12-2021

A Case for the Decriminalization of Simple Possession of Narcotics in Mississippi

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A CASE FOR THE DECRIMINALIZATION OF SIMPLE POSSESSION OF NARCOTICS IN MISSISSIPPI

By

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A thesis submitted to the faculty of The University of Mississippi in partial fulfillment of the requirements of the Sally McDonnell Barksdale Honors College.

Oxford, MS

December 2021

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DEDICATION

This thesis is dedicated to my parents, Michael and Neddie Joye Tolleson. Thank you for always prompting me to remember who I am.

ACKNOWLEDGEMENTS

This project was made possible by the support of many people. Without their kindness, I am not sure it would have come together this way.

First, thank you to Cliff Johnson, who has advised me well and provided every bit of support needed to complete this project. Thank you for your ideas, your validation, and your patience. I appreciate you for treating me as an equal in our discussions. Your trust and encouragement throughout this process mean a lot.

To my interviewees, thank you for providing your wisdom and experiences for an undergraduate thesis. Your words give this project value.

To the wonderful women of Crossroads Ministries, thank you for opening my eyes to the many ills of our systems. I have more respect for all of you than you know, and I hope the next steps are smooth, stable, and filled with joy.

Lastly, thank you to the Sally McDonnell Barksdale Honors College. I have spent more waking hours in this building than everywhere else on campus combined. This program and its people have become home to me, and I have cherished every second of it.

ABSTRACT

STROUD ALLAN TOLLESON: A Case for the Decriminalization of Simple Possession of Narcotics in Mississippi (Under the direction of Director Cliff Johnson)

Through its incarceration of simple possession offenders, Mississippi is failing to acknowledge the severity of addiction and importance of mental health. In this paper, I will examine Mississippi's history of opinion and policy on drug use. In order to gain a better understanding of addiction and Mississippi's criminal justice system, I interview several individuals with experience in varying aspects of these issues. Mississippi has one of the highest rates of incarceration in the United States, with stringent laws regarding the possession of narcotics. Mississippi's mental health resources have been deemed unconstitutionally deficient on more than one occasion, and addicts are receiving inadequate care due to a combination of these two factors. In order to remedy these shortfalls, I recommend a full-scale decriminalization of simple possession of narcotics in Mississippi, with an expansion of mental health resources. I also emphasize the need for educational measures on substance abuse, addiction, and mental health, in order to end the negative stigma towards these issues and improve overall public health.

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LIST OF ABBREVIATIONS

ASAM	American Society of Addiction Medicine
CSA	Controlled Substance Act
DMH	Department of Mental Health
DPA	Drug Policy Alliance
MDOC	Mississippi Department of Corrections
NMUPD	Non-medical use of prescription drugs
STPP	School-to-Prison Pipeline
TIS	Truth-in-Sentencing

I. BACKGROUND AND THE WAR ON DRUGS

There are approximately 29,000 incarcerated people in the state of Mississippi between state prisons and local jails, a rate of 1,031 per 100,000 people (Prison Policy Initiative 2021). Mississippi has the second highest incarceration rate in the country, and the largest contributor to this statistic is the felony charge of simple possession of narcotics, with between 1,000 and 2,000 of Mississippi's inmates falling into this category. In the case of Mississippi and general American opinion surrounding this issue, many have believed this is a drug abuse problem with a root of individual choice. Popular opinion posits that we have a drug problem, and the result is seen in the horrifying reaction that is the War on Drugs. Instead, the reality is centered on addiction and a system that is failing to provide adequate support for the major mental health implications of drug abuse.

Addiction is a disease, which is a concept that I will discuss in more detail in the mental health section of this paper, and Mississippi's prison system has long exhibited actions that are counter to this fact. In 1970s America, President Richard Nixon began the war on drugs with the Controlled Substance Act (CSA), which placed regulations on illegal drugs and gained widespread support from the public (History.com Editors 2017). Although it was generally accepted, there were ulterior political motives that have had effects that are relevant to the topic of this paper. A major component of the war on drugs was the antagonization of Black people and predominantly Black communities. John

Ehrlichman, the policy chief for former-President Nixon, went on record in 1994 as saying,

> We knew we couldn't make it illegal to be…Black, but by getting the public to associate Blacks with heroin, and then criminalizing [them] heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course, we did (History.com Editors).

As both the Blackest state in the country and one with a bleak history of racism, Mississippi embraced this War on Drugs, and the effects are still being felt in 2021 through disproportionately high percentages of incarceration of Black people, specifically regarding drug-related crimes. Black men "make up 65% of the prison population" in Mississippi, despite only "[making] up 34% of the male population" (Summers 2018). This is a direct result of the blatant racism behind the War on Drugs.

In Mississippi, there is a practice that systematically exacerbates these particular effects of the War on Drugs, known as the 'School-to-Prison Pipeline' (STPP). In this framework, there is an emphasis on punishment for misdeeds by youth, whereby a public-school student who frequently breaks the rules will be sent to a juvenile detention center following their suspension or expulsion. A deleterious practice, the STPP is designed to disadvantage low-income students who come from situations that break the rules. In an article from the Widener Journal of Law, Economics, and Race, the issues with Mississippi's STPP are noted:

> Unfortunately, the students most affected by the STPP are the students in need of the most help, including students living in low-income or homeless conditions, minority

> students, students learning the English language, and students with disabilities. Two conditions create the basis for the STPP: (1) punishment-based disciplinary policies combined with (2) economically limited public schools struggling to provide at-risk children with an education (Burris 2011).

This article speaks to the "misplaced priorities" that Mississippi has when comparing emphasis on education funding to that of prisons. As of 2011 when the article was published, Mississippi was notorious for denying funding for Mississippi's public schooling systems, yet it had the highest rate of approval in the United States for discretionary spending to fund prisons (Burris). These two juxtaposing factors create a dangerous cycle of poor education and high punishment levels, with each of these correlating with the other.

Mississippi's punitive mindset further exacerbates this problem when it relates to the non-medical use of prescription drugs (NMUPD) that has become prevalent in this state's youth. In a 2012 study conducted by *Addictive Behaviors*, researchers determined the scope of this particular issue by surveying several thousand Mississippi public school students between the 6^{th} and 12^{th} grades. Their results showed that 442 students, out of the 6790 surveyed, had a "lifetime prevalence rate of NMUPD" (Viana et al 2012). They also concluded that these particular students were distributed fairly evenly amongst grades, saying "32.1% were in grades 6–8, 31.7% in grades 9–10, and 36.2% in grades 11–12" (2012).

Because of the high rate of incarcerated drug offenders between the ages of 18-25, there is a likelihood that many of these people began while still in high school, or while high school-aged. The trend in Mississippi's STPP causes this youth demographic to be

disadvantaged if they are caught with narcotics in schools. Forgiveness is not the standard in this state, but censure is. If students in these situations were treated with compassion and were educated on substance abuse and the dangers of addiction, their chances of graduating high school and avoiding incarceration would be much higher. The referenced study speaks to the reasons for the abuse of these drugs, demonstrating an additional problem in the system: the misplaced attitudes towards addiction.

II. THE TRUTH ABOUT ADDICTION

Addiction is something often misunderstood, and people have suffered through imprisonment as a result. In an interview with Dr. Chad Trosclair, an addiction medicine specialist who has worked in this field for the last 20 years, many of them in Mississippi, I was informed on the common misconceptions surrounding addiction. When addiction was first discussed publicly, there was an issue in description. Dr. Trosclair says:

> Over the past 30 years, we really learned a lot about addiction that we didn't know. When we first started describing…the behaviors that went along with it. So, it was defined by the behaviors. When reality is, those behaviors are just symptoms of the disease…In the last 30 years, [scientists have] done a lot of research into the biology of addiction, and how it happens in the brain. And what we found is, there are a lot of misconceptions about addiction. One is, first and foremost, is that drugs cause addiction…We hear that all the time, but it's a common misconception. And I go as far to say is, drugs rarely if ever cause addiction. So usually, there's a problem in a person's brain, before they ever use a drug or alcohol that causes addiction (C. Trosclair, personal communication, October 13, 2021).

By ‘defined by the behaviors,’ Dr. Trosclair is speaking to the common misconceptions that public and scientific opinion held for many years. There are many behaviors to which this applies. An example may be spending more money than one has in order to

obtain more of whatever substance to which they are addicted. Another example would be intense urges that cause irrationality and irritability. If defined in this way, there is a dismissal of the disease-factor of addiction. Although these behaviors were (and still are) used to define addiction, they are merely symptoms of the overarching disease of substance abuse disorder.

In recent years, the American Society of Addiction Medicine (ASAM) created a new definition that far more accurately portrays addiction and defines it by the factors that cause it, not by the behaviors that result from it. The definition provides:

> Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences. (ASAM Board of Directors 2019).

An addendum to this new definition states, "Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases." The purpose of this additional statement is to show not only that addiction is a disease, but also to note that it is treatable, albeit not easily.

