Department of Legislative Services

Maryland General Assembly
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Revised
FISCAL AND POLICY NOTE

House Bill 797 (Delegate Patterson *et al.*)
Judiciary

Nonviolent Drug Offenders - Drug Treatment Alternative to Incarceration

This bill requires the commitment of certain drug dependent offenders to treatment services rather than incarceration.

Fiscal Summary

State Effect: This bill would significantly reduce State correctional costs and increase drug and alcohol abuse treatment services costs. Annual general fund correctional costs could decrease by $1.0 million to $2.4 million in a first year of operation and by $1.7 million to $3.8 million per year thereafter. State general fund expenditures for treatment services could increase by $8.3 million to $19.7 million annually.

Local Effect: Potential significant correctional cost savings for local detention facilities.

Small Business Effect: Meaningful. In FY 2002, all residential drug and alcohol treatment service providers in the State had admissions of 1,138 patients. With State spending on certain treatment services expanding by between $8.3 million to $19.7 million, this bill would significantly impact the residential treatment provider industry to the extent that existing businesses would tend to expand and new businesses would likely open.

Analysis

Bill Summary: This bill requires a court to require each defendant found guilty of a first or second violation of certain controlled dangerous substances offenses to undergo an

evaluation of eligibility for drug treatment by an alcohol or drug counselor. Unless the court states in writing that it is contrary to the interest of justice to do so, the court must commit a defendant to the Department of Health and Mental Hygiene (DHMH) for drug treatment as a condition of probation before or after judgment instead of incarceration if: (1) the defendant is found guilty (as a first or second offense) of certain primary controlled dangerous substances offenses, or of a crime resulting from drug abuse or addiction, as determined by the court; (2) the offense or offenses for which the defendant is charged do not involve violence or the threat of violence; (3) the defendant was not convicted of a "crime of violence" within the previous five years; and (4) a drug and alcohol counselor determines the defendant to be eligible for drug treatment.

The bill alters current provisions authorizing a court to commit a defendant with an alcohol or drug dependency to DHMH for voluntary inpatient, residential, or outpatient treatment as a condition release by providing that the dependency be determined by a drug and alcohol counselor and specifying that the treatment be an appropriate treatment program as recommended by the counselor, rather than specifically to inpatient, residential, or outpatient.

A probation imposed under these provisions may not be revoked for a drug-related violation except upon: (1) the courts consultation with the defendant's drug treatment counselor; and (2) a recommendation by the treatment counselor that no modification to the conditions of probation is likely to promote the defendant's successful completion of the treatment program.

The bill provides for a criminal conviction to be vacated and the expungement of official records when a defendant committed to treatment under these provisions successfully completes the treatment program.

The State Commission on Criminal Sentencing Policy must adopt, and revise as necessary, sentencing guidelines to ensure the drug treatment program established by these provisions is implemented in accordance with these provisions.

Current Law: Before or during a criminal trial or prior to sentencing, a court may order DHMH to evaluate a defendant to determine whether, by reason of drug or alcohol abuse, the defendant is in need of and may benefit from treatment if it appears to the court that the defendant has an alcohol or drug abuse problem or the defendant alleges an alcohol or drug dependency. The court must set and may change the conditions under which the examination is to be conducted.

Except in a capital case, on consideration of the nature of the charge, the court: (1) may require or permit an examination to be conducted on an outpatient basis; and (2) if an outpatient examination is authorized, must set bail for the defendant or authorize the

release of the defendant on personal recognizance. If a defendant is to be held in custody for examination: (1) the defendant may be confined in a detention facility until DHMH is able to conduct the examination; or (2) the court may order confinement of the defendant in a medical wing or other isolated and secure unit of a detention facility, if the court finds it appropriate for the health or safety of the defendant.

If the court finds that, because of the apparent severity of the alcohol or drug dependency or other medical or psychiatric complications, a defendant in custody would be endangered by confinement in a jail, the court may order DHMH to either place the defendant, pending examination, in an appropriate health care facility or have local health department staff, or other qualified, appropriate personnel immediately conduct an evaluation of the defendant.

Unless DHMH retains a defendant, the defendant must be promptly returned to the court after an examination. A defendant who is detained for an examination may question at any time the legality of the detention by a petition for a writ of habeas corpus.

Procedures governing an evaluation of a defendant are specified. Before a court commits a defendant to DHMH for evaluation, the court must consult with Alcohol and Drug Abuse Administration (ADAA). DHMH must provide the required evaluation services. DHMH has the obligation to engage in reasonable efforts to facilitate the admission of a defendant to an appropriate evaluation facility.

