



The Illinois Consortium on Drug Policy

Intersecting Voices:
Impacts of Illinois' Drug Policies

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ILLINOIS CONSORTIUM ON DRUG POLICY

The Illinois Consortium on Drug Policy is comprised of non-profit organizations, scholars, and policy makers who work in diverse fields impacted by drug policies. The Illinois Consortium on Drug Policy is housed at Roosevelt University's Institute for Metropolitan Affairs, in Chicago, Illinois.

Mission

The Consortium's primary objectives are to promote alternatives to current drug policies and to serve as a forum for the open, honest, and thoughtful exchange of ideas. We aspire to serve both the general public and populations significantly affected by drug policies through careful analysis of current policies in the areas of housing, employment, education, healthcare, and economics, and by offering sensible, prudent, and economically viable alternatives to ineffective policies. The Consortium seeks meaningful change by increasing dialogue, heightening public awareness, meeting with legislators, and expanding outreach to other organizations that are also impacted by drug policies.

Project Goals

Intersecting Voices: the Impact of Illinois' Drug Policies aims to educate policymakers, the media, and the general public about the impact of Illinois drug policies on diverse populations across different spheres of life. This project will mobilize organizations to reevaluate policies and to bring awareness about the effects of these policies on individuals in their area of focus, through case studies and media outreach.

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Executive Summary

The *Intersecting Voices: Impacts of Illinois Drug Policies* project aims to demonstrate how Illinois drug policy effects residents in a wide variety of ways. Drug policies impact housing, treatment, law enforcement, education, jobs, and the economy. Because of the pervasiveness of drug use, the issue touches people of every race, age, and gender living in every part of the state. To tell this story, the project presents the cases of several Illinois residents from a variety of walks of life whose lives have been effected by drug use. It is our hope that these stories, and the policy research that we have used to contextualize them, will help readers to better understand the importance of effective drug policies for all of us.

Reducing Drug Supply

Supply reduction efforts continue to receive more funding than demand reduction efforts, despite the fact that demand reduction efforts, like treatment, have been demonstrated to be effective, while the study of interdiction efforts has been almost entirely neglected.

- The United States spent a total of \$12.686 billion dollars on interdiction and law enforcement strategies, while only \$6.136 billion was spent on education and prevention strategies.

Incarceration

In 2005, \$1.21 billion was allocated for corrections, a more than three-fold increase over 1990 figures. In Illinois, the number of individuals incarcerated for drug offenses increased dramatically over the past two decades, both for sales and possession offenses.

- In 1983, 456 persons were incarcerated for a drug offense; in 1993, 6,352 individuals; and by 2002, 12,985 individuals entered prison for drug offenses.
- Since 1983, the number of incarcerated drug offenders increased by 2,748 percent, which represented the fastest growing segment of the prison population.
- In 2002, Illinois taxpayers spent approximately \$280 million to incarcerate drug offenders.

Illinois now incarcerates more individuals for possession of drugs than it does for drug sales.

- In 1993, sales convictions represented 68 percent of all drug offenders entering prison, while drug possession accounted for 31 percent.
- In 2002, possession offenses represented 54 percent of the newly incarcerated, while sales accounted for 45 percent.

Race

The nation's current policies, which heavily favor interdiction and law enforcement, have had particularly racially disparate effects in Illinois. According to the latest data available for analysis (2002), Illinois now has the dubious distinction of leading the nation's drug enforcement efforts in several key areas:

- Illinois ranked first in the per capita rate of incarcerated African-Americans convicted of drug possession offenses.
- Illinois incarcerated more individuals for drug possession than any other state reporting, except for California. Illinois ranked second in black to white disparity in incarcerating individuals for all drug offenses.
- Illinois ranked second only to California in the number of individuals incarcerated for drug offenses.
- Illinois' ratio of incarcerations of black to white prisoners for drug possession offenses was the second most disparate in the country.
- Other than California, Illinois incarcerated more blacks for drug possession than any other state.

Incarcerations for drug offenses have increased greatly from 1983 to 2002 for both blacks and whites, but African Americans have been impacted much more severely than whites.

- The number of African Americans incarcerated for drug offenses rose 5,347 percent while whites incarcerated for drug offenses rose 666 percent.

Racial disparities in current and incoming prison populations are apparent in both drug sales and possession offenses.

- In 2002, the percentage of African Americans entering prison for possession violations was over 55 percent, while less than 48 percent of white prison entrances were for possession offenses.