The issue in people's brain about which Dr. Trosclair is speaking relates to dopamine levels, or rather deficiencies within the dopamine receptors that a person might have. There is a primitive part of our brain, what we know as the "pleasure reward center," that takes over in 'survival' situations. While reasoning and logic come through the prefrontal cortex, the pleasure reward center is a portion of the brain over which people have very little control. As Dr. Trosclair puts it:

> This part's more primitive, and it…makes us do things in survival situations that we normally wouldn't do. So, if you're starving to death, you might do things that you normally wouldn't do, because this part of the brain would take over, and you wouldn't even really be thinking about it. Well that's what happens with addiction, this part of the brain can hijack, and people start making decisions based on that part of the brain taking over. And then happens because there's not enough of a neurochemical… called dopamine, getting to its receptors (Trosclair).

Genetics and environmental changes can impact a person's brain to make them more or less susceptible to addictive behaviors. A spike in dopamine can cause an ethereal feeling, what we call a 'high'. Some people are better suited to be less impacted by fluctuations in dopamine.

> There [are] many different genetic causes that can cause a problem either with the dopamine receptor, or the process of dopamine getting to the receptor. So, depending on where that problem is, is going depend on what kind of addiction a person has. So, there are many, so called, different addictions. But, the root problem is the same, the person has what's called low dopamine tone (Trosclair).

In order to understand addiction and move the process forward towards rehabilitation, we have to first understand what causes addiction. Varying levels in dopamine has much to do with genetics, but can also be impacted by a person's environment and experiences. Low dopamine tone can cause many different reactions in people's brain, which Dr. Trosclair explains:

> Dopamine tone is just a measure of how much dopamine is getting to the receptors or how [many] receptors you have.

> If you don't have enough of one or the other, you're not going to have enough dopamine tone to feel normal, and you're going to have symptoms of that. The symptoms are usually trouble with focus or concentration. You may get irritable and frustrated really easily, may have trouble getting motivated or wanting to do things. You don't enjoy things as much as other people, you might feel depressed, you can have problems with sleep and memory. So all of those are, are symptoms of low dopamine tone. And, what happens is when this part of the brain gets to a certain level below normal dopamine tone. It starts to look for ways to raise dopamine. And there are a lot of things in the world that raise our dopamine, but the main ones that are associated with addiction are, number one, drugs, but there are also behaviors like sex and gambling (Trosclair).

When people with low dopamine tone react to these symptoms, their actions to attempt to increase their dopamine can cause exaggerated reactions than might occur in someone with normal dopamine levels. When substances that increase dopamine levels are introduced to someone in these scenarios, they tend to cause a large increase in dopamine, or a spike. The aftermath of this temporary spike tends to cause dopamine levels to decrease beyond the normal level, due to the irregular dopamine tone in that person's brain. The results of this process can engender an addiction. Dr. Trosclair describes this process:

> If you don't have a problem [with low dopamine tone], you go back to normal, and you feel fine. The people who have low dopamine tone crash back below normal, and it actually goes below where their baseline was. And, they have to do it again, because…their brain wants to get back to normal.

> So, it's going to go to whatever gives them the most dopamine. And then, it's a downward spiral because as you spiked dopamine, you lose dopamine receptors. There [are] some drugs, or alcohol that can cause damage to the cells that make dopamine. Once you've spiked and crashed, you want to go back up again. So…the baseline, keeps getting lower and lower and lower, so you want to spike more and more. To try to keep it in that range of normal, you have to compulsively do it because it's only short lived. It just gets worse and worse, and then it becomes unmanageable… If you're doing it just to be able to function, you might start out doing it because it makes your mood a little better, or helps you concentrate a little better, or it helps you cope with stress and not be so overwhelmed. Because these are all symptoms of people with low dopamine rates. So, they're using it for those reasons to begin with, and they feel better. But then over time, it gets worse and worse. And now they're just doing it to be able to function (Trosclair).

As far as treatment to relieve addicts from this necessity, there are a couple different routes that can be taken, and they can work in conjunction with one another. The most popular of these is a treatment program, which typically take the form of a 12-step program. The other option is treatment through medication. Dr. Trosclair notes the purposes and benefits of each of these:

> The focus is on treating the low dopamine states. There [are] two ways to do that, one's with medication. There are some medications that work for some people. Not all medications work for every person. Because…different people have different reasons for having this problem. Depending on why you have the problem is going to decide on what medication

> is going to work for it… The medications help the cells that make the dopamine get the dopamine to the receptors. Then, you also have a problem with the receptors being down regulated… When you spike dopamine a lot, your brain compensates by down regulating dopamine receptors, [but] you can get those dopamine receptors to come back. And one way to do that is by working [through] a recovery program, like 12-step or something like that. They found that through research because 12-step has been around a lot longer than the science behind addiction. So, they wanted to figure out why a 12-step worked to treat addiction, if it was a low dopamine problem. They found that people who work a recovery program had more dopamine receptors than people who don't. So, the process of going through that recovery actually increases the dopamine receptor density and helps you to therefore increase dopamine tone (Trosclair).

As he says, 12-step programs have been around for a long time, and they have been proven to work. On the other hand, medications used to treat addiction are far newer and more controversial. Some popular examples of these types of medications are Suboxone and Methadone. These types of medicine activate the opioid receptor and creates an increased level of dopamine. However, a notable difference between this increase, when compared to that caused by an illegal drug, is that it doesn't raise the person's dopamine significantly above their baseline. It is specialized to balance a person's dopamine tone, causing it to neither spike nor crash.

People have mixed reactions to drugs like Suboxone. Dr. Trosclair, who prescribes it when necessary, is a proponent of Suboxone, as long as it's properly regulated. There are many people who can recover from addiction using only a treatment

program, but some people need the help of medicine to stop them from having intense withdrawals from the substances to which they are addicted. Some see this as a bonus, others do not. Judge Andrew Howorth notes his experience with Suboxone being prescribed in drug court:

> It started as the miracle drug. If physicians recommended Suboxone, we would allow it in the recovery program. And then we learned very quickly, there was no recovery with Suboxone. Yeah, it's not [that] different than methadone...and the trick is it can be abused (Howorth).

To counter this point, Dr. Trosclair describes a situation which many would view as abuse of the drug. An important point to note is this scenario does not involve the regulated administration that is essential for it to work as it is designed:

> When somebody is not in treatment, and they're on the street, and they're looking to feel better, they'll use whatever they can. But, they're using it in a sub optimal way and in a sub optimal environment. They're only getting a pill here and there. So, they take it, and they feel better. They're not getting high, they're going from feeling [bad] to feeling normal again. But then when they stop, [and] they're not taking an adequate dose, they're going to go back down to where they were before, and they're going to go into withdrawal, and it's going to make them want to seek other drugs or look for more Suboxone. So, it's really just undertreated addiction rather than abusing. They are misusing it because they're not using it as prescribed. But, they're not abusing it. They're not using it to get high; they're using it to feel better (Trosclair).

With that said, I heard varying perspectives and experiences with Suboxone, one of which I will detail in the following section. Regardless, the point remains that treatment must start with treating a person's low dopamine state. Addiction is a gut-wrenching disease, but treatment is possible. Having treatment methods that are effective in helping people to recover from addiction is essential in moving toward policies that are more humane and produce better outcomes.

III. MISGUIDED RESPONSES

a. The Simple Possession Charge

The specific charge on which this paper is focused is the simple possession of narcotics. The definition, as provided by Mississippi Code § 41-29-139(c), states that this applies to "the unlawful possession of any controlled substance that is not validly prescribed." Mississippi classifies drugs on a scale known as schedules that range from Schedule I to Schedule V. Schedule I drugs include opiates, hallucinogenic, depressants, and stimulants. Schedule I drugs can range from heroin and methamphetamines, to marijuana. These are what Mississippi considers the highest and most dangerous classification of narcotics, possession of which can result in a felony charge.

In researching the simple possession charge and its prevalence in this state, a roadblock to fully understanding the issue came in the lack of statistics regarding how many people are in Mississippi prisons for simple possession. In an interview with Oxford Police Chief Jeff McCutchen, he said, "It's rare that you will see a simple felony possession, then go serve time. I think when you do a deep dive into the people who got time, there was a whole lot more to that case" (J. McCutchen, personal communication, October 7, 2021). For example, someone might be arrested for possession with intent to sell, but they will plea down to simple possession.

The punishment for possession of Schedule I and II narcotics varies depending on whether it is charged as a misdemeanor or felony. In order to qualify as a misdemeanor,

there has to be “less than one-tenth of a gram (or one dosage unit)” that is found, although this can still qualify as a felony, depending on the case (Steiner 2013). For reference, a gram is roughly the weight of a single paper clip or dollar bill (Niklas 2021), so one tenth of one of these items would be the weight of narcotics that would be required for a person to potentially downgrade the charge from felony possession to a misdemeanor. This is a tiny portion of any form of narcotics, yet it carries a penalty of up to $1,000 and a year in prison, even in the case of a misdemeanor. Once upgraded to a felony, possession of this classification can carry a fine anywhere from $10,000 to $1,000,000 and anywhere from 1 to 30 years in prison, depending on the volume of what is found.

There are often complexities to the simple possession charge. It does not matter whether the person had intent to sell, petit larceny or another crime coupled with this charge and pled down, or the simple possession was an accurate charge from the start. Viewed from the perspective of addiction as the most influential factor in these crimes, the tiers of punishment for those found guilty are both disproportionate and inappropriate. Whether it be a first offense or not, prison has proven time and again to not be the answer for addicts.

