serious debate about drug and alcohol policy reform. This diverse group of individuals formed three teams to debate the best practices of prevention, enforcement and treatment approaches. Team members studied the results of innovative programs across the United States and compared these efforts to programs in Canada and Europe. They heard testimony from individuals who have implemented successful programs in Alabama, California and Florida as well as the drug court in Kalamazoo, Michigan.

The recommendations that follow represent the some of the best practices in the area of drug and alcohol prevention, enforcement and treatment, with the objective of meeting specific needs in Grand Rapids and its surrounding areas.

Summary of the Current Situation

Note: Drug abuse is defined as the inappropriate and/ or illegal use of alcohol, prescription drugs, controlled drugs, and/or "designer drugs."

The United States and its individual state governments have taken an enforcement approach to the "drug problem" since the passage of the Harrison Narcotic Act of 1914 and Prohibition (1920—1933). This approach has not resulted in a reduction in the use of mood-altering drugs, including alcohol, in the United States.

Some of the problems which have resulted from the enforcement approach include 1) the growth of black market trade, which creates an economic counter-culture and removes significant revenues and earnings from the tax base, 2) the violence resulting from the abuse of alcohol as well as the trading of illicit drugs, and 3) the explosive growth of law enforcement personnel and correctional facilities over the past several decades.

In spite of a continued increase in the allocation of public funds and resources to support the enforcement approach, the use of alcohol and drugs by our society has continued to increase, along with the adverse consequences of such abuse. Prevention efforts have been limited in scope and success.

Substance abuse has been identified as the nation's number one health care problem, and greatly increases the cost of medical services. Some of the health consequences that are most costly and dangerous include HIV/AIDS, complications during pregnancy and resulting birth anomalies, accidental injury and death, and violent injury and death.

Studies have shown that as many as 40% of all patients in general hospitals are there because of complications related to alcoholism. Illicit drug users...make more than 370,000 visits to emergency rooms each year, and since both alcohol and drug use may result in serious injury, people using substances disproportionately need care in high-cost trauma centers.[1]

In spite of popular belief, it is <u>not</u> crack, cocaine, heroin or other illegal drugs which appear repeatedly as the common denominators in violent crime, but, in fact, <u>alcohol</u>. Of the violent offenders incarcerated in state prisons, 21% were under the influence of alcohol, and no other drug. Violent offenders under the influence of crack, cocaine, and heroin when they committed a crime account for only 4%. Alcohol is also a common denominator in property crime (17%) and drug law violations (14%) appearing with far greater frequency than other drugs.[2]

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[1] "Substance Abuse: The Nation's Number One Health Problem," Institute for Health Policy, Brandeis University, October 1993, 38.

[2] U.S. Department of Justice, & Federal Bureau of Investigation, 1996. *Crime in the United States, 1995: Uniform Crime Reports*. Lanham, MD: Bernan; Pernanen, K.

Many treatment professionals believe that substance use disorders (addiction and abuse) are medical conditions which have a broad impact on the national health arena, which should, therefore, be viewed as public health issues. However, the current enforcement approach tends to overshadow the prevention and treatment of drug use, abuse and addiction.

It is estimated that as many as 50 to 84% of those incarcerated in the nation's prisons are there because of alcohol or drug related crimes.[3] Prosecution for drug related offenses occupies 50% of the trial time of our judiciary system and takes the time of 400,000 policemen, compounding the cost of substance abuse to the legal system.[4]

Programs aimed at drug interdiction and enforcement cost the United States approximately 30 billion dollars annually.[5] Prison populations have doubled in the past decade, recently reaching 1.4 million.

The cost of the correction programs in Michigan has increased nearly 19 times between 1976 and 1996: from 65 million to 1.27 billion dollars annually. The cost to maintain Michigan's prison system now accounts for more than 15% of the State's annual budget.[6]

In October of 1997, the prison population in Michigan of 42,319 exceeded capacity. This prompted Governor Engler to conclude that Michigan needs five new prisons to accommodate the increasing numbers of people who are incarcerated.

The racial composition of prison populations suggests to some that the enforcement approach has had a profound, and disproportionate, affect on people of color. Some have suggested that over 80% of drug users are white, although minorities comprise 74% of those incarcerated for drug offences. One explanation for this dramatic disparity relates to the purchasing habits of white users, who tend to conduct drug transactions behind closed doors, in business districts, or suburban communities, where law enforcement efforts are less vigilant. Street dealers and many drug users in inner city neighborhoods are easier to locate and apprehend. [7]

Once incarcerated, treatment programs for non-violent addicts in the Michigan prison system are limited or non-existent. Without treatment, many professionals believe that addicts released from prison return to their communities with the same problems that caused them to go to prison in the first place. Few inmates released without treatment change their criminal behavior. Some people theorize that fear of punishment is not a deterrent to drug abuse and resultant crime.

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[3] Buckley, William F, "The War on Drugs is Lost," *National Review,* February 12, 1996. Mayor Richard Giuliani of New York City, October 1, 1997. Richard McKeon, Assistant to the Director of Michigan Department of Corrections, January 24, 1997.
[4] Buckley, William F, "The War on Drugs is Lost," National *Review,* February 12, 1996.
[5] "Decriminalizing Drugs," Editorial, *The Ottawa Citizen,* April 14, 1997
[6] *Prison Legal News*, July 1997, 12.
[7] The Drug Policy Task Force, New York County Lawyers Association, October 1996, Section V.

