LG inc.
Since 1974

Rethinking Classification

A Comprehensive Approach to Creating A New Classification Culture in the Massachusetts Department of Correction

James Keown
June 2024

Lifers' Group Inc. // Assist | Advocate | Inform

PO Box 43
Norfolk, MA 02056

@LifersGroupMCINorfolk

Rethinking Classification

James Keown

Contents

Rethinking Classification 1

Rethinking the Classification Process 2

Rethinking Facilities 3

Suggestion 1: Classification and Parole Board staff should collaborate with all residents as the law requires. 4

Rethinking Substance Use Treatment 5

Suggestion 2: Establish a Collaborative Substance Use Treatment Plan 5

Suggestion 3: Covert a DOC facility to Serve as a Dedicated Substance Use Treatment Center 6

Rethinking Housing 6

Suggestion 4: The DOC should establish a primary rehabilitation mission for each facility. 7

Suggestion 5: The DOC should develop more housing units organized around rehabilitative opportunities and special populations. 8

Rethinking Policing Inside Facilities 9

Suggestion 6: The DOC should adopt the "California Model" of officer engagement by transitioning unit officers to unit managers (UM). 10

Suggestion 7: The DOC should maintain a police force, not a police state. 11

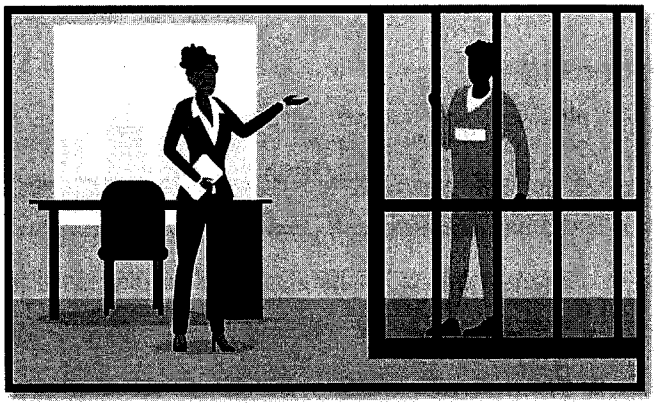
Rethinking Access to Minimums 11

Suggestion 8: Establish a cadre-like program that allows low risk lifers the opportunity to live and work at minimum security facilities. 12

Conclusion 12

Closing Notes 13

Rethinking Classification



The Massachusetts Department of Correction's classification process is the central element of the rehabilitation continuum. How an incarcerated person is classified determines where that person will be housed, what programming that person should engage in, and how that person will be viewed as a future risk. The classification process includes input from select staff, the use of standardized assessments, and the use of commercial software. Out of the process, each incarcerated resident is assigned an **Object Point Base Score (OPBS)** that determines the resident's security level and is provided a **Personalized Program Plan (PPP)** that recommends rehabilitative programming the resident should complete.

Much of the classification process occurs with little or no input from the individual who is being classified and with limited input from the people who are most involved with the individual's rehabilitation, such as educators and volunteers. Residents typically meet with a **Correctional Program Officer (CPO)** once a year in the days preceding a reclassification hearing to review the resident's current PPP. The CPO inquires at this meeting if the resident wishes to have any additional programming added to their PPP. Other than this annual review, residents have almost no agency during the classification process.

In contrast, a significant amount of the classification process is governed by the COMPAS software application.[1] COMPAS uses screening questions and evaluative factors, such as age, to generate scores on risk and recidivism. The application, however, is a *black box* even to staff that use the tool because the algorithms driving the software's decision making are known only to the private vendor.

Much of the classification process occurs with little or no input from the individual who is being classified and with limited input from the people who are most involved with the individual's rehabilitation, such as educators and volunteers.

Since 1995, the DOC has also utilized the OPBS to determine a resident's custody assignment.[2] The OPBS mixes both static data, such as 'Severity of Current Offense,' and fluid data, such as 'Age,' to generate a classification score.[3] The objective score can be overridden by classification staff using one of many **override codes**. Some of these codes are mandatory, such as 'Code E' – which prevents those

[1] COMPAS is an application developed by Northpointe, Inc. At the time of this paper, Massachusetts DOC uses Northpointe Suite version 8.19.2.14632.