Again, Mississippi has strict laws when it comes to simple possession, but a challenge for this state’s legislature is the lack of a similar federal law on which to base its simple possession charges. According to the United States Sentencing Commission, first-offense simple possession charges carry “a misdemeanor [charge] under federal law which provides that an offender may be sentenced to a term of imprisonment of not more

than one year, fined a minimum of $1,000, or both" (Reimer 2016). However, this charge can be skewed when a state court with separate laws becomes involved.

In an interview with Assistant U.S. Attorney John Meynardie, I was provided with insight into how the federal prosecution practices differ from the state of Mississippi. As a disclaimer, these are Mr. Meynardie's private opinions; he is in no way speaking for the U.S. Attorney's office, and is simply relaying his own experiences and thoughts on the matter. In terms of experience with simple possession, Mr. Meynardie says:

> I've been dealing with federal narcotics issues for a little over 20 years… [but] the history is a little bit different in the federal courts than it is in the state courts... In 20 years of doing it, I've never charged a simple possession case… I have opinions on simple possession, but we don't do simple possession in the federal courts. So, I don't have experience prosecuting those. But I do have some experience, knowing the effect of a lot of state court prosecutions on defendants and how that affects when they end up in federal court because it enhances their sentencing (J. Meynardie, personal communication, August 13, 2021).

The federal system's lighter sanctioning guidelines are more in line with some states that place an emphasis on rehabilitation, but the line gets blurred in Mississippi.

Despite these considerations, Mississippi's government is tireless in its efforts to disadvantage those whom it deems harmful to its population. A prominent example of this trend is through Mississippi's Truth-in-Sentencing (TIS) Laws. These began for Mississippi in the 1990s, at a time when the criminal justice system was, possibly, even more focused on dominance and punishment than it is today. A result of this is noted by

the Vera Institute of Justice: “most people serving these inhumane sentences are Black Mississippians–disproportionately impacted by sentencing laws put in place at the height of the ‘tough on crime’ era.” (Nelson 2020).

TIS, in most states, refers more to a concept that is practiced in a court than an explicit policy that all must follow, but they are somewhat different in this state. According to a report in Mississippi State University’s journal, *Punishment & Society*, “Mississippi’s TIS law [passed in 1995] is unique compared to those passed in other states in that the 85 percent requirement applies to all groups of offenders, including non-violent offenders.” (Wood & Dunaway 2003). After the passage of these laws, “Mississippi’s state prison population more than doubled and corrections cost increased three-fold.” (Salter 2019).

These guidelines have since been relaxed, and parole is granted at a higher rate due to a 2014 law signed by former-Governor Phil Bryant that requires that “those convicted of nonviolent offenses [must] serve at least 25 percent before being eligible for parole.” (Salter 2019). Despite this improved guideline, Mississippi’s attitude towards incarceration remains firm. As of this year, Mississippi has the second highest incarceration rate in the country, and if it were its own country, it would have the 2nd highest rate in the world, both only behind Louisiana (Widra & Herring 2021).

b. Mississippi Prison Statistics for Drug Offenses

Based on a public records request that I submitted, the Mississippi Department of Corrections (MDOC) reports that there are 1,274 people incarcerated in Mississippi's prisons for simple possession, as of June 2021, with an average of around 1,380 over the past 6 years (MS Department of Corrections 2021).

Mississippi Department of Corrections
Custody Population by Specific Primary Offense Impacted by HB 585
For Report Period

Specific Offense	June 2014	Dec 2014	June 2015	Dec 2015	June 2017	Dec 2017	June 2018	Dec 2018	June 2019	Dec 2019	June 2020	Dec 2020	June 2021
Grand Larency	520	399	385	362	458	367	331	378	290	283	219	260	198
Forgery	263	194	167	151	185	160	130	164	114	107	71	69	66
Shoplifting	218	176	125	109	124	82	94	107	79	85	61	46	46
Possession of a controlled substance	1561	1252	1133	1182	1471	1470	1518	1536	1525	1563	1207	1240	1274
Distribution of/possession with intent	2742	2521	2560	2519	2847	2267	2135	2231	2118	2110	1791	1698	1670
Total	**5304**	**4542**	**4370**	**4323**	**5085**	**4346**	**4208**	**4416**	**4126**	**4148**	**3349**	**3313**	**3254**

Table 1: Inmate Population with Simple Possession Charges via MDOC 2021

Using data from MDOC's 2020 Annual Report, there are some insights into the demographics of these offenders. As a disclaimer, the following statistics are developed for the total population of drug offenders, including dealers, those with additional theft charges, etc. However, the standard deviation for simple possession offenders is insignificant in comparison with the total population. That being said, the demographic statistics are shown in the table(s) below:

Age

Age	Male	Female	Total	Percent
18-19	2	0	2	0.09%
20-29	385	64	449	21.21%
30-39	771	132	903	42.65%
40-49	479	71	550	25.98%
50-59	153	29	182	8.60%
60-69	28	2	30	1.42%
70-79	1	0	1	0.05%
Total	1,819	298	2,117	100.00%

Table 2: Age Range of Drug Offenders

via MDOC 2020

The highest frequency age range for both male and female inmates is 30-39. With the majority of all incarcerates being below the ripe old age of 40, there is an argument to be made that preventative educational measures could be an effective tool to combat drug abuse.

Race

Race	Male	Female	Total	Percent
White	874	255	1,129	53.33%
Black	916	41	957	45.21%
Hispanic	16	1	17	0.80%
Other	10	1	11	0.52%
Unknown	3	0	3	0.14%
Total	1,819	298	2,117	100.00%

Table 3: Demographics of Race Among Drug Offenders

via MDOC 2020

The racial demographics from last year are interesting. Here, we see that the majority of drug offenders in Mississippi are white. Unfortunately, these statistics are not

divided into types of drug offenses, so it is difficult to tell if this white majority also applies to simple possession.

Length of Sentence

Offense	Average Sentence Length in Years
Drug Intent	8.4
Possession of Drugs	5.4
Sale of Drugs	9.7

Age at Sentence

Offense	Average Age at Time of Sentence
Drug Intent	35
Possession of Drugs	36
Sale of Drugs	35

Table 4: Average Length and Age of Sentences via MDOC 2020

The average length of sentence for simple possession of narcotics is 5.4 years, which indicates that the majority of cases are tried as felonies because the misdemeanor charge carries a one year maximum. This, coupled with the average age of 36 for this offense, means that the average inmate with simple possession charges will be over 40 years old before release from prison.

Male

Offense	Black	White	Hispanic	Other	Unknown	Total
Drug Intent	194	163	6	3	0	366
Possession of Drugs	381	562	8	4	2	957
Sale of Drugs	341	149	2	3	1	496
Total	**916**	**874**	**16**	**10**	**3**	**1,819**

Female

Offense	Black	White	Hispanic	Other	Total
Drug Intent	6	44	0	1	51
Possession of Drugs	17	172	1	0	190
Sale of Drugs	18	39	0	0	57
Total	**41**	**255**	**1**	**1**	**298**

Table 5: Gender Demographics among Drug Offenders via MDOC 2020

Lastly, the percentage of incarcerated persons who are drug offenders is higher for females than males, in comparison to the total population. The total prison population for men in Mississippi in 2020 was 17,956 people, and for women it was 1,471 (MDOC 2020). This shows that the male population makes up around 92.4% of the total prison population, whereas the female population makes up around 7.6%. However, the rate of women with drug offenses is nearly doubled when compared to total prison population at 14% of cases, and men make up the remaining 86%.

c. Drug Court

In Mississippi, the current standard for rehabilitation is through the process of Intervention Courts, or drug court, as I will refer to it for the purposes of this paper. Over the course of my research, I had the opportunity to speak with two drug court judges (one retired, one current), with one of the two playing a large role in the inception of the Mississippi drug court system. In the process of these interviews, I was able to gather ample information about the operations of drug courts: I discovered what works, and even more so, what does not. At the beginning of this process, I gathered that drug courts are aimed towards accomplishing "three primary goals: (1) to reduce recidivism, (2) to reduce substance abuse among participants, and (3) to rehabilitate participants" (State of Mississippi Judiciary 2021).

In terms of whether or not drug courts were successful in their mission, I received mixed opinions. I had the opportunity to interview Judge Keith Starrett, who is largely responsible for the introduction of drug court into the Mississippi judicial system. He claims that around 75% of those who go through drug court graduate, saying "75% of them stay clean and sober [and are successful] the rest of their lives. [But,] 25% [of people] recidivate [and] they usually end up going back to jail" (K. Starrett, personal communication, September 8, 2021). Meanwhile, in an interview with Andre DeGruy, the chief public defender in the Office of the State Public Defender, he compared the graduation rates of Mississippi's drug courts to those of a fictitious high school scenario. He said, "I have some concerns about our drug courts…about half of [those going through drug court] don't…graduate…. If you had a high school that 50% of the kids who enter high school don't graduate, you'd be shutting that high school down" (A. DeGruy,

personal communication, August 3, 2021). Although this argument highlights one of the major issues of drug courts in their inability to successfully rehabilitate participants, this comparison is unfair. Graduation from high school is a fairly linear process, with some outliers. Recovery from addiction, on the other hand, is far less linear. Whether the discrepancy between these two claimed statistics is due to national versus state success rates or something else entirely, the lack of reporting and prevalence of low success rates appear to be issues in drug court's effectiveness.