Substance abuse continues to be viewed by many as a crime, a moral issue or a symptom of an underlying psychological disturbance, as opposed to a physical health problem characterized by addiction to alcohol or other drugs. Many believe addiction treatment has been misunderstood and under-funded.

Substance abuse treatment is viewed by many to be characterized by poor coordination and cooperation with other systems including health care, child welfare, criminal justice, mental health, education and the faith community.

Some professionals in Kent County have concluded that the community suffers from service gaps related to detoxification alternatives, residential treatment options, pharmacotherapeutic interventions and coordinated case management.

The lack of funding for treatment is believed by many to have had a negative impact, in particular, on the indigent, women and children, adolescents and people diagnosed with both drug abuse/addiction coupled with another mental health diagnosis (sometimes referred to as the "dual diagnosed").

A. Prevention

A community effort to improve existing enforcement and treatment systems must, first and foremost, stress prevention. There is consensus among drug task force members that the prevention of drug use, abuse and addiction is the single most important intervention.

Primary prevention is a process which avoids, or at the very least, minimizes, illegal and inappropriate use, abuse and addiction. Successful prevention eliminates the enormous social, economic, legal and personal costs in ways which even enforcement, early diagnosis and treatment cannot begin to approach.

The belief that **prevention is a process, not an event**, represents a critical component of effective prevention programming, and must be recognized and accepted as the foundation for a thorough prevention initiative.[8]

A successful and comprehensive prevention effort must support the development of healthy children and families (and therefore communities), as opposed to implementing a program to eliminate alcohol, tobacco and other drug abuse.

It is important to recognize that high-risk groups and hard-to-reach populations will require greater levels of investment of time and funding. Well-planned programs for each specific population, with multiple, consecutive approaches are required.

Funding is crucial. Institutions and funding sources must prioritize prevention efforts and commit adequate funding to ensure systemic change.

Recommendations

Above all, the community must develop a public health approach to the problems associated with high rates of drug abuse and addiction. The public health model would compliment and/or replace penal-based approaches to drug policy with medical or other alternative policy models that view substance abuse and related problems as primarily a public health issue.

A comprehensive prevention program must address risk and resiliency factors that occur in five domains: the individual, the family, the peer group, the school/workplace, and the community. The most effective efforts are those which extend across all domains, utilizing widespread community collaboration and partnerships.

[8] Kumpher, Ph. D., Carol. "What works in the Prevention of Drug Abuse: Individual, School and Family Approaches" (draft), University of Utah, 1997, 71.

1. Parenting Education

- **Promote education and support to families** (Parents can protect against adolescent risk behavior when they monitor and share activities with their children);
- **Expand programs such as "Families and Schools Together (FAST);"** [9] **and**
- **Encourage businesses to offer educational programs for working parents.**

2. School Education

- **Support and encourage schools in their efforts to foster a sense of "connection" between students and their schools** (Students need to believe they will receive fair treatment, feel "close" to people at school and generally feel they are "part of the school." In addition, studies have shown that smaller classes are better designed to meet children's developmental needs, and contribute to the growth of resilient, productive youth);
- **Support programs which encourage academic success** (Academic success helps to protect against many health risks, including depression, suicidal thoughts and attempts, violence, substance abuse, and earlier age sexual activity);
- **Support the implementation of Kent Intermediate School District's Safe and Drug Free Schools and Communities program and Shared Vision Education Agenda developed in November 1997;**
- **Support the implementation of Kent County Healthy Kent 2000 goals and objectives;**
- **Provide comprehensive and consistent alcohol, tobacco and other drug prevention education, which is complimented by appropriate school policies to students K-12;** [10] **and**
- **Support the implementation of Life Skills Training (or other research theory based curriculum) in middle schools, with booster sessions for 9th and 10th graders throughout the community.**

[9] Families and Schools Together (FAST) is a national program developed by the Family Services Association headquartered in Madison, Wisconsin.
[10] 1997 National Drug Control Strategy for Youth, Goal 1, Objective 4

3. Mentoring Programs

- Support parents and other adult mentors in encouraging young people to engage in positive healthy life styles, and in modeling behaviors to be emulated by youth; [11]

- Support schools in the development and implementation of peer assistance and peer leadership programs; [12]

- Encourage employers to adopt policies that provide opportunities for employees to be mentors. This could be in the form of release time, flex-time, and initiating youth-to-work programs; and

- Encourage adults and older youths to have clear expectations of non-substance use. (Parental disapproval of substance abuse is an important protective factor. [13])

4. Increased Faith Action Involvement

- Provide opportunities for positive youth involvement outside of the church itself (Youth ministers need to go where "at risk" youths congregate.); and

- Evaluate church practices in the context of church policies to ensure the message of acceptance is clearly reflected in actions.