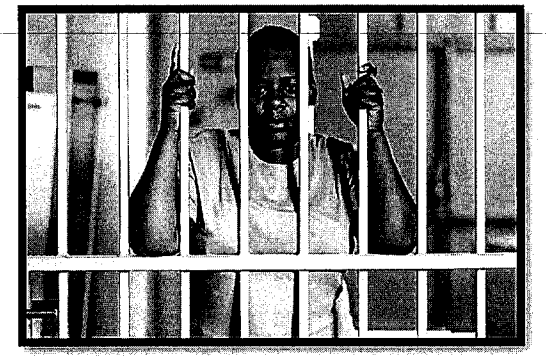
[2] *Massachusetts Object Point Base Classification Manual,* Massachusetts Department of Correction, November 2019.

[3] Ibid.

serving Life Without Parole from being considered for placement at minimum security regardless of their documented risk level. Others are far more subjective, such as 'Code R,' which allows a score to be overridden because "[t]he facts or notoriety of the offense presents a seriousness that cannot be captured in the score."[4] While residents are typically made aware of mandatory overrides at their initial classification hearing and annual reclassification hearings,[5] subjective overrides are regularly made after hearings by either institutional classification staff or reviewing staff at DOC headquarters without any explanation.

The lack of agency and transparency in the classification process invites an attitude of distrust from the population who the process is most supposed to benefit, which complicates the rehabilitative continuum.

Rethinking the Classification Process



The challenges facing the present classification process are amplified by the department's silo approach to rehabilitation that prohibits a seamless classification strategy that engages residents continuously from day one of incarceration through successful transition to the free world. For example, at the institutional level, education (which reports to one director in the DOC), self-help programs (which report to a different director), and substance use programming (which is managed by a private vendor) all function mostly independent of one another. There are few systems in place, other than the department's **Inmate Management System (IMS)**[6], to connect these resources to help manage a resident's rehabilitation. Instead, residents must deal with each program independently, which easily leads to confusion and frustration for both residents and programming staff as programs sometimes work at cross purposes.

The current process is also complicated by the DOC's **over-investment in security staff**, who do not see themselves as part of the rehabilitation process,[7] and **under-investment in traditional rehabilitation staff**, such as CPOs, educators, mental health clinicians, and social workers.

The lack of agency and transparency in the classification process invites an attitude of distrust from the population who the process is most supposed to benefit, which complicates the rehabilitative continuum.

[4] Ibid.

[5] Residents not being reviewed for transfer often don't receive formal reclassification hearings, so notice of the mandatory overrides is usually made during the meeting between the CPO and resident to review the PPP.

[6] The IMS is the DOC's database system that tracks each resident's relevant data. The system is used by all staff, but access to data is restricted based on a particular staff member's clearance. Volunteers have no access to IMS. For education and programming, there does not appear to be any section where individualized notes on a resident's progress can be recorded.

[7] Notes from 2019 meeting with Massachusetts Correctional Officers Federated Union (MCOFU) leadership at MCI Norfolk.

Rethinking the classification process starts by thinking about how best to serve each resident so that they have a rehabilitation plan they are invested in. This involves understanding what currently is motivating a resident (e.g., desire to earn good time, desire to be prepared for parole, desire to be more employable, etc.) It also involves recognizing that a person's motivation is likely to shift over time, especially as a person ages and grows through rehabilitative programs. Next, the department should educate a resident on how particular programming connects to a resident's motivations and on how it increases the resident's chances for success. Then, staff should conduct consistent and regular check-ins to evaluate a resident's progress. This allows the annual reclassification hearing to be part of an ongoing conversation rather than a once a year administrative procedure.

To achieve this goal, classification must be integrated into the daily life of every incarcerated person. This requires the reimagining of the department's physical facilities, staffing matrices, and resources. It also demands a cultural shift that places the individual at the center of the classification process and promotes the individual's agency and buy-in throughout. **Rehabilitation must shift from being something the state attempts to do to a person to being a collaborative process the state engages with the incarcerated person in developing and managing.**

Rethinking Facilities

With the exception of a handful of specialized facilities and units,[8] DOC facilities are divided by security level. As of July 1, 2024 the department will operate one mixed maximum/medium security, four medium security, and three minimum security facilities for men; and one mixed maximum/medium/minimum for women.[9]

Newly incarcerated men enter the DOC at maximum/medium security Souza Baranowski Correctional Center (SBCC), while women enter the system at MCI-Framingham (MCIF).