If a court finds in a criminal case that a defendant has an alcohol or drug dependency, the court may commit the defendant as a condition of release, after conviction, or at any other time the defendant voluntarily agrees to treatment to DHMH for inpatient, residential, or outpatient treatment. Before a court may commit a defendant to DHMH, the court must: (1) offer the defendant the opportunity to receive treatment; (2) obtain the written consent of the defendant to receive treatment and for the reporting of information back to the court; (3) consult with ADAA; and (4) DHMH must provide required services.

The procedures for admission of a defendant to the appropriate treatment facility are provided. A defendant's withdrawal of consent to treatment must be promptly reported to the court. Procedures for returning a defendant to the court, further proceedings, and the commitment of such a defendant are specified.

Any time served by a criminal defendant held for evaluation or committed treatment must be credited against the sentence imposed by the court.

In determining whether an inmate is suitable for parole, the Parole Commission must consider ten specified factors, including the physical, mental, and moral qualifications of the inmate and the progress of the inmate during confinement.

Background: Due to recent increases in prison population growth and the growth of budget deficits, many states have recently tried to modify their sentencing and release policies, particularly with respect to nonviolent drug offenders. The latest prisoner survey released by the U.S. Justice Department in July 2003 found that after two years of slowing prison growth, the nation's incarcerated population rose at three times the rate of the previous year.

Many states have recently begun making changes in sentencing and release policies in order to limit and control incarceration costs. Some have sought explicit treatment alternatives to incarceration – especially for the nonviolent drug offender. For example, since 1993, Kansas has operated under presumptive sentencing, which is based on the assumption that incarceration is reserved for serious offenders. In Arizona and California, as a result of ballot initiatives, the approach to drug offenders has shifted to mandated treatment rather than incarceration.

In a typical year in Maryland, 20,000 offenders are placed under the supervision of the Department of Public Safety and Correctional Services (DPSCS) for drug convictions, with over 75% of those offenders being granted probation rather than incarceration at the Division of Correction (DOC). Those receiving terms of incarceration, rather than probation, are often repeat offenders who are often also involved in other serious offenses. Over the past five fiscal years, the drug offender standing population has increased nearly 18% from 4,648 offenders in 1999 to 5,477 in 2003.

DPSCS currently attempts to provide treatment to the less dangerous of those drug offenders and gives them consideration for early release, but most are not minor drug users and almost none are first-time, simple drug possession offenders.

Mandated Treatment

The Arizona approach to drug offenders shifted to mandated treatment rather than incarceration after passage of a 1996 ballot initiative. That initiative imposed a luxury tax on liquor for the program's revenue stream. Half of the revenue goes to the probation departments to cover the cost of drug treatment interventions, and half goes to the Arizona Parents' Commission on Drug Education and Prevention to promote parental involvement in children's education on the risks and health-related problems caused by alcohol and substance abuse. Studies have shown that in Arizona those individuals who complete treatment for drug abuse are also successful in completing probation, while those individuals who do not complete treatment remained in the criminal justice system.

The luxury tax on liquor generates about $6.4 million annually, and in fiscal 1999 the net cost avoidance to Arizona with drug treatment programs was $6.7 million.

In Arizona, the probation officer caseload is set by statute. The Probation Department has developed caseload ratios that, in conjunction with population projections, allow accurate forecasting of probation service requirements. Arizona law allows for public funding of obstacles to treatment, including transportation, child care, and testing.

The treatment model established by the 1996 initiative is entirely incentive-based and does not allow for sanctions for noncompliance. One result is that there may be more treatment program dropouts but fewer reoffenders than there would be under a traditional sanction-based, jail-based system. Under Arizona law, offenders not complying with treatment may not be incarcerated, providing incentive to abscond from treatment with no recourse available to the law enforcement community.

California adopted a similar initiative requiring certain nonviolent drug offenders (usually first and second time offenders) to enter treatment programs rather than prison. It excludes offenders who prove to be unamenable to treatment. Parole violators who commit nonviolent drug possession offenses must complete drug treatment in the community rather than being returned to prison. The program received an initial $60 million and then $120 million annually through 2005 to 2006, to be distributed to the state's 58 counties.

County drug program administrators in California have reported that, since July 1, 2001, more clients than anticipated have been hard-core addicts in need of more intensive services. Whether this is a temporary effect is, as yet, unknown. Full statewide program participation data is not currently available. According to legislative analysts in California, the best data suggests that just under 54,000 offenders were found to be eligible for treatment under the program during the first year of implementation.

The law establishing the program has no termination date, but funding for the program ends after fiscal 2005 to 2006. The Department of Alcohol and Drug Programs is required to allocate funds each year to county governments to cover the cost of implementing this measure. Funds are allocated on a formula that distributes 50% on a base allocation, 25% on number of drug arrests, and 25% on drug treatment caseload.