5. Program Coordination

- Support and enhance the ongoing efforts to coordinate and share resources among community, school and neighborhood groups (Build partnerships among young people, parents, police, prosecutors, probation officers, corrections officials, youth and social service personnel, teachers and other school officials, judges, and health professionals. These partnerships will encourage the active exchange of information, monitor at-risk youth and violent offenders, and coordinate resources as part of an ongoing prevention and intervention strategy);

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[11] National Drug Control Strategy for Youth, Goal 1, Objective 5

[12] Two examples of peer assistance and leadership programs are SEALS at Northview High School and STAND at Grandville Middle School.

[13] 1995 PRIDE Study

- **Encourage therapists to consider community programs (for example, Big Brother, Big Sister, 4-H, or church programs) as alternatives to traditional therapies; and**

- **Utilize the inventory of existing and planned programs throughout the community. Disseminate information about existing programs to ensure broad community awareness about available resources.**

6. Media

- **Portray youths as resources rather than as community problems** (Secure media cooperation in reviewing current practice with regard to negative press and increase coverage for positive stories about youths. Encourage the media to evaluate the placement of photographs, reports and headlines in the context of a commitment to the positive portrayal of youths.);

- **Pursue a vigorous advertising and public communications program dealing with the dangers of drug, alcohol and tobacco use by people of all ages;**

- **Create partnerships among the media and professional sports organizations to avoid the glamorization of the use of tobacco, alcohol and illegal drugs; and**

- **Limit billboards that promote alcohol and tobacco products in at-risk neighborhoods.**

7. Other

- **Continue to support and enhance youth employment programs;** [14]

- **Promote the development and use of "Community Asset Maps;"** [15] **and**

- **Enlist community support for school health clinics, tutoring programs, after-school and weekend enrichment programs, youth leadership training, family counseling and crisis intervention.**

[14] An example of such a program is one at the East Hills Neighborhood Association, sponsored by Project Turnaround.

[15] Community Asset Mapping is a process where a community or neighborhood identifies and documents its strengths, for example: churches, civic organizations, health and human service programs, etc.

Specific Prevention Strategies:

- A single coordinating entity should be identified for assisting communities and other organizations in developing innovative and effective substance abuse prevention policies, strategies and programming.

- A board comprised of private and public sector representatives should advise the coordinating entity. The entity should submit an annual report to the city government via the Mayor that describes the status of interagency planning and coordination for substance abuse prevention.

- The coordinating entity should develop an action plan, based on comprehensive community needs, resource assessment and data on individual and community assets. This plan should incorporate the activities of law enforcement, schools, community-based organizations, grass-root efforts, faith communities, service providers, media, and state and local governments.

B. Enforcement

1. Mandatory Sentencing and the Redefinition of Priorities in the Criminal Justice System

Background

The Anti-Drug Abuse Act of 1986 was enacted to reduce the incidence of drug related crime by imposing harsh, mandatory sentences. The criteria for these sentences are based solely on the weight of the drugs in the offender's possession at the time of arrest. No further consideration for the offender's past criminal record, character or circumstances is taken into account.

Mandatory sentencing has filled our prisons with mostly young minority males who were convicted of illegal sales on the street.[16] The legislation that has tied sentencing to the amount or weight of illegal drugs in possession at the time of arrest has, in many instances, resulted in penalties that are far greater than those for serious acts of criminal violence. [17]

The population of the nation's prisons is increasing at a rate of 5% per year, with 1.182 million people incarcerated at the end of 1996.[18] It is estimated today that 70% of those presently held in federal prisons are there for drug-related crimes, often mere possession and personal use. [19] This has occurred at a time when violent crime in the United States has been steadily decreasing. [20] It has been asserted that the government's policies regarding drug use have resulted in a population explosion within our prisons. Others assert the decrease in violent crime is due to the incarceration of potential offenders.

A number of organizations have expressed their opposition to mandatory sentences, including a panel of federal judges which, in September 1997, reported that mandatory sentences should be rescinded and replaced with guidelines that give judges greater discretion. This will encourage sentences that are tailored to specific offenders (e.g., first time offenders versus chronic, repeat offenders). The spokesperson for the panel of judges stated that mandatory sentencing has turned judges into "unwilling executioners" who are prevented from taking into consideration any mitigating circumstances. [21] A 1995 opinion authored by another judge concluded that these sentencing policies put men and women in prison for years, ruining their lives and the lives of their families, at a cost of billions of dollars. [22]

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[16] "Young Black Men in Justice System, *Washington Post,* October 1995.
[17] Nadelmann, Ethan A., "Drug Prohibition in the United States: Costs, Consequences and Alternatives," *245 Science 939*, September, 1989
[18] "Crime in the United States," Federal Bureau of Justice Report, June 23, 1997
[19] Ibid.
[20] *Grand Rapids Press*, October 5, 1997, Page A3.
[21] "Judges Condemn Set-Minimum Sentences," *USA Today*, September 10, 1997, Page 3a.
[22] Senior Circuit Judge Myron Bright Opinion: US v Hively, 61 F.3d 1358, 1363, (8th Circuit 1995).

Some of the other unintended consequences that have resulted from the "war on drugs" are the huge profits that are made in the trade of drugs. Like prohibition in the 1920's, drug policy in the United States has "created more and more skillful and more highly remunerated and more dangerous criminals." Organized crime and urban street gangs feed on the illegal drug trade. Teenagers have found drug dealing to be a better road to prosperity than attending school. The immense profit associated with the distribution of drugs has contributed to corruption within law enforcement, including police officers and US Customs inspectors. [23]

It has been suggested that the present drug policy has contributed to the incidence of violent crime in the United States, by permitting, and even causing, the drug trade to remain such a profitable business.