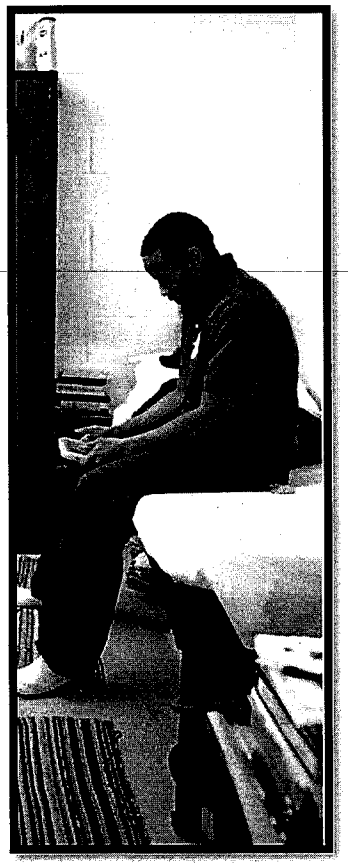
[8] The specialized facilities/units are: Massachusetts Treatment Center (a medium security facility for those charged with sex offenses and those civilly committed under MGL c. 123A), Old Colony Correctional Center (primarily for those diagnosed with more advanced mental health challenges), Lemuel Shattuck Hospital (Eight North Unit), Massachusetts Alcohol and Substance Abuse Center (for those not sentenced but committed by a court under MGL c. 123 Section 35), and Bridgewater State Hospital (for those civilly committed, both sentenced and not sentenced, under MGL c. 123, and those detained for competency and responsibility evaluations by the court).

[9] This paper assumes the pending closing of MCI Concord set for June 2024.

Rethinking Classification

Classification staff assigned to SBCC's and MCIF's **Reception Center Units** perform the initial classification for all new residents. If approved for lower security after the initial classification process[10] is complete – which can take several weeks –male residents are transferred to another DOC facility, while women are generally transferred to a lower security unit at MCI Framingham.

The **2018 Criminal Justice Reform Act** amended the statute governing classification to guarantee that the reentry process begins at the point of intake at the Reception Centers. Under the law, DOC and the **Parole Board** are required to work together to establish a path toward parole for every parole eligible individual.[11] Based on the written comments of the Parole Board and statements from CPO and institutional parole staff, this is not currently happening. Instead, many residents are receiving no guidance from parole until their first parole hearing – sometimes more than a decade after they enter the DOC. Parole decisions regularly feature requests from the Parole Board for individuals to complete programming that was not part of their PPP. Sometimes, the programming the Parole Board recommends is not even offered at the facility housing the resident.



Suggestion 1: Classification and Parole Board staff should collaborate with all residents as the law requires.

It is critical that residents be able to work with both classification and parole staff to create and manage an effective PPP. In addition to the general orientation provided at the Reception Centers, the DOC should provide a detailed guided orientation class on the Orijin tablet that introduces all of the programs and resources offered by the department.[12] Following the orientation class, the resident should meet again with staff to develop a comprehensive rehabilitation plan that takes into account substance use needs, medical needs, desire for academic or vocational education, and the need for supplemental programming – such as 'Anger Management' or 'Sex Offender Treatment.'

The plan should include both short-term and long-term goals and should be memorialized in a document that maps the resident's rehabilitation path. Each year, classification and parole staff should review the resident's progress (also required by law) and work with the resident to update goals and the map.

---

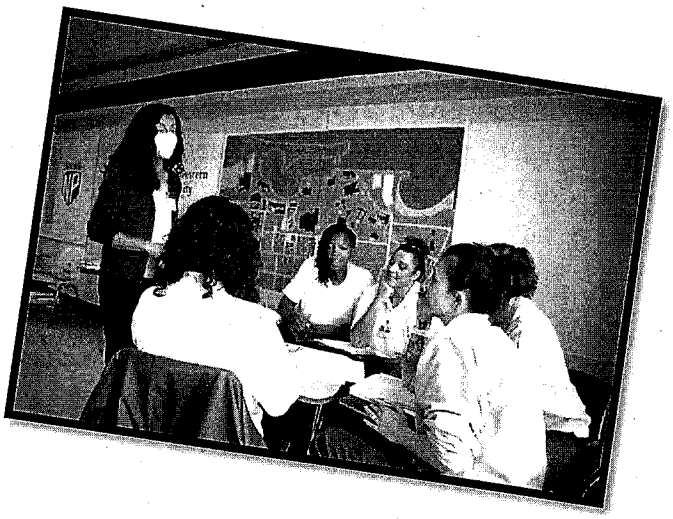
[10] An exception to this process is that any male resident serving the sentence of Life Without Parole must spend at least one year at SBCC.