To break this process down, I will discuss how drug court works. In an interview with a retired drug court judge, Judge Andrew Howorth, he broke down the application process. In order for someone to qualify for drug court, they must have "an eligible charge [with] no crime of violence [and] no sex offense" (A. Howorth, personal communication, October 6, 2021). There is a plethora of charges that qualify as eligible for application to drug court. There are often several charges stacked on someone, or they are repeat offenders. Some courts, such as Judge Howorth's, have an open-door application policy, whereby potential candidates can submit their applications regardless of their charge. Other courts require that the applicant be referred, whether by law enforcement, prosecutors, family members, or others. Due to a lack of resources and scale, there are only a select number of slots available in each jurisdiction's drug court. Once someone is accepted into drug court, they receive "a professional assessment to determine whether they need treatment" (Howorth). Based on the results of their assessment, the person can be recommended for a wide variety of treatment options, including inpatient treatment, intensive outpatient treatment, weekly meetings, etc...

Placement depends on the severity of the person's addiction and the feasibility of their recovery.

Interestingly, I received very different answers in my interviews regarding the prevalence of simple possession in drug court. In Judge Howorth's experience, very few of those who went through drug court were there for simple possession. There was typically much more going on behind the scenes on in their charges:

> [My drug court] rarely [had] simple possession cases of a controlled substance because it carries the three-year maximum. And they can get a better deal as a first offender than drug court…they're going to get non-adjudicated probation, they're probably going to be given an opportunity to get it off their record…They're not going to take drug court. Like, I can either spend three years with [a judge] with his foot on my neck. Or I can take three years of supervised probation, [which is] probably going to be cut to one [year] where all I have to do is go see a probation officer once a month for about 12 months, may get drug tested once or twice, depending on whether the whether the Department of Corrections has enough money to drug test me. And then after a year, I'm off and my record is expunged (Howorth).

While the system allows for this to happen, it is not set up to encourage rehabilitation for addicts guilty of simple possession, which will only allow the problem to persist.

When Judge Starrett was asked about simple possession charges and their prevalence in drug court, he responded, "simple possession is…one of the main reasons people get in drug court" (K. Starrett, personal communication, September 8, 2021). He also mentioned theft and embezzlement as charges that were often seen in drug court.

These additions likely indicate those who were committing additional crimes to fund their addiction.

Another discrepancy seen in Mississippi's drug court system is the level of funding from one jurisdiction to the next. According to Judge Howorth, every drug court has to start with a system in which drug court participants are required to pay their way through their treatment. Once a court is established, there's a chance that grant money will allow the court to pay for a participant's treatment, as was the case in Judge Howorth's court. The issue with this trend, particularly in Mississippi, is the racial disparity in which it results. Because Mississippi's Black population is statistically disadvantaged in terms of financial status, their ability to go through a drug court in which they're required to pay for treatment becomes less feasible. Differing statistics regarding the balance between white and Black drug court participants are asserted depending on the source. However, a report by the Office of the State Public Defender shows that drug court participation consists of 63% white people and only 35% Black people (shown below), despite Black people making up more than 60% of the prison population (Office of State Public Defender 2018).

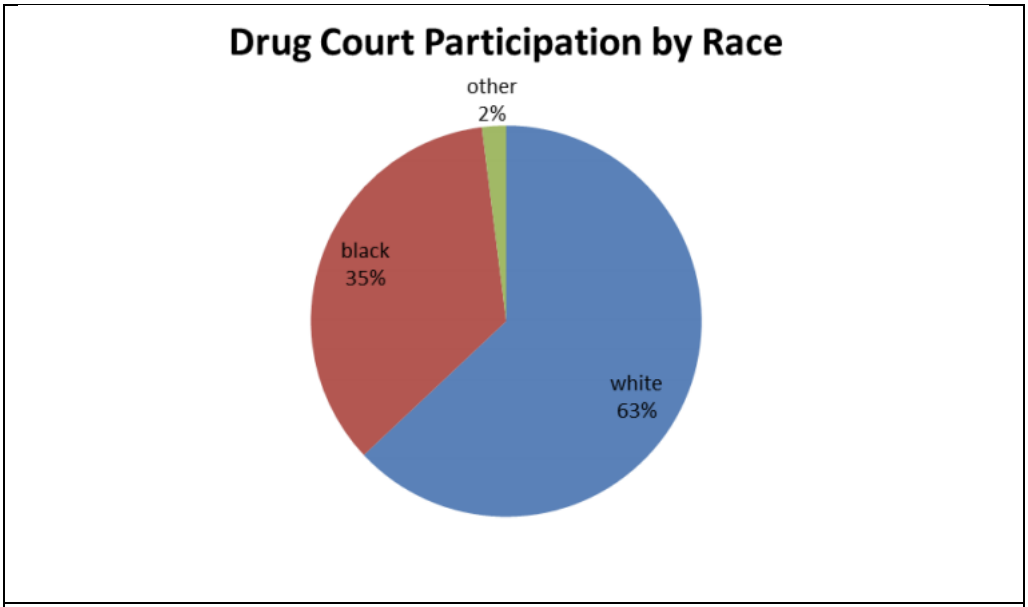

Figure 1: Drug Court Participation by Race

via Office of State Public Defender

Therefore, drug court, as it stands in most counties, is an inequitable system to treat Mississippians. The motivation for someone to go through drug court if they have to pay for it is very low, but this can change if the funding changes. Again, in Judge Howorth's court, the program received grant funding that they use to pay participants' ways through treatment. With that system in place, the conversation to encourage someone that treatment is positive is entirely different. Judge Howorth details that conversation:

> You'd be interested in seeing how that conversation goes in drug court. Say, I'm going to need you to go in treatment. Yeah. And... sometimes they go, Oh, no, no, no, I'm going to lose my job and whatever. You know, this is not a punishment. This is an opportunity...Because most people appreciate that in the very beginning, when you say, I'm

> going to put you in an inpatient treatment program, and we're going to pay for it because… we have grant money for that. So, in the early days [when people had to pay their own way through drug court] ...where you shake down grandma for the money, that's hard. Okay, that's really hard. When you can pay for treatment for the people in the program, and you don't have to leave them out and quibble with somebody about where the money is going to come from to put somebody in a treatment program. That's how we used to do it. But once we got grant funding for that, it's like, I'm going to put you in treatment, and you're not going to pay for it. And this is not a sanction, never a sanction, this is an opportunity because we're going to get you on the right track. And you got to commit yourself, because no, if you say you're going to treatment, whether you like it or not. Well, if they ever catch hold, it's going to be at least two weeks in, and that's a little bit late. Because they're going to be going, what am I doing here? It's just like prison (Howorth).

This level of funding in which the participant does not have to pay for drug court is leagues above the majority of the state, but it is only a step in the right direction. While the treatment provided by drug court can be helpful, the barriers to entry, for many, are cumbersome. In courts where payment is required, it can be very difficult for participants to hold a job to fund their treatment. If things do not go well, their stay at drug court can be prolonged or even terminated, depending on the severity, thus harming their trajectory towards recovery. Judge Starrett explains the system of response-based sanctioning:

> You can expect relapses. Almost everybody in drug court, relapses at least once you expect relapses, but you just address them. You sanction them if necessary, and the sanctions are graduated. You know, you ratchet them up... If

> they do it one time, maybe, you know, come do five hours of community service. You do it five times, well, let's see about two weekends in jail. So that's the kind of thing that you ratchet it up, depending on the number of times. You do enough to get their attention (Starrett).

Though I agree that it would be inappropriate and unfair to expect recovery of addicts on the first try, I fear that sanctioning for mistakes is a dangerous precedent to set. If someone has to spend two weeks in jail instead of getting two weeks of treatment, they are far more likely to relapse again or harm their recovery in other ways. Undoubtedly, addiction and mental health are intertwined, yet Judge Starrett mentions a discrepancy between these two factors in describing a funding opportunity that was up for grabs between drug court and the Mississippi Department of Mental Health:

> A lot of powerful politicians have come on board [with drug court]. Our senators and congressmen in Mississippi, Trent Lott and Thad Cochran, were big supporters. Roger Wicker is a huge supporter of drug courts. Senator Cindy Hyde-Smith, she was largely responsible. This is back when she was in the State Senate. But, she was largely responsible for making drug courts what they are today because she was able to get the funding that drug courts needed to go statewide…And they tried to take it away from her…The Mississippi Department of Mental Health tried to take the money that she got for drug courts away. And she fought like a dog. I mean, she really got nasty. And I was proud of her. And she won. I mean she got the money that we needed to make drug courts what they needed to be in Mississippi (Starrett).