Recommendations

- Repeal mandatory sentencing;
- Re-establish the priorities of the criminal justice system to focus on major traffickers;
- Reserve serious penalties for sales to minors or where violence occurs in the drug trade;
- Restore judicial discretion to the sentencing process, in order to focus attention on the large traffickers and dealers who commit violent acts;
- Establish a drug court; and
- Provide sentencing alternatives for non-violent offenders and/or "small time" dealers which reintegrate those individuals into society, with conditions, so that they have opportunities to contribute to the community in positive ways.

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[23] Mayor John H. Logie, State of the City Address, January 9, 1997.

2. Drug Court

Background

National statistics suggest that 60--85% of all criminal defendants are either arrested under the influence of alcohol and/or other drugs, or are charged with crimes meant to support their substance abuse. Many are non-violent offenders who cycle through the criminal justice system without access to treatment. [24]

A study conducted by the Institute of Justice Drug Use Forecasting Program found that 65% of males and 57% of females arrested in 1993 were under the influence of drugs at the time of their arrest. Many of these offenders indicated they had not received any drug treatment prior to their arrest. [25] Treatment programs for incarcerated offenders are not available or even offered in many instances. [26]

While a drug court continues to represent processing within the criminal justice system, many have come to view prosecution in this model as supporting a forum for focused attention to the dynamics of criminal offences that result from drug abuse. In such a setting, the offenses may be as broad as Driving Under the Influence (DUI), domestic assault charges while under the influence, or shoplifting to support a drug habit. [27] This represents an opportunity to offer treatment to offenders at the time of sentencing, and existing drug courts report significantly lower rates of recidivism (less than 4%) for individuals completing the full program. This is sharply contrasted compared to results reported in the criminal justice system, where recidivism rates of 45% are indicated for offenders convicted of drug possession. [28]

It is important to note that the drug court model can be implemented in Grand Rapids even without the repeal of mandatory sentencing, thus presenting an immediate opportunity to reengineer this aspect of enforcement.

Advocates of the drug court model believe that treatment is most effective when provided soon after arrest and when an individualized assessment has been conducted to determine the appropriate treatment approach and duration. Programs are designed to provide alternatives to incarceration, allowing substance-abusing offenders to remain in the community. The continuity necessary to support change is provided through the use of judicial authority, coordination of treatment efforts, and regular program monitoring by staff.

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[24] Annual Report on Adult Arrestees, National Institute of Justice Drug Use Forecasting Program, 1993.
[25] Ibid.
[26] Buckley, William F, "The War on Drugs is Lost," page 37, *National Review,* February 12, 1996. Richard McKeon, Assistant to the Director of Michigan Department of Corrections, January 24, 1997.
[27] For a list of the offenses that are handled in the Kalamazoo Drug Court, see Appendix, Tab 4: Drug Court.
[28] Drug Court Experience: Drug Court Clearinghouse and Technical Assistance Project, and Bureau of Justice Statistics, Drugs and Crime Facts, 1994.

The drug court system increases the likelihood for rehabilitation through early intensive treatment, encourages personal accountability on the part of the offender and includes a stringent drug-testing component to monitor compliance. Offenders may be referred to the program as a pre-trial or probation condition, or as a requirement of a "diversion program." Elements of the diversion program may include substance abuse counseling, employment and/or school attendance, community service and a plan for restitution to victims. Weekly urinalysis testing ensures adherence to the diversion program. The judge determines an individual's specific program with advice from the program staff and the prosecutor. Successful completion of the program may result in discharge from probation, or dismissal of a probation violation or pending charges.

Recommendations

- Establish a drug court for Kent County and the City of Grand Rapids (The estimated cost of a drug court for the City of Grand Rapids is $210,623: see Appendix, Tab 4 for detail.);
- Expand the program for drug detection within the justice system;
- Designate the Community Corrections Advisory Board as the advisory entity for fiscal and administrative coordination of the drug court system;
- Seek funding through grant application(s), a tax increase, and matching funds from the City of Grand Rapids and Kent County;
- Provide additional judicial resources, professional staff and facilities necessary to operate the drug court system;
- Observe, and communicate with, existing Drug Courts (e.g, Kalamazoo, Michigan, Ocala, Florida, etc.);
- Implement recommendations of the Community Platform for the Reform of Juvenile Services in Kent County; and
- Develop a list of offenses that will be referred to the drug court.

3. Drug Detection Within the Justice System

Background

An individual's first contact with the justice system, usually precipitated by arrest, can and should be used as an opportunity to identify abusers of Alcohol and Other Drugs (AOD).

It is believed that there is increased receptivity to treatment during the pretrial phase. Without identification and intervention at this critical juncture, many alcohol and other drug offenders will rejoin the general population and continue to deny the nature of their problems, remain unaware of existing treatment resources, and avoid treatment.

The screening process used to identify AOD abusers may be used at any or multiple points of contact as an individual moves through the justice system. A procedure for AOD screening is in place today in the 61st District Court. This provides a record for future reference in the event that an individual does not go on to criminal prosecution.