[11] MGL c. 124 § 1 (g): "determine at the time of commitment, and from time to time thereafter, the custody requirements and, **after consultation with the parole board,** program needs of each person committed to the custody of the department and assign or transfer such persons to appropriate facilities and programs." (emphasis reflects 2018 Criminal Justice Reform Act amendment.)

[12] Orijin (formerly APDS) is a private vendor the DOC uses to provide a free education/programming tablet to all residents. The tablet currently has a document listing all programs, but it has limited information about the programs and how a resident will benefit from each offering. Residents must rely on word-of-mouth from other residents to learn which programs may be best suited for their rehabilitation.

Rethinking Substance Use Treatment

New residents are also evaluated for substance use issues at both Reception Centers. Some residents are prescribed specialized treatments, such as **Medicated Assisted Treatment (MAT)**. Those diagnosed with some level of substance use challenge will eventually be enrolled in the **Correctional Recovery Academy (CRA)**. CRA is an intensive substance use program run by Spectrum, a private vendor that contracts with the DOC. CRA bills itself as a 'therapeutic community,' but Spectrum's programming operates on a behavior modification model (which most recovery programs find to be ineffective). The program operates at most department facilities and requires participants to live together in a unit(s) that simulate an inpatient therapeutic community for at least six-months while they attend daily meetings and classes.



The current operational structure of CRA poses two challenges to the classification process. First, CRA participants are considered part of the general population of the facility where they live. While participants live together, they intermingle with people not in CRA any time they leave their unit. This prevents CRA from replicating the successful 'intensive healing community' models used outside of prisons that allow a person to seek treatment away from their normal community. Because of this, CRA is seen by many residents and staff as a prison program, not treatment for a medical/mental health issue. This stigma mitigates any effectiveness the treatment might have for many residents.

Second, residents often do not enter CRA until their sentence is well underway. Some do not engage with CRA until they are near their parole eligibility date. This shifts substance use treatment from providing the foundational assistance a person needs to rehabilitate and live outside prison successfully to merely an opportunity to maximize good time to reduce a sentence while ticking off a checkbox for parole.

Suggestion 2: Establish a Collaborative Substance Use Treatment Plan

Any person with a substance use disorder should be able to engage with treatment services to address their condition from day one in the DOC. This should include classification and parole encouraging qualifying residents to enter an intensive treatment program immediately following a proper medical and mental health evaluation. Classification, parole, medical, mental health, and the resident should collaborate to develop a treatment plan that is reviewed and updated every six months.

> ***Treatment should be the first stop...***

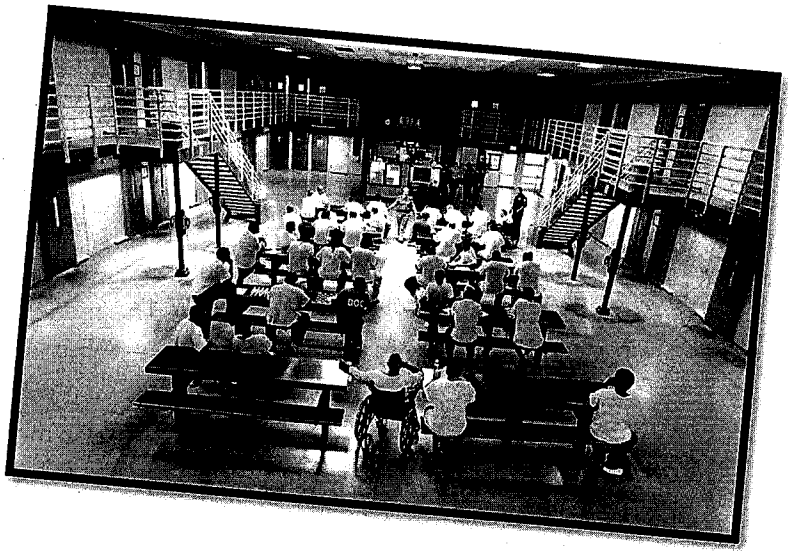
Suggestion 3: Convert a DOC facility to Serve as a Dedicated Substance Use Treatment Center

The department should have a dedicated **Substance Use Treatment Center** for sentenced residents that concentrates programming on a single campus, rather than running programs across the system. This facility should feel like a treatment center, not a prison, and should operate on a proven therapeutic model (such as Recovery Centers of America on the outside). The Substance Use Treatment Center should be the first stop after the Reception Center for any person with a serious substance use problem. It should also be a facility where residents who relapse can go for additional treatment. The Substance Use Treatment Center should not be a punishment. It should operate as a place where residents want to go to heal.