Drug courts acquired this funding to spread throughout the state, which was necessary for their survival and legitimacy. However, my initial reaction to this quote is confusion as to why the two entities, drug courts and the Department of Mental Health, cannot work together using this funding to better mitigate the growing addiction rates in this state. Also, the politician he mentions, Cindy Hyde-Smith, is a polarizing force in Mississippi's political elite. There are few, if any, bipartisan policies which she supports. And, according to a report by University of Virginia and Vanderbilt University's Center for Effective Lawmaking, Hyde-Smith was "rated the least effective senator in Washington [DC]," using an unbiased, data-driven approach (Harrison & Ganucheau 2021). Although her work to get drug courts funding happened well before this rating was conducted, I worry about the implications of her support and its seeming denial of mental health initiatives. When fully funded, drug court can provide a helpful service for addicts with charges that involve violence or intent to sell. However, Mississippi's mental health system must also be examined and improved for drug court to reach its potential.

d. Mississippi's Mental Health System

Mississippi's mental health resources are woefully inadequate. In 2011, the U.S. Department of Justice submitted a letter to then-Governor Haley Barbour detailing the results of its review of Mississippi's system that is supposed to support those with mental illnesses. It states:

> Our review reveals that the State of Mississippi has failed to meet its obligations under Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12131-12134, and its implementing regulations, 28 C.F.R. pt. 35, by unnecessarily institutionalizing persons with mental illness or [developmental disabilities] in public and private facilities and failing to ensure that they are offered a meaningful opportunity to live in integrated community settings consistent with their needs. The United States looks forward to working with the State of Mississippi to develop an appropriate remedy to resolve these concerns (Assistant Attorney General Perez 2011).

This review marked the beginning of a conflict between the U.S. Department of Justice and Mississippi's mental healthcare systems. Mississippi was put under pressure for its "insufficient steps to reallocate existing resources for mental health" (2011). Based on this report, Mississippi favors institutionalization of mental health patients far more than the rest of the nation, with 55% of its mental health budget going towards institutionalization, compared to the national average of 27%. An article from the Mississippi Free Press on this issue states, "Institutionalization rips human beings out of their home communities, and authorities must avoid this action wherever

possible" (Judin 2021). Whether it be incarceration of the criminally convicted or institutionalization of those with mental illnesses, Mississippi seems to prefer keeping those it deems anomalous out of the public eye. In 2016, the Department of Justice filed a lawsuit against Mississippi for its shortcomings in this area, citing a "[discrimination] against adults with mental illness" (U.S. DoJ 2016).

The conflict continues in 2021, with a recent ruling by U.S. District Judge Carlton Reeves. In his ruling, he addresses the unconstitutionality of Mississippi's mental health treatment for residents. Judge Reeves states:

> Ten years have passed since the United States issued its findings letter describing in detail how Mississippi's mental health system was over-institutionalizing citizens. Five years have passed since the United States filed this lawsuit seeking to fix that problem. Two years have passed since trial, where the United States proved the violations with evidence…Mississippians with serious mental illness need help and this Order seeks to give them the help they so desperately need (CAUSE NO. 3:16-CV-622-CWR-FKB)

Judge Reeves calls for a monitor to be brought in to ensure that Mississippi be brought up to the minimum requirements for ADA compliance. Part of this requires that Mississippi begins collecting comprehensive data on its mental health programming, in order to determine which parts are working and which aren't (Stribling 2021). Judge Reeves mandated Mississippi to submit a plan to the Department of Justice with these, and several other, requirements within 120 days (Willingham 2021). He also issued a deadline of 180 days for the completion of the final plan (2021). To delay this process and prevent itself from accountability, Mississippi has requested an extension of this deadline because it intends to appeal Judge Reeves' ruling.

To address the timeline given by Judge Reeves, a legal team representing Mississippi writes, “Mississippi will suffer irreparable injuries from undue interference with its mental health system and a fundamental alteration of that system” (Willingham 2021). Judge Reeves mandated a clinical review to make sure Mississippi’s mental health resources are able to meet the needs of those with mental illness. Mississippi’s legal team opposes this requirement (2021).

The Mississippi Department of Mental Health (DMH) has been described by Mississippi state representative, Tom Miles, as a “punching bag” in budgetary discussions, meaning its budget is likely to get cut quickly and thoughtlessly (Smith 2017). From 2009 to 2011, $42 million was cut from the DMH, removing around 15 percent of its budget (2017). Only a year after the Department of Justice’s 2016 lawsuit, Mississippi cut an additional “$14 million…amounting to 6 percent of the [DMH’s] budget” (2017).

Mississippi’s mental health services are not only unconstitutionally inadequate, but leaders are unwilling to correct their shortcomings. This furthers the stigma that mental health is not important and that addiction is not a disease. The result is a population of Mississippians who are unable to obtain the resources they require and deserve. Research published by the American Journal of Men’s Health suggests that the stigma behind mental health “is one of the most frequently cited barriers to professional help seeking,” and the result is often self-medication (Lynch et al. 2018). Self-medication is the process whereby someone uses a substance to treat their problems, without the aid of a medical professional. This problem can arise due to the constant reinforcement that mental health is not important, real, or valid. So, people who are struggling with mental

health are less likely to seek out resources. In the case of Mississippi, this is the first part of the issue. Even if Mississippians are not influenced by this stigma, their ability to seek out and receive treatment is greatly limited by the inadequate services that are offered. With addiction, the issue persists. The American Journal of Health Education states, "Self-medication may lead to addiction," and the two have negative interplay on mental health (Nobiling & Maykrantz 2017).

IV. AN INTERVIEW WITH A FORMER INMATE

Much research on prison systems and the problems within them deals with the statistical and economic implications of prison. Seldom does academia involve personal interactions from an incarcerated person or formerly incarcerated person's viewpoint. While the monetary impacts and the demographics involved with prison statistics are certainly important in shaping policy, the human aspect of prison need not be overlooked.

In order to gain more perspective on this issue, I had the opportunity to interview a woman from Crossroads Ministries. A Canton, Mississippi based nonprofit, Crossroads is a place "for women coming from prison. They struggle with addiction and more, needing education, life skills and a safe place as they regain their self-worth" (Crossroads Ministries 2018). For purposes of discretion, the identity of this woman will remain anonymous.[1]

The primary theme of this interview involved her experiences with prison and with addiction, and her words describe the reality of prison for addicts, and her message revealed one primary theme, "Incarceration is not helping anyone with a drug addiction." She recounted how the punishment she received was grossly disproportionate to the "crime" she committed:

[1] I disclosed her identity to my thesis advisor to allow for confirmation of my source and fact checking.

> Mine was a simple possession charge. That's how I ended up in prison. I possessed a very small amount of methamphetamine. I don't even think it was a gram. It was probably less than a quarter of a gram. It was probably not even enough for my personal use. I think it was a bag with some crumbs in it or something, and that can get you a possession charge…They charged me with a felony… [For that charge,] I was in prison about eight months all together. And then before that I spent like, nine months in jail.

When asked what her experience was like while she was in prison, she recounts some of the dehumanizing realities she faced:

> I'm going to tell you what your day is like when you go to prison… Your day is like, you go in, and they give you a bunk. They've stripped you of everything, like you have nothing but your clothing. You get up to eat, you go back to your bunk, and hopefully someone will have something you can read. You do not get to go to the library. You're in a lot of processing for about three months, where you see other girls come and they go. If you're lucky, someone may put some money on an account where you can order snacks from [the] canteen. If not, you'll eat two meals a day. And you're stuck in [a] huge holding area…day in and day out, for months…with nothing going on. There [are] no classes. You can write letters, if you have a pen and paper. Occasionally you'll get to go to Bible study or something like that. Maybe once every two weeks. But there's nothing going on there. I mean, there's absolutely no structure. There's no programming. There's just nothing unless you're there to do [an] extended amount of time. Yeah. And most of the people

> with simple possession charges are not in prison long enough to have access to any of the programs.

While people with simple possession charges might not be there long enough to engage in the loose programming that prisons may provide, they are incarcerated long enough to lose virtually everything. I recall a meeting with my advisor for this project, Cliff Johnson, where he detailed the major changes in a person's life that can occur after just three days in prison: first you lose your job, then your house, car, properties; and in a lot of cases, you lose your family and friends.

As far as rehabilitation measures, prisons in Mississippi are abhorrently counterproductive for addicts. According to my formerly incarcerated source:

> To kind of get an idea of what is available in prison. I know that they do have some type of drug and alcohol rehabilitation…classes, but the problem with that is they'll sentence you to that. But, you may have to actually spend [a] longer amount of time in prison, just waiting to get into the classes. If you're ordered to take those classes, you have to wait for the other people to graduate. So, say that you're sentenced to a six-month long alcohol and drug program. You're sentenced to six months, but you could spend 8, 10 months or longer in prison waiting to get into that class.

The programs she mentions are outlined in the MDOC 2020 Annual report, seen below:

MDOC Inmates Served by Alcohol and Drug Programs

LOCATION	SERVED	COMPLETED	CAPACITY
(MSP) A&D programs	127	63	120
(CMCF) A&D Program for Males and Females	257	116	191
(CMCF) 720 Treatment Program	562	83	180
(SMCI) General Population Program Area	192	165	100
3 Community Pre-Release Centers	158	116	132

Table 6: Prison Alcohol and Drug Programs

via MDOC 2020

These low-capacity measures are inadequate for the recovery of inmates struggling with addiction. Based on the information disclosed by MDOC, the total capacity for these treatment programs is 723 slots, which fails to cover even half of the inmate population with simple possession charges, disregarding all of the other drug offenses for which people are incarcerated.

To make matters worse, addiction can worsen for people in prison:

> It was actually easy to get drugs inside the prison, and then they come out of prison with a whole new set of issues. Not just an addiction, but now you have all these other things stacked against you. You have a felony. You can't pass a background check to get a good paying job. You can't find housing because you have a felony on your record. It is so hard to find housing. The girls that just are moving out [of Crossroads]. Three of them get together and rent a house together. Well a lot of parole officers will not let you live with somebody who has a felony conviction. A lot of times, the family member who is a convicted felon coming out of prison live in their homes, so you know it's just adding

> another layer of difficulty to the person's life, I feel like. And, you're in prison with people who have mental health issues and who have murdered people or who have violent criminal history and are not stabilized on medication. It's just very, very stressful.