Recommendations

- Provide on-going education of personnel within the justice system to ensure the earliest possible identification of AOD abusers;
- Enhance intake screening at Kent County Correctional Facility to include alcohol and other drugs;
- Recommend/offer treatment, with incentives, to those offenders who test positive for alcohol and others drugs at the time of arrest; and
- Recommend/offer treatment during incarceration in city, county and state correctional facilities to offenders who have substance abuse problems.

4. Treatment During Incarceration

Background

Two programs developed by the National Institute on Drug Abuse (NIDA) have demonstrated impressive success rates of 90% for inmates completing all three phases of treatment. [29]

The first phase of the program is initiated 18 months prior to release from prison, and focuses on meeting the behavioral expectations of the program: following instructions, assuming responsibility for actions, and cooperating with authority. Once the inmates begin to behave differently, they think differently and more positively. Then the staff addresses the thoughts and feelings which may have led to criminal behavior in the first place.

The second phase of the program involves residential work release in a therapeutic community over a 6-month period, helping inmates move through the difficult process of release from prison to working full time, making adjustments to living in freedom and taking responsibility for their lives and welfare. Participants have therapy sessions, workshops and employment counseling.

Upon graduation from the residential program, the individuals enter a 6-month program to fulfill probation and/or parole stipulations after their period of work release. They have counseling, undergo urine test monitoring and are encouraged to attend 12 step programs, while continuing to work at the jobs they started in work release.

The success rate is higher than 90% for inmates going through all three phases. Recovery is less effective for those who do not receive continued treatment in all three phases. [30]

The Canadian system has only one fifth as many inmates per capita as the American system. Canada's success relates largely to the fact that they begin, upon incarceration, to provide the support inmates need to become productive citizens when they leave. Additionally, they have integrated their social agencies to reduce redundancy in programming which has improved coordination of community resources and resulted in the more efficient use of available funds. As a result, recidivism rates and the overall prison population are significantly lower than in the United States. [31]

A controlled study to evaluate the effectiveness of various treatment modalities for drug abusing workers concluded that hospital treatment with aftercare is the most effective form of treatment, with the lowest rate of recidivism. This approach in particular lends

[29] "Drug Treatment in Prisons: A New Way Out," pages 2 & 3.
[30] Ibid.
[31] Donald Andrews and Paul Gendraou, American Corrections Association Congress, 1997.

itself to application in the prison system: longer treatment programs during incarceration followed with close supervision by parole officers facilitate a drop in recidivism. [32]

Increasingly, experts believe that drug addiction can be treated effectively. Dr. Alan Leshner, Director of the National Institute of Drug Abuse (NIDA) writes: "Advances in science over the past ten years have revolutionized our understanding about drug abuse and addiction ... drug addiction is a treatable disease and...is a preventable behavior." [33]

Recommendations

- Recommend Kent County as a location for one of the state facilities expected to be built in the State of Michigan. Implement a model program at this site which includes the following three phases of treatment: an 18 month program preceding release which focuses on expectations of behavioral change and addresses the feelings and thoughts which led to criminal behavior; a residential work release in a therapeutic community; and a 6 month aftercare program which provides counseling, urine testing, and participation in a 12 step program;

- Establish a minimum level security option other than jail;

- Ensure that existing residential programs in the community provide the necessary support and structure associated with strictly supervised aftercare programs;

- Employ standardized screening tools to identify inmates with the greatest opportunity to succeed and to minimize participation of inmates with a personality disorder (anti-social) who will not benefit from treatment and rehabilitation;

- Require the Michigan Department of Corrections to utilize treatment programs for non-violent substance addicted inmates;

- Continue to support coordination among social service agencies in Kent County to ensure the most efficient use of funds; and

- Develop local assessment criteria in order to identify offenders who should be directed away from prison into an alternative programs via processing in the Drug Court System.

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[32] Walsh, et al, "Treatment Options for Alcohol Abusing Workers," *New England Journal of Medicine*, September 12, 1991.
[33] Leshner, MD, Alan. "Understanding Drug Abuse and Addiction," *National Institute on Drug Abuse*.

5. Earning and Learning Skills During Incarceration

Background

The results of existing educational programs provided to individuals during their incarceration suggest that the cycle of substance abuse and recidivism can be broken. Generally, the goals of these programs involve: 1) building self esteem through education and use of role models, 2) providing vocational training so that those incarcerated will develop skills and have earning power once they are released, and 3) providing programs that will allow prisoners to earn money using their vocational skills while incarcerated.

A number of programs provide education for inmates today, including GED and adult education programs and work release programs.

Although it is difficult to quantify measurable results from these programs, the task force has a clear perception that educational/vocational training has an effective and positive benefit.

Recommendations

- Expand existing educational programs provided to individuals during their incarceration;
- Establish a "central clearing house" for Kent County to maintain an inventory of existing programs and serve as a referral source for motivated inmates; and
- Seek additional public/private funding to enhance the capability of existing programs through the school systems and other programs. (This will require a broad effort to increase awareness of the substance abuse problem and its cost to the community.)