After a resident successfully completes treatment, classification and parole staff should meet with the resident to review the resident's goals and rehabilitation map. The clarity of sobriety often has a significant impact on an individual's ability to set positive goals. The tools residents acquire through treatment also often shift their motivations. These important changes need to be acknowledged and reflected in a resident's plan before they are transferred from the Substance Use Treatment Center.

Rethinking Housing

Massachusetts has traditionally promoted the importance of static housing. In other words, a person remains at the facility they are classified to until their point level allows for movement to lower security, their point level requires movement to higher security, or a security issue requires a lateral move to another facility of the same security level. The department rarely approves lateral moves requested by residents unless an extraordinary compelling need exists. Typically, access to a particular program does not qualify as a compelling need.



Over the past decade, the DOC has attempted to homogenize the rehabilitative programming menu across all medium security facilities (where most residents are classified to be housed). The department's goal appears to be to offer the same programs at every institution as much as possible. The reality is, however, that it is impossible to make every facility the same. For example, MCI Norfolk was built in a unique style in an effort to promote certain types of programs. The institution's housing units, large auditorium space, and expansive industries infrastructure is not replicated in any other facility in the state. These design features lend themselves to opportunities at MCI Norfolk that cannot be easily replicated at other medium security institutions without significant capital investment. The day-to-day operations inside the facilities also function very differently – even among facilities with the same security level. For example, MCI-Shirley is managed as a highly segregated facility that

discourages individuals in different housing units from comingling except in certain programs. Residents have little say in how the facility functions other than a handful of resident-run programs. In contrast, MCI-Norfolk allows for much more freedom of movement and has a self-governance body called the Norfolk Inmate Council that helps facilitate many activities at the facility.

Rather than ignore the diversity of physical spaces across the DOC, the department should leverage these differences to develop unique rehabilitation spaces. If one facility has a structure more suited for vocational education, center those opportunities there. Likewise, if one facility is better suited for traditional education, center those resources there. The rub is that the department must then allow residents the ability to transfer from one facility to another as long as a security issue does not foreclose such a move.

In addition, the department should look to expand resident agency in facility operations. The 'Council' model at MCI Norfolk should be replicated across the system. Representatives from each facility should be able to use technology, such as Zoom, to meet regularly to discuss issues that affect all incarcerated people and to collaborate on solutions.

Rather than ignore the diversity of spaces across the DOC, the department should leverage these differences to develop unique rehabilitation spaces.

Suggestion 4: The DOC should establish a primary rehabilitation mission for each facility.
Each department facility should have a primary rehabilitative mission, such as vocational training or academic education. The DOC should organize the operation of each facility around its mission. This means establishing housing units that support the institution's mission, such as the Living Learning Unit at MCI Shirley that houses many of the residents engaged with post-secondary education. It also means providing residents access to specialized resources, such as laptop computers or vocational institutional work assignments.

Part of the classification process should include mapping out a resident's housing plan as they advance through their rehabilitative program. As part of this process, all programs should be open to all residents to apply to regardless of where they are presently housed. For example, a resident at North Central Correctional Institution (NCCI) in Gardner may wish to attend Boston College at MCI Shirley. Similarly, a person serving a lengthy sentence at MCI Shirley may have completed much of the programming available there and wish to enroll in the welding programming or work in the Metal Shop in Industries at MCI Norfolk. A person's current housing should not prevent them from benefitting from a DOC program.

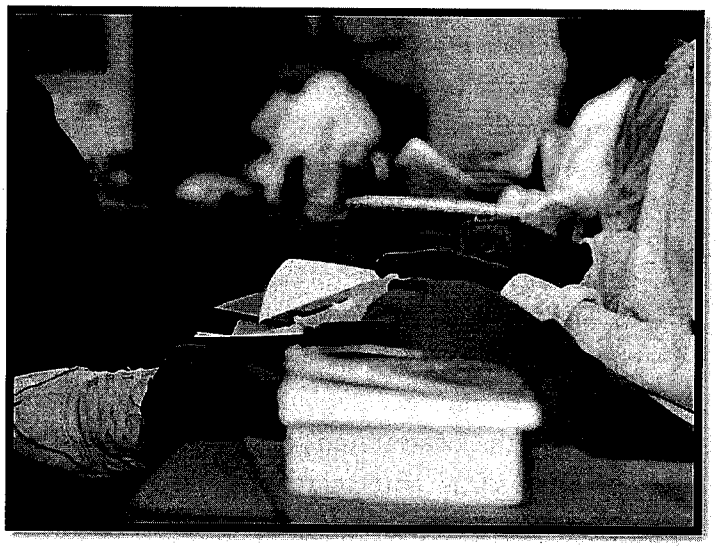
Housing is an often overlooked element of a person's rehabilitation. The unit a person lives in has a tremendous influence on a person's actions. Staff and residents at almost any facility can quickly