In other conversations I've had with people who were formerly imprisoned, I've heard stories about people arrested for possessing opioid pills or marijuana. When they got to prison, they were surrounded by much 'harder' substances that furthered their addiction: heroin, methamphetamine, etc. The ease of this was due to a slew of issues, one of which involves the prison guards being willing to smuggle in drugs for the inmates in exchange for money or sex. The low pay and unfortunate conditions for state-employee guards allows this to occur.

As recognized by my source, the difficulties for women coming out of prison are particularly acute. As a society, it seems we often either expect women to easily assimilate back into their communities, or we expect them to fail and end up back in prison. The second of these is far more likely because the system is set up for failure. It is set up for repeat offenses.

As far as other rehabilitation measures that might be in place, this woman has not been through drug court, but she has family and friends who have. She says:

> Drug court is...not easy to complete. You have to have resources to do drug court. You have to be able to work a job. You have to have a vehicle. You have to be able to stop whatever you're doing and go take random drug tests any time of the day, two or three days a week, and it's expensive. You have to be able to afford to do drug court. Yeah. And a lot of people don't have that option. I just wish they were

> more state funded rehabilitation places because it's so hard to get into a rehab without insurance.

While Crossroads includes counseling and various short-term rehabilitation measures, it's not a solution due to its timeline issues:

> Crossroads is one place that works on addiction…There's counseling and things like that, but also mostly transitional thing, I think. You know, people are not here long enough to book a 12-step program like Celebrate Recovery. We're not there long enough to start and finish a 12-step program.

The issues with lack of state support for government-funded rehabilitation measures are not universal. Mississippi is lacking in this area, while some other Southern states have far better resources than this one:

> And I think there are very few rehabs in this state that are actually government funded. I know that in other states, some of the other [women in Crossroads] that have been to rehabs in other states can tell you that their sentencing laws are different there. You know, access to resources, is a lot more like they have more access to better resources to help them with addiction problems. In other states, like Louisiana for example, has outpatient, and they have a few state funded rehabs. I went to one in Louisiana.

Addiction and mental health go hand-in-hand, and each work against the other. If someone has mental health issues, they'll be made worse by an addiction. If someone has an addiction, they will worsen the mental health issues with which that person is dealing. This trend happens far too often in Mississippi's prisons:

> We definitely have mental health crisis. There are so many people in prison with mental health issues that if they had

> access to treatment [things might get better]. [But they're] probably trying to self-medicate, they're also drug addicts, people out there with mental health disorders that try to self-medicate through drugs, through illegal drugs…And then you have your drug addicts that end up with mental health issues because of their addictions. There's just not enough funding, health care. But I definitely think that incarceration is not helping anyone with a drug addiction. Most of the girls that I know will tell you there were more drugs in prison [than outside of it].

My source has never been prescribed Suboxone or other addiction medications. However, she knows people who have, with varying results. She describes those situations:

> I can only tell you my experience, and the limited amount of experience I have with [Suboxone] is through the people that I know that were on those medications. One of them had a bad crack addiction, and she was able to stop using crack cocaine, and she is actually kind of stable. She's stayed out of trouble, and it's working for her. Another person that I know [that] uses Suboxone…she only used it to get a prescription filled. She would sell half of it, so she would have money to last for the month, and [she'd] take the medication. Then, when the medication would run out, she would do whatever else she could to get other drugs. She's was running out of medication because she was selling them. If she did not have it, she had to have opiates, so I don't know how well it actually works... Poor people are going to sell what you give them to try to get by. If they don't have money to feed their kids, they're going to sell the drugs that you try to use to help them with.

This point is consistent with Dr. Trosclair's belief that the administration of Suboxone needs to be regulated, or it will be sold or misused. These experiences that friends of this woman have had are in line with that description. However, there are some discrepancies between this woman's experience and Dr. Trosclair's statements about whether or not Suboxone can be abused, and whether someone is able to get high while taking it. She recounts:

> People do abuse it. You can get high off of it. I do know that. I've done it. I have done Suboxone, and... it's another high. You can take it, mouth it down and shoot it up. You can snort it. And you can get very high. Trust me, you can get very high off Suboxone. I have snorted it, and I have shot it up. So, I know that you can get high off of it.

Because of this perceived ability for the abuse of this drugs, those who are being prescribed it are not going to disclose this information to their physicians. She does mention that Suboxone, in her experience, is effective in blocking the ability to get high from other things.

> If you're taking Suboxone, you cannot get high on opiates, but you're high on Suboxone, so it doesn't matter. [But] no drug addict…in their right mind is going to go in [the doctor's office] and say yes, I can get high on this. Especially if you're prescribing it for them. Because, they do not want you to know that because then you won't prescribe it. So, they're not going to be truthful and say, Oh, yeah, by the way, the medicine that you're giving me, I can get high on it... They're not going to tell you that because they're scared that you'll stop giving it to them.

Her perspective is essential, not only in figuring out what the problems are, but it also provides a valuable insight into how we can fix these problems. In the case of this woman, she has been sober for three years (and counting), and she notes what made that possible, and just as importantly, what did not:

> I know for me… I'll say that prison, that's not what's kept me from relapsing on drugs, you know, all the times I was in jail before didn't keep me from using drugs… Spending months in jail didn't [help]. But, the times that I did go to rehab, I did learn a lot about addiction. And, [these] times that I did go to rehab are the times that I was able to stay sober, [and they're] the longest periods of time away from addiction, in my life., Had it not been for those times, I wouldn't have had any of the years of sobriety. Had I not had the chance to go into rehab and learn other ways of coping and how to work a 12-step program, go to meetings, where I can have a support system with other people trying to stay clean and sober. I think the most important thing about a rehabilitation program is finding other people that are also working to stay clean and sober and learning from them...You've got to have a support system and you're definitely not going to find that in prison.

V. INTERVIEWEES' OPINIONS ON POLICY CHANGES

During the interview processes, I asked several of the interviewees their ideal policy change, if any. As a disclaimer, these are purely the personal opinions of the interviewees. Some recommend a full-scale upheaval of the current simple possession policy, and others think a few things need to be tweaked or the narrative shifted. Their opinions are quoted below:

Formerly incarcerated person:

> Well, if I could change the policy, the first thing I would do is I would make it a misdemeanor for someone who is not caught with anything but paraphernalia. You know, I would not…try to ruin someone's life with a felony charge… I wish there was state funded rehab and [that we] would never put anyone, especially a first-time offender with possession charge into prison, and then maybe spend some time and have it non-adjudicating, or something. But, I would sentence them to AA meetings or something like that, not prison.

Dr. Trosclair:

> I definitely think the people who are supplying it and the people are making it available, that should definitely remain criminal. Also, that's not going to fix the problem. It's going

> to deter it, at least somewhat. As far as people being criminally prosecuted for using drugs, I don't think that's the way to go. For the direction of treatment as it is, as an illness. I think if we do that, it would be more successful. Especially intoxication, those people need medical help, not jail (Trosclair 2021).

Andre DeGruy:

> I think the idea of reclassifying all drugs to misdemeanors...just talking about simple possession is...I think, probably a better way… Sending [simple possession offenders] to prison...that harm is so great with no public safety gain at all… If all we do is reclassification…you [have] 1500 fewer people or 2000 fewer people in prison, [and]…the guard to inmate ratio is already improved.

Assistant U.S. Attorney Meynardie:

> I think [reclassification is] probably a better idea than complete decriminalization, and particularly for drugs that are not marijuana. I really think that people who are drug users, particularly if they're addicts, they need help... And, jail is rarely the help that they need… I have a real problem with incarceration for simple possession… If we could put more of our resources into [rehabilitation] and less of our resources into locking people up, that's a very good idea. Whether it's reclassification or whatever the case may be... but that takes money.

Chief McCutchen:

> I think the totality of that crime should have a slide. So, this is the first time maybe you don't go to prison. Maybe it doesn't even go on your record. Maybe it's drug court, maybe it's mandatory drug court. Maybe it's sent to a mental health facility. Maybe we put these tools in place to give them a chance. Or maybe you're just a chronic drug dealer, you know, like, then the scale has to slide differently. But I think until we can get mental health in our schools [as] a part of the curriculum, then we're going to keep repeating this because for most [cases] it's an addiction… If the demand doesn't change, then the supply is going to keep coming (McCutchen 2021).

Judge Starrett:

> Legalization of drugs…that's not the right way to go… You can't just open the doors. You can't just slap them on the wrist if they continue to abuse drugs because they just ratchet their problem on up. It gets worse. It doesn't get any better unless you figure a way to help them turn it around. So, you've got to work on community safety, that's got to be a very important part of what we do in the criminal justice system. We want to improve it and want to make it better. But, we've got to have some tools and one of those tools is present. If somebody is just not going to do right, you protect the community, by locking them up… [However] I'm a big believer in not sending people to prison for their first offense, I think that they ought to get second or third chances. As long as they don't hurt somebody, as long as they're not dangerous to themselves or others, then they

should be allowed a criminal justice alternative [such as drug court] (Starrett 2021).