6. Evenhanded Enforcement

Background

Drug arrests in Grand Rapids have increased by 48% from 1993 to 1997. Arrests in the Grand Rapids Police Department "Charlie Sector" (the area bounded by Hall Street SE and Fulton Street NE) are two to five times higher than in other sectors of the city. [34] The inner city of Grand Rapids is home to 94% of Kent County's poor blacks, along with 85% of poor Hispanics and 51% of poor whites. [35] Nationally, unemployment among blacks is 9.3% and 7.8% among Hispanics. This compares to an unemployment rate among whites of 4.6%. [36]

Research suggests that unemployment or underemployment often drives illegal activity. Some community leaders believe that drug sales represent a family's attempt to supplement their living expenses. In any event, unemployment, poor money management skills and general economic depravation appear to cause inner Grand Rapids to be an at-risk community.

It is generally accepted that overt drug transactions occur regularly in lower socioeconomic areas. Such blatant disregard for the law prompts law-abiding citizens to demand more police action. As a result, there are many more "stops" (i.e., lawful searches of citizens) in the Charlie Sector of Grand Rapids than in other sectors. Some of these searches produce drugs and large sums of cash resulting in arrests. The violent crime and general atmosphere associated with drug abuse and its distribution require a significant investment of enforcement efforts in these neighborhoods. At the same time, many residents view this added police presence as oppressive.

Recommendations

- Increase the percentage of minorities on the police force to more closely match the demographics of the community;
- Expand community officers' interaction with residents via block club and community association membership and participation;
- Encourage officers to live in the communities they patrol;
- Implement mentoring, trade and training programs for at risk youth and young families; and
- Evaluate and address the perceived disproportionate number of liquor stores in the Charlie Sector; discourage "urban flight" (the phenomenon where residents who increase their earning power leave for suburban neighborhoods); and enforce the laws which prohibit the practice of red lining (i.e. lending policies which exclude mortgages for designated geographic areas in a community).

[34] Monthly Management Report, Grand Rapids Police Department, December 1997.
[35] 1990 Census of Population, US Bureau of the Census.
[36] US Bureau of Labor Statistics, January 1998.

C. Treatment

1. Financing and Supporting Resources for Treatment

Background

Treatment services for substance abuse and addiction are under-funded in two key respects: a lack of public dollars designated for treatment and the exclusion of many treatment and rehabilitative services from private health care insurance. The current practice of enforcement, which results in incarceration of substance abusers, adds significant expense without the benefit of treatment or rehabilitation.

Federal alcohol taxes brought in approximately $5.7 billion in government revenue in 1989. State and local alcohol taxes brought in more than $7 billion in 1987. These taxes, however, have not kept up with the use rates, in terms of consumption, nor have they matched the pace of inflation. "If the federal tax on liquor had been adjusted for inflation from 1951 on, a bottle of scotch today would cost an additional $5.50." [37]

The "Liquor Tax" which was implemented in Michigan several years ago, adds 1.85% to the cost of liquor, and may be used at local county discretion for prevention and treatment services. (The tax applies only to distilled spirits and does not apply to beer or wine.) This excise tax is expected to yield approximately $754,195 in funds for Kent County in 1997. Currently 50% of these funds are allocated to substance abuse prevention and treatment: they are distributed to treatment programs through an application process which is approved by the Substance Abuse Advisory Council, which reports to Kent County Department of Public Health.

It has been suggested that an increase in federal, state and local taxes on alcoholic beverages will reduce consumption, particularly among adolescents. An effort to increase the tax on beer several years ago had community support from public health officials, although the lobbying efforts of beer distributors appear to have prevented this increase from being approved.

The limitations and/or exclusion of mental health and substance abuse treatment coverage in insured health care benefits have impacted access to treatment by employees. This has contributed significantly to the downsizing or even closure of a number of substance abuse treatment programs in recent years. Some believe that this phenomenon has contributed to the further fragmentation of substance abuse treatment.

Area professionals and the Kent County Health Department have indicated that there are significant gaps in treatment and the continuum of care. For example, The

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[37] "Substance Abuse: The Nation's Number One Health Problem," *Institute for Health Policy*, Brandeis University, October 1993, page 56.

American Medical Association has identified five levels of detoxification treatment, however only
two levels of detoxification treatment are available in Kent County at this time. Additional gaps exist in the form of residential treatment options and overall case management. Insufficient funding has resulted in waiting lists for the indigent. Other under-served populations include women and children, adolescents, and people diagnosed with both drug abuse/addiction coupled with another mental health diagnosis (sometimes referred to as the "dual diagnosed").

Finally, our courts, prisons and jails are overwhelmed and overcrowded as a result, in part, of the number of offenders with drug convictions, or addicts who have been charged with crimes to support their addiction. It is estimated that fewer than 20% of prisoners who admit to substance abuse are receiving treatment. William F. Buckley, Jr. states that treatment is seven times more cost effective than incarceration. In other words, one dollar spent on the treatment of an addict reduces the probability of continued addiction seven times more than one dollar spent on incarceration. [38] The Rand Corporation cites similar figures, indicating that a 1% reduction in annual drug consumption over the next 15 years would require spending $783 million of source-country control, $366 million for interdiction, $246 million for domestic enforcement, or $34 million for treatment. [39]

Recommendations

- Allocate all of the funds generated from the liquor tax to support and enhance prevention and treatment programs;

- Increase the tax on alcohol, beer and wine and allocate these funds to finance treatment services;

- Support efforts to establish parity for substance abuse treatment with other disease coverage. The City of Grand Rapids and other public employers, should increase the benefits to its employees for substance abuse treatment, and encourage other employers to take similar action. Develop and disseminate information about the cost benefits of treatment for dependent or addicted employees;

- Re-direct money designated for criminal justice and interdiction to enhance financing for community-based treatment; and

- Divert money obtained from drug forfeiture to treatment and prevention. (State law currently allocates these funds to enforcement.)