identify which units are considered the more troublesome or the more relaxed. This range of good units to bad units seems to be accepted as inevitable in the DOC. Rather than attempt to restructure the culture, housing staff often use a particular unit's reputation to determine who should be placed in the unit. People seen a troublesome are often sent to units seen as troublesome. People seen as relaxed are often sent to units seen as relaxed. This biased housing policy only reinforces an already dysfunctional culture.

The declining population across the system offers the DOC an opportunity to create new housing practices that seek to incentivize program participation and positive behavior.

Suggestion 5: The DOC should develop more housing units organized around rehabilitative opportunities and special populations.

The longest running alternative housing unit in the DOC is the **'Lifers House' (Unit 2-2) at MCI Norfolk**. This unit opened in the 1980s for those serving life sentences. One motivation for providing alternative housing for this special population was the realization by the department that those serving longer sentences, such as life, generally pose fewer security problems, work many key institutional jobs, facilitate many of the self-help groups, and generally provide a sense of stability to an institution. The 'Lifers House' was originally developed to support these individuals by offering access to resources and activities not available in other units. Residents had to apply to live in the 'Lifers House' and admission came with an expectation to live according to guidelines unique to the unit. While Unit 2-2 is still called the 'Lifers House' at MCI Norfolk, it has lost most of the features that set it apart. In fact, there are people placed in the unit who are serving short sentences simply because Unit 2-2 had an open bed when it came time to move a person.



By contrast, the DOC opened the **Building Responsible Adults Through Validation and Education unit (BRAVE)** at MCI Concord in 2021 "to support incarcerated emerging adult men, some of whom are fathers, by creating an opportunity to have a positive experience while incarcerated that will benefit their familial relationships and communities."[13] Within this unit (developed using a grant from the US Department of Justice), the department offers specialized programming, visits, and recreational activities designed to support this special population. The BRAVE program has been a tremendous success and is often heralded by DOC officials, state leaders, and prisoner rights advocates. Unfortunately, high profile programs like BRAVE and the DOC's School of Reentry as Boston Pre-Release reach only a miniscule portion of the department's population (approximately 0.0125%).

[13] *Massachusetts Department of Correction Program Description Booklet*, April 2024.

More recently, MCI Shirley opened a **Living Learning Unit (LLU)**[14]. In the almost year since the unit opened, the LLU has yet to meet the expectations set by DOC officials in 2023 when they announced plans to create a specialized living space dedicated to education. The biggest hurdle has been a dominant culture among the correctional officers at MCI Shirley who disagree with the DOC mission to offer higher education to incarcerated people. This toxic culture infected the rollout of the unit almost from day one when officers began writing disciplinary reports for individuals engaging in activities that they had been told were allowed, such as accessing the fenced-in space outside the unit. When men gathered in the unit's recreation space for a small Restorative Justice circle, officers reported the activity as a potential Security Threat Group. In April 2024, the DOC began converting cells that had been single cells in the unit to double cells, a move that further retreated from the original vision for the LLU.

Building on the success of the BRAVE unit and learning from the lessons of the LLU and 'Lifers House,' the DOC should develop as many specialized units as possible within each facility based on a facility's rehabilitation mission. This could include restoring units dedicated to lifers and long-termers that provide the resources they once did, creating units for elderly residents, establishing vocational training units, developing veterans' units, and more.

There will certainly be people who may choose at first to ignore rehabilitation opportunities in lieu of general recreation or "doing their bid." Units for these people should be created not to punish them but to educate and encourage them to participate in rehabilitation programs.