Youth and Drug Use

For many Illinois youth, substance use initiation begins at an early age. Analysis of the 2003 Treatment Episode Data Set (TEDS) of publicly funded treatment demonstrated:

- 56 percent of all Illinois heroin treatment participants first used heroin before the age of 18. Of these, over 5 percent were aged 11 or younger, while 21 percent were between 12 and 14 years of age.
- 72 percent of methamphetamine treatment participants first used methamphetamine before age 18 and nearly 10 percent first used methamphetamine by age 11. About 29 percent first used between ages 12 and 14, while 34 percent began using between 15 and 17 years of age.
- 65 percent of cocaine treatment participants used cocaine before age 18, and nearly 10 percent first used cocaine earlier than age 12. Twenty-five percent began using cocaine between the ages of 12 to 14, and about 30 percent used cocaine for the first time between ages 15 to 17.
- Nearly 90 percent of marijuana treatment participants first used marijuana before the age of 18.

Since the elimination of D.A.R.E. funding in Illinois, a comprehensive drug education strategy for Illinois youth has yet to be implemented. The Illinois State Board of Education does state goals for drug education, but no standards or strategies exist for systematic implementation of these goals into curricula.

Substance Use Disorders and Treatment

Successful treatment should be geared towards the individual's particular barriers, needs, age, gender, ethnicity, and culture.

- In 2004, over 1.2 million Illinois residents suffered from a substance use disorder (including alcohol).
- Of these individuals, only about 10 percent received treatment.
- In Illinois, approximately 266,000 individuals had both a substance use disorder and a mental health disorder, but only about 6 percent received care for both.

Social benefits of treatment include:

- Improved health, better employment outcomes, reduced criminal offense rates, increased self-monitoring, and reduced serious health problems.

Numerous studies that have analyzed the cost savings of treatment demonstrate positive financial outcomes. Treatment is cost effective in a number of ways:

- If \$2.3 million were spent on treatment, Illinois taxpayers would save about \$40 million dollars per year.
- Treatment lowers criminal activity and criminal recidivism (e.g., incarceration costs, criminal prosecution costs, and costs of drug-related crime).
- Treatment increases the number of taxpayers through employment.

Homelessness and Substance Use Disorders

It is estimated that anywhere between 30 percent and 50 percent of homeless individuals have a substance use disorder. Chicago's emergency shelters alone served 13,108 unduplicated clients in 2004, up from 11,050 individuals in 2003.

For each homeless individual housed, the costs are approximately:

- \$22 per day at a shelter; \$60 per day in jail; \$61.99 per day in prison; \$437 per day in a mental hospital; and \$1,201 per day in a hospital.
- \$20.55 per day to house an individual in permanent supportive housing.

Women and Substance Use Disorders

Individuals with substance use disorders report high rates of physical, sexual, and emotional abuse and neglect during their childhood. The rate of childhood sexual abuse among females with substance use disorders is twice as high as that found in the general female population. Women suffering from substance use disorders also face gender-specific barriers, including:

- Childcare, family responsibilities, and greater likelihood of a co-occurring disorder such as depression.
- Many live well below the poverty line, are more likely to be unemployed, and have lower levels of education than men.

Women and Incarceration

- The total number of females admitted to prisons in Illinois from 1983 to 2002 increased by 664 percent.
- In 2002, over 90 percent of Illinois' newly incarcerated women were convicted for non-violent offenses. About 38 percent were incarcerated for a drug offense.
- From 1983 to 2002, the number of incarcerated women convicted of a drug offense increased by 4,041 percent, from 32 to 1,325 women.
- In 2002, 60 percent of incarcerated female drug offenders were convicted for drug possession.
- It is estimated that nearly 80 percent of incarcerated women suffer from substance use disorders, but fewer than 20 percent of all incarcerated women have access to substance abuse treatment programs while incarcerated.
- Eighty-five percent of incarcerated women in Illinois are mothers.
- Each year at least 25,000 Illinois children are impacted by maternal incarceration and at least 60,000 children will have their mothers spend time in a state prison while they are growing up.

Since the 1997 *Adoption and Safe Families Act*, grounds for terminating the parental rights of incarcerated parents have expanded. Incarcerated parents who want to keep their parental rights are expected to “discharge parental responsibilities” while incarcerated. However, numerous barriers frequently prevent parents from fulfilling these state requirements. Perhaps the most significant of these barriers is physical separation. The majority of incarcerated parents were detained more than 100 miles from their last place of residence.

Education for Incarcerated Individuals

Post-secondary education has been proven successful in reducing recidivism rates and helping individuals find and maintain employment.