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[38] Buckley, William F., "The War on Drugs is Lost," *National Review*, February 12, 1996, 37.
[39] "Fixing a Failing System," Join Together, February 1996, 10-11.

2. Harm Reduction

Background

Harm reduction theory accepts the existence of harmful behaviors with the primary goal of reducing their negative effects. The basic concept of harm reduction involves moving an individual slowly down the continuum of risk (also referred to as disease management). It also examines individual attitudes to offer ways to decrease the negative consequences of high-risk behavior. Behavioral scientists have documented how harm reduction theory has been successful in impacting public health issues such as smoking, drunk driving, and wearing seat belts.

In the area of drug use and abuse, harm reduction is achieved by addressing and decreasing various kinds of drug related harm in practical ways that appeal to and are chosen by each individual drug user. These may include abstinence, control of one's drug use, addiction treatment on demand, access to quality medical care, and empowerment to improve daily living through housing opportunities, employment, job training, child care, mental health and/or family counseling.

An approach to the drug problem that is aimed at harm reduction would decrease our current dependence on law enforcement and correctional institutions and decrease the amount of black market trade and violence which characterize the illegal drug business. Great Britain, Scotland, Germany and Switzerland have achieved significant reductions in both crime and HIV infection rates as a result of their Harm Reduction programs.

a. Harm Reduction: Needle Exchange

Infections that may result from IV drug use include Hepatitis B, Hepatitis C, cytomegalovirrus, Epstein-Barr virus, T-cell leukemia, Septicemia, Endocarditis and Malaria. The most widely recognized infection that may result from injection techniques and needle sharing is HIV, the virus that causes AIDS. [40]

The AIDS epidemic has dramatically impacted the public health system. Of the documented AIDS cases in Kent County today, one in four is the result, either directly or indirectly, of injection drug use with contaminated needles. As of January 1997 the cumulative number of cases of HIV/AIDS in Kent County was 563; 139 were the result of injection drug use. [41]

The accepted average cost for lifetime treatment of AIDS is $120,000; cases in Kent County which are the result of needle contamination represent, potentially, an estimated $16.7 million in health care services. [42]

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[40] Community Health Outreach Workers and The Harm Reduction Coalition Report: October 1996.
[41] 1997 Michigan AIDS Report, Michigan Department of Community Health.
[42] Community Health Outreach Workers and The Harm Reduction Coalition Report: October 1996.

While it is acknowledged that it is possible to purchase needles at a relatively low cost and without violation of any laws in Michigan, significant transmission of disease continues in our community through sharing of needles.

In an effort to augment public health system efforts, community-based organizations have mobilized to respond to the complex needs associated with the AIDS epidemic, providing treatment and prevention programs. Six major studies at the federal level have demonstrated the value of needle exchange programs in preventing the spread of the HIV/AIDS epidemic. None of these trials resulted in an increase in drug use. [43]

There are 125 harm reduction programs operating in 29 cities in the United States, including Michigan. They are financed by private and non-federal funds. The programs
have been successful in reducing the rate of disease transmission and have also served as a bridge to treatment for some individuals. [44]

Recommendations

- Implement a comprehensive harm reduction program which includes needle exchange, similar to the program established by the Chicago Recovery Alliance. (The Chicago Recovery Alliance program is one of the most effective in the United States and has a long established record of success.);

- Seek initial funding from foundations and private donations. Appeal for public funds after the harm reduction program has demonstrated effective outcomes;

- Establish a fixed site for comprehensive harm reduction which includes (in addition to current testing sites) testing and/or health care services. Include a component for mobile outreach to ensure contact in targeted areas; and

- Enlist support from other community-based organizations to provide health care, treatment and other ancillary services.

[43] Community Health Outreach Workers and The Harm Reduction Coalition Report: October 1996.
[44] Ibid.

b. Harm Reduction: Medically Supervised Treatment of Drug Addictions

Background

The principle goal of substance abuse treatment for addicts is clearly total abstinence, however it must be recognized that this approach is not effective with all addicts. Medically supervised treatment of drug addictions represents a component of harm reduction and can be viewed as an alternative for those who are unable, at this point in time, to become drug free through abstinence.

The goal of harm reduction was the rationale behind the decision to institute a methadone maintenance program. By allowing heroin addicts to get a similar drug, prescribed as a medication by physicians, they would no longer need to prey on other people to get the money they needed to purchase their drug. In effect, the Government became their drug supplier. Many people now believe that methadone maintenance is as valid as the abstinence-based treatment methods.

There are no similar programs available for people who are addicted to other illegal substances, such as cocaine and marijuana. A program for cocaine addicts, for example, might use a longer acting medication, such as methamphetamine, dispensed in carefully controlled dosages.