Rethinking Policing Inside Facilities

As previously highlighted, most uniform staff do not currently see themselves as part of the rehabilitation process. These officers see their role as security alone. But they do not see the link between security and rehabilitation. For some officers, this disconnect is frustrating. California correctional union boss Steve Durham is one such officer. Officer Durham notes, "[c]orrections officers... are literally sick and tired from being cogs in a machine that doesn't work, for incarcerated persons, or for guards who want a career that doesn't kill them."[15]

California has begun transitioning San Quentin Prison and seven other state prisons into rehabilitation facilities designed on the Norway incarceration model. This model promotes, among other things, "interpersonal relationship between officers and residents."[16] One way this is achieved is by requiring officers to participate in rehabilitative programming with residents, "which creates mutual respect and trust with the incarcerated population."[17] Another way this is achieved is by shifting the roles of housing unit officers from enforcement to assistance. Officer Durham, who visited with officers in Norway

[14] MCI Shirley opened a second LLU in June 2024 to house Tufts University students who were transferred from MCI Concord due to that institution closing. The unit also houses Industries workers.
[15] "Union Boss Backs California Model." *San Quentin News*, January 2024.
[16] Ibid.
[17] Ibid.

notes, "the attitudes and mindset of Norwegian officers appeared not only healthier, but in terms of interaction between residents and officers, far more casual."[18]

The California officers' union, who once opposed the transition of San Quentin, now sees how the model benefits officers. The union proudly calls it the "California Model."[19] "It comes down to the mental health and well-being of our staff," Officer Durham says. He adds that U.S. officers have to gain the trust of the incarcerated population to act as their mentors. "We have to try to change."

Suggestion 6: The DOC should adopt the "California Model" of officer engagement by transitioning unit officers to unit managers (UM).
UMs can come from the ranks of the DOC security staff, but they should not wear uniforms. UMs should also actively engage with the unit's population. A unit UM should be the first contact a resident reaches out to with a problem or question. Likewise, the UM should recognize when a resident might be experiencing difficulty and either reach out to the resident directly or ask another staff member, such as mental health, to do so.

The *California Model* requires much more than new polo shirts for staff members. It requires the department to invest in ongoing training that demonstrates how the model benefits the staff member, how the model benefits the resident, and how the model improves public safety. The department also must provide UMs with the training and resources to identify and address potential issues in the unit that go beyond security.

When a person steps into a Massachusetts prison, she or he is surrounded by people in uniform. For outsiders, the visual can be jarring and reinforces the idea that prisons are spaces of oppression. For those on the inside, the uniforms all blend together to the point that it becomes impossible at times to see the individual wearing it. This disassociation contributes to the culture inside prison whereby the bad acts of one officer stain everyone else who wears the same uniform. Likewise, when a resident is caught in a conflict with a staff member, the uniform can trigger an outsized response from the resident because of their previous experiences with law enforcement.

[18] Ibid.
[19] Ibid.

Suggestion 7: The DOC should maintain a police force, not a police state.

Prison needs security in the same way communities need security. But that security force should feel small and steady, not all-encompassing. There is a place for uniformed officers to police institutions, respond to security incidents, investigate issues, and engage with the community. The primary job of inside security should be to create a holistic safe environment. Many incarcerated people, however, especially Black and Brown people, do not feel safe surrounded by officers in uniform. For many, a heavy officer presence triggers trauma and causes ongoing anxiety that makes it difficult for these individuals to advance in their rehabilitation. The idea of officers and their roles may seem far removed from classification, but the issue shows how intertwined these items are and how damaging it can be to work in silos. Reducing the presence of uniformed personnel inside facilities will help the department better meet its classification goal to "[p]romote successful reintegration to a law abiding and productive life."[20]

Many incarcerated people, however, especially Black and Brown people, do not feel safe surrounded by officers in uniform. For many, a heavy officer presence triggers trauma and causes ongoing anxiety that makes it difficult for these individuals to advance in their rehabilitation.

Rethinking Access to Minimums

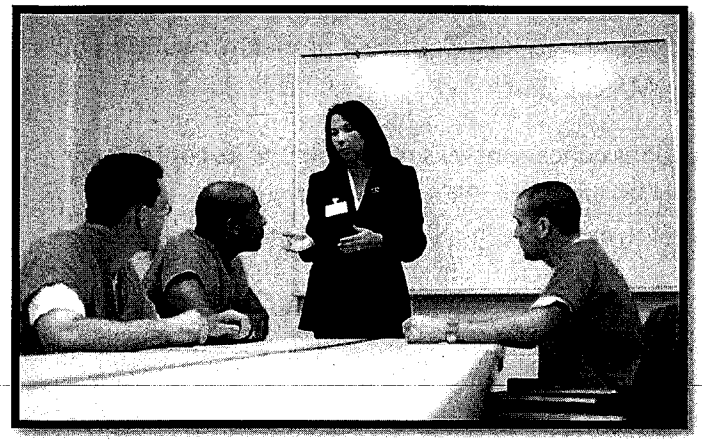
The DOC has long struggled to develop a comprehensive and consistent philosophy to operate minimum security facilities. Prior to the *tough-on-crime* movement, the DOC operated several minimum security facilities. Any resident, regardless of sentence, could work to qualify for placement at a minimum. For approximately 30 years, however, the department has steadily decreased the use of minimums and made it so fewer and fewer people can even qualify for minimum placement.