Judge Howorth:

> Let's talk about decriminalization, and this is a total devil's advocate thing. I'm not sure how I feel about decriminalization…When you talk about decriminalization as improving the lives of people who are negatively impacted by drugs and drug addiction, you can make it an equally compelling argument that they don't end up with this many criminal charges and they have more opportunities later on in life and all those sorts of things are all true. And that when you get around to the devil's advocate, if you go too lightly on illegal drugs, then you cut into my potential population for drug court participants, people that actually need it, but haven't engaged in quite enough anti-social behavior to get them in drug court. I'm not saying that they shouldn't decriminalize [simple possession] …but, in terms of addicts, you're closing the door, you're making it harder for addicts to find their way to drug court (Howorth 2021).

VI. RECOMMENDATIONS

When considering different policy reform concepts, one of the most attractive routes is reclassification. Reclassifying simple possession charges from felonies to misdemeanors would solve many of the issues that addicts, once caught, can face. Felony convictions ruin lives and often further exacerbate substance abuse. However, in the current system, even misdemeanor charges tend to carry prison sentences of up to one year. Although reclassification is a route that might garner support from Mississippi's legislators on both sides of the aisle, I am fundamentally opposed to punishing addicts for something over which they have no control. Therefore, I am recommending a full-scale decriminalization of the simple possession of narcotics, with the very important addition of a comprehensive standardized education curriculum on substance abuse, addiction, and mental health for Mississippi's youth.

A common argument against decriminalization is that it will drastically increase drug abuse and worsen public health and safety. Based on other areas that have undergone a full-scale decriminalization of drugs, the results show the opposite of these assumptions. As an example, Portugal instituted a comprehensive decriminalization of all drugs in 2001. Because that was 20 years ago, there is substantial data that indicate its effects. According to the Drug Policy Alliance, Portugal's decriminalization has resulted in "fewer people arrested and incarcerated for drugs…More people receiving drug treatment…Reduced [incidences] of HIV/AIDS and drug overdose…and Reduced social

costs of problematic drug use" (DPA 2017). In addition, drug use levels have decreased in Portugal, over the years. Drugs are still an issue in all places, but where they are not criminalized, the stigma is less harmful and education rates on substance abuse are higher.

This recommendation is not for those with violent offenses or those who sell, or intend to sell, these substances. Decriminalization is not a dismissal of the severity of narcotics, but rather, an acknowledgement that incarceration is an inappropriate route to take for those who possess and use drugs. Also, decriminalization is not legalization. Under this reform, it will still be illegal to possess and use drugs, but it will not be criminal. The result of this is that someone who possesses narcotics will not be criminally prosecuted, nor will they be sent to jail. That being said, there will still be accountability measures in place because it will still be an administrative violation, but that will be through rehabilitation. It should be noted that mandated rehabilitation is less likely to be effective if the person does not want to be there or want to get better. However, it is a more restorative route to take than prison, despite the outcome. That being said, a major goal is to alter the stigma around rehabilitation and addiction, in general, in order for people to be less resistant to rehabilitation, despite its requirement.

In order to accomplish this goal, we must eliminate the schedule classification of drugs. A tiered list of severity of different substances furthers the misconception that some drugs are far worse than others. While the effects vary among different substances, anything that can be abused, and to which people can become addicted, can be equally as harmful and difficult to escape as anything else. If someone is discovered to possess illegal narcotics, they should have the narcotics confiscated, be mandated to an

assessment with a mental health professional to determine whether or not they are addicted and need treatment, and if deemed necessary, mandated to treatment. If they do not show signs of addiction, they still have the narcotics confiscated, and they are mandated to weekly meetings for whatever span of time is appropriate to help monitor and educate them on the dangers of substance abuse.

As far as treatment options for those who have an addiction, there will be a few choices, depending on the severity of the disease. Each of these treatments will be 100% state-funded, requiring no copays or invoices from those being treated. I will discuss ways to make this possible later in this section. For those needing the most help, inpatient treatment will be offered, where the person needs to stay in a treatment facility until they show enough progress to downgrade to the next option. This trickles down to partial hospitalization, in which most of the day is spent at treatment, but they return home at the end of each day. After this, there would be an intensive outpatient option, in which the timespan of meetings is shorter and less frequent, but still helpful for addicts who have either made significant progress or have a fairly young addiction. Finally, for those who do not have an addiction, they will be recommended to basic outpatient counseling, which will not be required, but highly encouraged.

I recommend that each incarcerated person who is currently in prison with simple possession charges be released from prison and mandated to treatment, according to these same standards. For those who remain in prison for carrying violent charges or those with intent, the drug court system will remain in place, but each jurisdiction will receive the level of funding necessary to pay participants' ways through the program.

Also, I recommend that the recreational and medical sale, and use, of marijuana be fully legalized in Mississippi. Marijuana is not nearly as physically addictive as other Schedule I narcotics. According to Psychology Today, symptoms that may arise from a dependence on marijuana are far more likely to be psychological, rather than physiological, which are "less severe and [more] manageable" (Archer 2012). Thus, most of the treatment options, save for possibly outpatient counseling, would be inappropriate for those who use this drug. More than half of the states in this country have fully legalized marijuana, so it has become archaic to be behind this curve. Thousands of Mississippians have been, and currently are, incarcerated for the possession of marijuana, with Black people being arrested at a rate nearly four times that of white people (ACLU 2013). This is all despite the general national opinion that it is not a dangerous substance (Daniller 2019).

Although halting incarceration for simple possession offenders is a massive step in the right direction, I believe that positive change is far more likely if the public is better educated on the dangers of substance abuse and addiction. In my interviews, I discovered that many people who deal with this issue are constantly confronted with people who believe that addiction is a choice rather than a disease. I believe educational measures will help alter this faulty perception, as well as create a more accurate, cohesive attitude towards public health and how to achieve it.

Currently, Mississippi requires that public school students take a health class for the length of one semester. I recommend that a comprehensive substance abuse and addiction module be added to this class in order for young adults to be made more aware of the dangers of these things before they enter either college or the professional world.

Before this, though, I think it's necessary to utilize the impressionable minds of elementary and middle school-aged youth through monthly assemblies in each public school in the state. Obviously, the language and specificity of the issues will be altered depending on the maturity of mind to which they are being relayed.

Removing the stigma behind mental health is also a critical part of positive change. In order to encourage Mississippians to acknowledge their mental health and to seek support when they need it, I also recommend that there be a mental health awareness curriculum in every public school. Both young people and adults struggle with mental health at some point. Raising awareness on these issues and the resources that are available, while people are still young, is likely to reduce the widely-accepted stigma behind mental health in Mississippi. Helping people to understand that asking for help is not only acceptable, but encouraged, is an important step towards preventing self-medication and creating a healthier populace.

The results will not be immediate, and there will certainly be shortcomings to this approach. But, I believe that over time, the attitudes towards people who struggle with addiction will improve, and people who use drugs will not be treated as second-class citizens, but rather as someone with a disease. All of these things would be goals, with a byproduct of improving societal health.

A major concern for people when discussing any state-funded social welfare programs is access to funding. No one wants their taxes raised, especially in Mississippi. To the question of how this policy recommendation could be financially feasible, I respond with one primary answer: Every dollar that was formerly being dedicated to housing simple possession offenders in prison should go towards the funding of

rehabilitation programs. The criminalization of narcotics costs the state and its taxpayers millions of dollars each year, and this would contribute a substantial portion of the resources needed for treatment. For reference, the table below shows the cost per inmate per day in Mississippi's prisons, as of 2018:

Allocated Costs	
Parole Board	$ 0.10
Operating Costs of the Unit	
Security personnel	22.43
Nonsecurity personnel	7.58
Other costs	
Food	2.89
Medical	10.28
Utilities	2.67
Subtotal: Operating Costs	*$45.85*
Other Costs*	
All Other Costs	7.77
Total Per Day Cost	**$53.72**

Table 7: Cost per Inmate via Peer Committee (2018)

$53.72 per day amounts to around $19,600 per inmate each year. With the average simple possession offender population of 1,380 over the last 10 years, around $27,000,000 would be saved each year through the halting of incarceration for simple possession. If allocated to Mississippi's DMH, this amount would increase their 2020 general operating budget of around $213,000,000 by over 12.5% (Mikula 2020). Any remaining money that needs to be dedicated towards these programs should be discussed

by the Legislative Budgetary Committee. Reducing the stigma involves raising the budgets for mental health services, rather than senselessly slashing them.

Understandably, people will forever seek to raise their dopamine levels in order to feel normal, and many will continue to use addictive narcotics to do so. But, I believe that punitive measures should not be taken against people who are trying to feel better and only harming themselves in the process. If rehabilitation becomes the new standard, and if people are properly educated on the reality of addiction, public health and safety will increase. Our current system of incarceration for simple possession offenders is inadequate and inhumane, and I advocate that the State of Mississippi does something dramatic to fix it.

List of References

ACLU. (2013, June). *Report: The war on marijuana in black and white*. American Civil Liberties Union. Retrieved November 9, 2021, from https://www.aclu.org/report/report-war-marijuana-black-and-white.

Archer, D. (2012, May 5). *Is marijuana addictive?* Psychology Today. Retrieved November 8, 2021, from https://www.psychologytoday.com/us/blog/reading-between-the-headlines/201205/is-marijuana-addictive.