Changing the social perceptions of "illegal" drugs, addiction and addicts would represent a dramatic reversal of the viewpoint that has prevailed for most of this century. Such a change requires the adoption of a medical and disease-based model for treatment. A public health strategy to deal with the drug problem will help to foster public compassion and understanding for members of our society who suffer from addiction. It can reduce drug related crime in two ways: first, by removing most of the illegal profits which keep traffickers in business, second, by reducing much of the crime that addicts commit to get money for drugs. Instead of buying drugs on the black market, addicts would be able to receive treatment that is monitored. [45]

Recommendations

- Allow physicians, with proper training, to dispense or prescribe maintenance drugs to addicts;

- Change the education of physicians and other health professionals to increase understanding about addiction and recovery, and the proper prescribing practices under various circumstances, depending on the patient's particular habit or dependence. This would include increased recognition for the specialty practice of addictions medicine;

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[45] Mayor John Logie: State of the City Address, January 9, 1997

- Change applicable Michigan law to allow medically supervised treatment by licensed physicians; and

- Revise and expand the laws that cover methadone maintenance programs. (The present method used to calculate income and methadone supply offers no incentive for the facilities and their professionals to encourage a reduction in use or complete withdrawal, in effect maintaining the patients' present levels of addiction.)

3. Drug Addiction Treatment: Outcome Evaluation

Background

There are often two phases in the treatment of drug addiction.

The first phase is the medical management of the symptoms of acute toxicity and withdrawal from a drug habituation. Treatment regimens for both acute intoxication and for withdrawal of addiction have been established based on accepted knowledge of brain biochemistry and on controlled clinical trials that have been repeated in several academic centers.[46] Such treatment fulfills the criteria established by private health care insurers and is generally reimbursed as medically necessary care.

The second phase is rehabilitation: an attempt to change behavior after withdrawal, usually in a residential, partial day, or ambulatory care setting. Most rehabilitation programs use multiple psychological methods to try to keep former addicts from returning to the use of illegal substances. These programs take place in residential units or on an ambulatory basis while the client lives at home.

Funding for drug rehabilitation in recent years has been negatively impacted by a reduction in public funds. Payment for drug rehabilitation services has also been reduced by the private insurance market and by the growth of managed care products like Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).

Recommendations

- Design and implement a study to prove further the effectiveness of drug rehabilitation, comparing the results in multiple settings (e.g., residential, out patient, and pharmaceutical management in a conventional medical office setting). Apply a similar approach to treatment programs in prisons: allow data collection and comparisons with a properly designed control group so that the effectiveness is obvious;

- Secure funding for this study from drug companies interested in studying the effectiveness of drugs such as bupropion, an antidepressant and anti-obsessive compulsive disorder drug. (By using funds from a drug company, there would be little, if any, need for additional public funding of this study.); and

- Solicit the involvement of local experts in the area of withdrawal from tobacco, to oversee a controlled study on withdrawal from substance addiction and resulting rehabilitation methods.

[46] Alan Leshner, MD, Talk at the National Institutes of Health.

Conclusion

There is no "silver bullet" or a simple solution which can deal with the current widespread problems of substance abuse. This is unfortunate in view of the enormous personal, medical, social, economic, and legal costs associated with substance abuse. Alcohol remains the drug of choice of today's substance abusers and its abuse and addiction still constitute, in the view of many, the area's largest substance abuse problem.

This Task Force believes that the prevention of substance abuse is the most effective and efficient approach to deal with the problems. Successful prevention eliminates or reduces significantly, the staggering costs of substance abuse enforcement and treatment. Primary prevention must be an on-going process. It begins with the establishment and maintenance of intact, two parent families and continues with the inculcation of solid personal values by parents in their pre-school children. Education adds strong values and preventive efforts throughout the school years, which must then be augmented by media, faith-based community, work place and peer group support of adults, including the elderly, to preclude substance abuse throughout life.

When prevention has failed and substance abuse is recognized in a given individual, a customized balance between enforcement efforts and medical and behavioral treatment is required. These two approaches are not mutually exclusive; rather they are complimentary and must be appropriately balanced for each person. At one end of the enforcement/treatment continuum lies the international drug cartel leader (who does not himself abuse the drugs he sells) for whom an exclusively enforcement approach is most appropriate. At the other end of the continuum lies the individual with a severe drug addiction, who has not yet entered the enforcement/legal system, for whom an exclusively medical intervention with detoxification and rehabilitation is required.

Cooperation and coordination among the various agencies and organizations, both public and private, is required to develop comprehensive effective and efficient prevention, enforcement and treatment. There is a general recognition of the need for a single entity to help coordinate prevention, enforcement and treatment efforts related to substance abuse in the Grand Rapids/Kent County area. Financial and personnel resources are far too limited to waste on unnecessarily duplicative and inefficient efforts.

This Task Force brought together a broad membership with diverse expertise, talents, perspectives, and vested interests. Many of these recommendations may be implemented in short order by organizations within Grand Rapids, its suburbs, and Kent County. Others require significant policy and legislative changes at the state and/or national levels.

The City of Grand Rapids has already assumed a leadership role by the Mayor's posing of the difficult questions associated with Drug policy reform. We now have the opportunity to emerge as a community engaged in active new programs to implement and test changes through the initiatives and recommendations described in this report.

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