In recent years, the DOC has closed two minimum security facilities and shuttered Bay State Correction Center, which operated much like a minimum. In addition, as of January 2024, approximately half of the beds at the state's minimum security facilities were empty – a trend that has been seen for several years.

DOC houses many people at a security level that simply doesn't align with their documented risk level. There are hundreds of lifers who have been determined to be low risk by COMPAS. Many of these people have not had a disciplinary report for years, some for decades. Yet, classification uses overrides to prevent these people from going to lower security where they could serve as a consistent backbone workforce.

[20] 103 CMR 420.06 (c).

Also, the SJC's landmark *Mattis* decision, which abolished life without parole for everyone under the age of 21, meant that approximately 200 additional people qualify for review to be placed at minimum security.



Suggestion 8: Establish a cadre-like program that allows low risk lifers and long-termers the opportunity to live and work at minimum security facilities. Lifers and long-termers have a lot of skills they can offer the DOC at minimum security. These residents can work as tutors, program facilitators, mentors, cooks, and more. The move to a minimum and the additional freedoms it affords would be a just reward for any person who has proven their ability to be a better person. Such a program would also meet the classification goal to "[p]lace inmates in the level of security required to ensure protection of the public, correctional staff, themselves, and other inmates."[21]

Conclusion

Almost three decades ago, the DOC began moving away from subjective classification toward a model using an actuarial tool. The goal was to remove bias from the system and provide for a fair and equitable classification process. The emphasis on assessments and software, however, has inspired a process that lacks agency and humanity. The individual who should be front and center is replaced by data. The person is boiled down to one number and a few recommendations once a year.

While the current process has eliminated some bias, it has added others. Many people see their classification score overridden because of the crime they were convicted of – a static fact that can never change no matter how long the person is incarcerated or how much they engage in programming. All people in the DOC are also marked permanently by their assessment for risk, which is conducted during intake and never updated. Factors like this allow data to be used to create a false impression of a person that hides systemic biases.

The incarcerated person must be the primary focus for the classification process. The resident must have agency during the process. There must be transparency throughout the process. And, classification must be integrated into all elements of the incarceration continuum.

Rethinking Classification begins by rethinking the culture of classification and then by examining all areas in the DOC touched by classification. As states like California are demonstrating, it is possible to create a system that inspires rehabilitation, rather than imposes rehabilitation.

[21] 103 CMR 420.06 (b).

If Massachusetts can build an enhanced and integrated classification system based on the provided suggestions, it will improve the lives of incarcerated people, department staff, and the general public. Most of all, it will contribute to public safety.

Closing Notes

This report may be copied, distributed or used by the reader as long as there is proper attribution, i.e., Lifer's Group Inc., MCI-Norfolk, PO Box 43, Norfolk, MA 02056.

Any comments, corrections, criticisms and/or questions concerning this report, any of its contents, or any other reports published by the Lifer's Group Inc. are welcome. Please direct all such communications, as well as any request for copies of this or any other Lifer's Group Inc. report to:

Gordon Haas
Chairman
Lifer's Group Inc.
MCI-Norfolk
PO Box 43
Norfolk, MA 02056

Lifer's Group Inc. reports on DOC Institutional Fact Cards, on DOC Expenditures and Staffing Levels, including Employee Expenses, Inmate Program Expenses, Inmate Medical Costs and annual average cost per prisoner, as well as on the three Central Office Accounts – Central Inmate Benefit Fund, Central Law Library Fund and Central Program Account. These reports are available at: realcostofprisons.org/writing or on Facebook @LifersGroupMCINorfolk.

We, the Lifer's Group Inc. Board of Directors and membership, continue to express our deepest appreciation and gratitude to Ms. Lois Ahrens, Founding Director of the Real Cost of Prisons Project for her untiring work for prison reform and her posting of our reports on her website: www.realcostofprisons.org/writing.

Notes

LG inc.
Since 1974

Lifers' Group Inc. // Assist | Advocate | Inform

PO Box 43
Norfolk, MA 02056

@LifersGroupMCINorfolk