ASAM Board of Directors. (2019, September 15). *American Society of Addiction Medicine*. ASAM Definition of Addiction. Retrieved October 22, 2021, from https://www.asam.org/Quality-Science/definition-of-addiction.

Assistant Attorney General Perez, T. E. (2011, December 22). United States' Investigation of the State of Mississippi's Service System for Persons with Mental Illness and Developmental Disabilities. *U.S. Department of Justice: Civil Rights Division*. Retrieved from https://www.justice.gov/sites/default/files/crt/legacy/2012/01/26/miss_findletter_12-22-11.pdf.

Burris, M. W. (2011). Mississippi and the School-to-Prison Pipeline. *Widener Journal of Law, Economics & Race, 3*(1). https://doi.org/http://www.antoniocasella.eu/restorative/Burris_2011.pdf

CAUSE NO. 3:16-CV-622-CWR-FKB (THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF MISSISSIPPI NORTHERN DIVISION July 14, 2021). Retrieved from https://www.mississippifreepress.org/wp-content/uploads/2021/07/273-Courts-order-on-remedies.pdf.

Crossroads Ministries. CrossRoads Ministries – About Us. (2018). Retrieved October 23, 2021, from http://www.crossroadsms.org/about-us.html.

Daniller, A. (2019, November 14). *Two-thirds of Americans support marijuana legalization*. Pew Research Center. Retrieved November 9, 2021, from https://www.pewresearch.org/fact-tank/2019/11/14/americans-support-marijuana-legalization/.

DeGruy, A. (2021, August 3). Personal communication. [Zoom meeting].

DPA. (2017, July). *It's Time for the U.S. to Decriminalize Drug Use and Possession*. Drug Policy Alliance Report. Retrieved November 1, 2021, from https://drugpolicy.org/sites/default/files/documents/Drug_Policy_Alliance_Time_to_Decriminalize_Report_July_2017.pdf.

Harrison, B., & Ganucheau, A. (2021, May 10). *Sen. Hyde-Smith's perceived ineffectiveness in Washington comes into focus in final days of Senate race*. Mississippi Today. Retrieved October 27, 2021, from https://mississippitoday.org/2020/10/30/sen-hyde-smiths-perceived-ineffectiveness-in-washington-comes-into-focus-in-final-days-of-senate-race/.

History.com Editors. (2017, May 31). *War on Drugs*. History.com. Retrieved October 9, 2021, from https://www.history.com/topics/crime/the-war-on-drugs.

Howorth, A. (2021, October 6). Personal communication. [Personal interview].

Judin, N. (2021, July 16). *'Trust, But Verify': Judge Orders Monitor for State Mental Health System, Adopts Recommendations 'In Full.'* Mississippi Center for Investigative Reporting. Retrieved November 7, 2021, from

https://www.mississippicir.org/news/trust-but-verify-judge-orders-monitor-for-state-mental-health-system-adopts-recommendations-in-full.

Lynch, L., Long, M., & Moorhead, A. (2018). Young men, help-seeking, and mental health services: Exploring barriers and solutions. *American Journal of Men's Health*, *12*(1), 138–149. https://doi.org/10.1177/1557988315619469

McCutchen, J. (2021, October 7). Personal communication. [Personal interview].

MDOC. (2012). *Mississippi Department of Corrections Cost Per Inmate Per Day By Facility Type*. https://www.mdoc.ms.gov/Admin-Finance/OffenderCost/Cost_Per_Inmate_Day_FY_2012.pdf

MDOC. (2021). *Mississippi Department of Corrections Custody Population by Specific Primary Offense Impacted by HB 585 For Report Period*. MDOC Public Records Request.

Meynardie, J. (2021, August 13). Personal communication. [Phone].

Mikula, D. S. (2020). *Mississippi Department of Mental Health Annual Report FY20*. Retrieved November 9, 2021, from http://www.dmh.ms.gov/wp-content/uploads/2020/11/DMH-FY20-Annual-Report-Reduced-Size.pdf.

Mississippi Department of Corrections. (2020). *Mississippi Department of Corrections FY 2020 Annual Report*. MDOC.gov. Retrieved from https://www.mdoc.ms.gov/Admin-Finance/Documents/2020%20Annual%20Report.pdf.

Nelson, M. (2020, July 1). *A First Step in Mississippi Toward Sentencing Reform and Fewer People in Prison*. Vera Institute of Justice. Retrieved October 17, 2021, from

https://www.vera.org/blog/a-first-step-in-mississippi-toward-sentencing-reform-and-fewer-people-in-prison.

Niklas. (2021, August 29). *List of common items that weigh 1 gram*. Weight of Stuff. Retrieved November 7, 2021, from https://weightofstuff.com/list-of-common-items-that-weigh-1-gram/.

Nobiling, B. D., & Maykrantz, S. A. (2017). Exploring perceptions about and behaviors related to mental illness and mental health service utilization among college students using the Health Belief Model (HBM). *American Journal of Health Education, 48*(5), 306–319. https://doi.org/10.1080/19325037.2017.1335628

Office of State Public Defender – Mississippi. (2018, September). *Overview of Racial Disparity in the Criminal Justice System*. Office of State Public Defender Reports. Retrieved from http://www.ospd.ms.gov/REPORTS/racial%20disparity%20update%202.pdf.

PEER Committee. (2018). *Mississippi Department of Corrections' FY 2018 Cost per Inmate Day*. Joint Legislative Committee on Performance Evaluation and Expenditure Review. Retrieved November 9, 2021, from https://www.peer.ms.gov/Reports/reports/631.pdf.

Prison policy Initiative. (2021). *Mississippi Profile*. Mississippi profile | Prison Policy Initiative. Retrieved October 9, 2021, from https://www.prisonpolicy.org/profiles/MS.html.

Reimer, M. K. (2016, September). *Weighing the Charges: Simple Possession of Drugs in the Federal Criminal Justice System*. United States Sentencing Commission.

Retrieved 2021, from https://www.ussc.gov/sites/default/files/pdf/research-and-publications/research-publications/2016/201609_Simple-Possession.pdf.

Ross, L. (2021, August 3). Personal communication. [Phone].

Salter, S. (2019, December 11). *Mississippi may be coming full circle on state's unwise corrections, judicial policies*. Clarion Ledger. Retrieved November 1, 2021, from https://www.clarionledger.com/story/opinion/columnists/2019/12/11/mississippi-corrections-policy-coming-full-circle/4384872002/.

Smith, S. (2017, December 28). *Doing Less with Less: Mental Health Care in Mississippi*. ProPublica. Retrieved November 9, 2021, from https://features.propublica.org/tyler-haire-mississippi/mental-health-care-in-mississippi/.

Starrett, K. (2021, September 8). Personal communication [Zoom meeting].

State of Mississippi Judiciary. (2021). *Intervention Court*. Intervention Courts - State of Mississippi Judiciary. Retrieved October 9, 2021, from https://courts.ms.gov/trialcourts/interventioncourts/interventioncourt.php.

Steiner, M. (2013, April 8). *Possession of a controlled substance in Mississippi*. www.criminaldefenselawyer.com. Retrieved October 12, 2021, from https://www.criminaldefenselawyer.com/resources/criminal-defense/drug-charges/mississippi-drug-possession-laws#:~:text=Schedule%20I%20and%20II%20substances&text=If%20charged%20as%20a%20misdemeanor,Code%20Ann.

Stribling, W. (2021, October 6). *State appeals judge's ruling to Reform Mental Health System*. Mississippi Today. Retrieved November 7, 2021, from

https://mississippitoday.org/2021/10/06/state-appeals-judges-ruling-to-reform-mental-health-system/.

Summers, Z. (2018, September 5). *ACLU of Mississippi releases blueprint with roadmap for cutting incarceration by 50 percent*. ACLU of Mississippi. Retrieved October 12, 2021, from https://www.aclu-ms.org/en/press-releases/aclu-mississippi-releases-blueprint-roadmap-cutting-incarceration-50-percent.

Trosclair, C. (2021, October 13). Personal communication [Phone].

U.S. DoJ. (2016, August 11). *Justice Department sues Mississippi for discriminating against adults with mental illness*. The United States Department of Justice. Retrieved November 9, 2021, from https://www.justice.gov/opa/pr/justice-department-sues-mississippi-discriminating-against-adults-mental-illness.

Viana, A. G., Trent, L., Tull, M. T., Heiden, L., Damon, J. D., Hight, T. L., & Young, J. (2012). Non-medical use of prescription drugs among Mississippi youth: Constitutional, psychological, and family factors. *Addictive Behaviors*, *37*(12), 1382–1388. https://doi.org/10.1016/j.addbeh.2012.06.017

Widra, E., & Herring, T. (2021, September). *States of incarceration: The global context 2021*. Prison Policy Initiative. Retrieved November 1, 2021, from https://www.prisonpolicy.org/global/2021.html.

Willingham, L. (2021, September 27). *State asks to delay order that it create mental health plan*. AP NEWS. Retrieved November 9, 2021, from https://apnews.com/article/business-health-courts-mississippi-mental-health-badad4cfb4a67224bd00366ab3d26d4c.

Wood, P. B., & Dunaway, R. G. (2003). Consequences of Truth-in-Sentencing: The Mississippi Case. Punishment & Society, 5(2), 139–154. https://doi.org/10.1177/146247450352001