Eligible offenders receive up to one year of drug treatment and six months of after-care. The courts may sanction offenders who are not amenable to treatment. Vocational training, family counseling, literacy training, and other services may also be provided. The program also requires that participating treatment programs be licensed or certified, with certain exceptions. Special funding for drug testing under the program was appropriated by the legislature in 2001.

According to one legislative analyst's estimate of net effects on state and local government budgets done at the time of the original proposal in 2000, the program would create net savings to the state of between $100 and $150 million annually, within several years of implementation, save additional capital outlay costs to the state of between $450 and $550 million, and result in net savings to local governments of about $40 million annually, within several years of implementation. Those estimates have not yet been verified.

An evaluation of the effectiveness and fiscal impact of the program is currently being prepared for the Department of Alcohol and Drug Programs California Health and Human Services Agency by UCLA's Integrated Substance Abuse Programs. According to the UCLA evaluation effort, the social and fiscal consequences of the program are currently unknown.

The House Special Committee on Drug and Alcohol Abuse and the Senate Special Committee on Substance Abuse have had an ongoing interest in the diversion of drug and alcohol dependent offenders to treatment rather than incarceration.

State Fiscal Effect: This bill would produce both a savings in State correctional and additional costs and additional costs for treatment services.

Correctional Savings

Some of the provisions of this bill would apply to defendants convicted for the first or second time of various drug possession or drug dealing offenses regardless of whether they have a demonstrated need of treatment. Although it is unknown how many of DOC intakes are first or second time offenders, fiscal 2003 data on the number of admissions, their average sentence length, and their average stay can be used for hypothetical bed impact projections.

In fiscal 2003, approximately 3,000 admissions were received with convictions for drug possession and no additional disqualifying crime of violence. The average sentence length was 12 months, with an estimated average length of stay of about eight months. Although very few true first time drug possession convictions result in incarceration, such sentences may be more likely to occur among the short-sentenced inmates received in the State prison system from Baltimore City since the one year and under population in other jurisdictions are sentenced to local detention centers. If it were assumed that as many as 33% of these admissions would have to be diverted from prison to probation under this bill, the impact could be a reduction of approximately 667 beds (1,000 admissions x eight months). If only 10% of these admissions would have to be diverted

from prison to probation under this bill, the impact could be a reduction of approximately 200 beds (300 admissions x eight months).

This bill would also apply to defendants convicted of nonviolent crimes "resulting from drug abuse or addiction, as determined by the court." With this group of defendants there is no restriction on the number of prior convictions for any drug or nonviolent offenses. In fiscal 2003, approximately 4,000 admissions were received with convictions for nonviolent offenses and no additional disqualifying crime of violence. The average sentence length was 24 months, with an estimated average length of stay of 12 months. Although it is unknown how many of these crimes would be determined to have resulted from drug abuse or addiction (and whether alcohol addition would qualify), the majority of DOC admissions have a history of illegal substance use or abuse. If it were assumed that as many as 50% of these admissions would have to be diverted from prison to probation under this bill, the impact could be a reduction of approximately 2,000 beds (2,000 admissions x 12 months). If only 25% of these admissions would have to be diverted from prison to probation under this bill, the impact could be a reduction of approximately 1,000 beds (1,000 admissions x 12 months).

It is noted that all of these bed reduction estimates would be somewhat offset by violations of probation for these individuals, but the anticipated number of such treatment failures is unknown without any direct experience under the bill.

Based on these estimates, the total bed impact to DOC for these two subgroups could range from 1,200 beds (200 + 1,000) to 2,667 beds (667 + 2,000). Assuming that these bed reductions could begin to occur immediately, of the 1,200 – 2,667 bed savings applicable to the potential 7,000 drug offenders now going through DOC intake without a disqualifying crime of violence, the bed savings would be between 700 and 1,667 beds in fiscal 2005, with a carry-over savings into fiscal 2006. In each subsequent year, bed savings based on such a dispersion of savings might continue to occur so that beginning in fiscal 2006 and beyond, there could be a first year bed savings of between 700 and 1,667 beds, plus the second year savings (originating from the prior fiscal year) of between 500 and 1,000 beds for a total of between 1,200 and 2,667 beds.

Currently, the average total cost per inmate for DOC, including overhead, is estimated at $1,850 per month ($22,200 annually). Excluding overhead, the average cost of housing a new DOC inmate (including medical care and variable costs) is $350 per month ($4,200 annually). Inmate medical care is handled under a fixed price contract with two providers. Excluding medical care, the average variable costs total $120 per month ($1,440 annually).

Accordingly, using current variable inmate costs of $1,440 per year, this bill could produce a savings for DOC of $1.01 million to $2.40 million in fiscal 2005 and $1.73

million to $3.84 million per year beginning in fiscal 2006. (Such savings could be about 10% less, if ADAA correctly estimates that 10% of this population would be found unsuitable to treatment – see *Treatment Costs* discussion below.)

However, the extent to which this bill could lead to alleviating the need for building any additional prison facilities, or the closing of any existing facilities, is not clear. Since DOC is currently operating systemwide at 164.11% of design capacity of the State's prison facilities, it is not clear when the bed savings expressed above would translate to reduced numbers of incarcerated persons to an extent that DOC might experience facility and/or overhead savings. It is clear that initial savings would only be experienced in reductions in nonconventional housing space and would, eventually, be experienced in alleviating the need for building new prisons. Based on a cost of approximately $101,000 per bed, the cost of building a new medium security 1,300-bed prison facility is currently estimated at about $131.3 million.

This bill would also affect the Division of Parole and Probation's intake in that these defendants would now be placed under probation supervision rather than sentenced to prison. However, under current provisions, if a court finds that a defendant has an alcohol or drug dependency, the court may already commit the defendant to DHMH for inpatient, residential, or outpatient treatment as a condition of probation before or after judgment, or as a condition of a suspended sentence. Data on the number of probationers already receiving such special conditions was not readily available.

Currently, DOC's short-sentenced defendants (12 months and under) and most local jail inmates would not have received supervision upon release by expiration from their terms of incarceration. Due to the lack of data on local jail releases for such defendants and a lack of data on prior record/substance abuse, the number of new probation intakes is unknown but could be over 3,000 annually. The longer sentenced inmates would have been supervised on parole or mandatory supervision eventually, so the impact to the Division of Parole and Probation is not as great other than the fact that probation supervision will begin earlier, and potentially last longer, depending on the length of probation imposed by the court.

Treatment Costs

ADAA reports that the persons committed to treatment under this bill would almost certainly need a highly therapeutic community treatment environment, rather than any other available residential treatment modality. Offenders who would normally be committed to a prison sentence require an extensive and highly structured treatment environment as offered in a therapeutic community. The cost of such treatment is estimated at $11,833 per year. ADAA reports that, while the cost of such care appears to be high, compared to that of a less restrictive treatment environment (other residential

treatment can cost about $4,900 per patient per year), current research demonstrates considerable benefit from initiating treatment at this level of care. A significant increase is found in program completion and employability while a reduction in drug use, arrest rates, and the offenders return to institutional incarceration is realized as the offender participates in the addictions continuum of care.

Based on the same data, as provided by DOC, and assuming that about 10% of the offenders covered by this bill would either refuse participation in such a treatment environment or would be found not suitable for treatment, the potential offender pool committed to treatment under the bill would be between 700 and 1,667 persons, annually. Accordingly, the annual treatment services costs are calculated to range between $8.28 million (700 x $11,833) and $19.73 million (1,667 x $11,833).

Since it is unknown how many of DOC intakes are first or second time offenders, and since all savings and additional costs cited above are based on DOC intake data without that qualifier, any actual savings or additional treatment costs under this bill cannot be more reliably estimated. It should also be noted that the bill's provision authorizing a judge to find it is contrary to the interest of justice to send an offender to treatment may minimally or significantly lessen the bill's fiscal impact, depending on the rate at which such findings are made.

The Office of the Public Defender believes that this bill could contribute to an indeterminate reduction in the costs of defense by encouraging dispositions without trial.

In addition, since there are not now a sufficient number of treatment slots to handle the number of persons committed to treatment under the bill, any additional costs or savings arising from these provisions could not occur in fiscal 2005. The extent to which additional treatment slots would be available in any future year cannot be reliably predicted.

The bill's requirements applicable to the Commission on Criminal Sentencing Policy could be handed with existing budgeted resources.

Local Fiscal Effect: While it is assumed that a savings would accrue to local detention center operations due to reductions in intake, and in average daily populations, such an effect cannot be reliably estimated at this time.

Additional Comments: Many of the inmates who are currently incarcerated for a drug-related crime without a concurrent conviction for a crime of violence, have long histories of drug dealing. DPSCS receives over 100 inmates per year serving sentences of at least 10 years imprisonment without eligibility for parole under various Maryland repeat drug dealer statutes. Many of these inmates are individuals who have been given an

opportunity to return to the community (often with special conditions for drug treatment entry) but who have re-offended through new drug offenses or other types of criminal activity and have returned to prison to serve sentences for probation or parole violation.

Additional Information

Prior Introductions: None.

Cross File: SB 501 (Senator Lawlah, *et al.*) – Judicial Proceedings.

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