- Education provides incarcerated individuals with future earning power, creates future taxpayers, and saves current taxpayers' dollars by lessening recidivism.
- The more education received, the lower the rate of returning to prison; a bachelor's degree has a substantially stronger impact on recidivism rates than do other forms of education.
- The average per capita cost of keeping each inmate in prison was \$21,124 over the past five years of available data (2001-2005), while the average cost of providing post-secondary education was approximately \$1,600 per individual per year.
- In 2002, Illinois would have saved between \$11.8 million and \$47.3 million, from the reduced recidivism associated with higher education programs for the incarcerated, were post-secondary education programs offered to these individuals.
- The sales, income, and social security tax revenue generated by the employment of these educated ex-inmates would have contributed an extra \$10.5 million per year to Illinois' economy.

Policy Recommendations

- Increase drug court programs to service more individuals, or provide a mechanism for non-violent drug possession offenders to receive time in treatment instead of time in prison.
- Increase incarcerated individuals' access to treatment, education, job training, and parenting classes.
- Provide services that help the formerly incarcerated re-integrate into society, including: housing services, childcare, employment, job training and education.
- Incorporate alternatives to drug-use parole violations, such as a provision for mandated treatment as an alternative to a return to prison.
- Establish a Drug Education Commission to focus on the development and implementation of a comprehensive, statewide curriculum, with guidelines for the amount of time devoted to drug education in Illinois.
- Illinois legislators should fund the “Treatment on Demand” initiative. Even though an advisory referendum for “Treatment on Demand” passed overwhelmingly in Cook County, it remains unfunded by the state.
- Implement comprehensive screening procedures for other mental health conditions for individuals with substance use disorders. Treatment plans should address the substance use disorder and other mental health issues at the same time.
- Allocate funding to programs that provide a variety of treatment approaches. For treatment of substance use disorders, “One size does not fit all.” Gear treatment towards the individual’s particular barriers, needs, age, gender, ethnicity, and culture to improve treatment success rates.
- Extend and fund “Housing First” policies for all of Illinois’ supportive housing providers.
- Fund the Women’s Residential Treatment and Transitional Pilot Program, which requires only \$155,000 in matching funds from the State of Illinois. Ninety percent of the program’s costs would be paid for with federal dollars.
- Foster care agencies should provide re-unification services for incarcerated parents.
- Reinstate higher education in Illinois for incarcerated individuals.

Introduction

The purpose of *Intersecting Voices: Impacts of Illinois' Drug Policies* is to demonstrate how Illinois' drug policy intersects with a number of different social spheres. Drug policies impact Illinoisans from diverse populations across different areas of life, including housing, treatment, law enforcement, education, jobs, and economics. Impacts of drug policies can also be analyzed based on racial, familial, age, and gender issues. Accordingly, drug policies play a part in most everyone's life.

Most Illinois residents would prefer to live in a state where drug use is not a problem. Illinoisans spent \$280 million dollars to incarcerate 12,985 individuals for drug offenses in 2002.^{1,2} At the same time, Illinois is experiencing the introduction of newer drugs such as methamphetamine into areas where little illicit drug use has occurred in the past, e.g. rural areas. Greater heroin use is also an emerging trend, where diffusion from the cities to suburban and rural areas has and continues to occur.

Treatment remains under-funded and insufficient considering the many Illinois residents who suffer from a substance use disorder—the majority of whom do not receive adequate treatment. In 2005, approximately 98,000 Illinois residents sought treatment through treatment providers funded in whole or in part by the Department of Human Services for a substance use disorder (including alcohol). Of those who sought treatment, nearly three quarters utilized services for illicit drug use disorders.³ Using the Substance Abuse and Mental Health Administration's projections, over one million individuals needed treatment in Illinois for either drug or alcohol use disorders,⁴ but only about ten percent received that treatment.⁵

Many Illinois residents know of someone who has suffered from a substance use disorder. When this person is a family member or friend or even a colleague, we generally seek to help

them to access treatment and by offering emotional and financial support. Sadly, this is not necessarily the case when someone we do not know suffers from a substance use disorder. When it is someone we know, we can understand a little better. We focus on their future—on getting whatever help they need. When it is someone we do not know, categorization of these individuals' as criminals seems a bit easier. We imagine their problems as consequences of irresponsibility, personal deficiencies, or immorality. We focus on their wrongdoing and not on the individual's situation and circumstances. Psychologists refer to this as the “Fundamental Attribution Error.”

Many believe that those who have substance use disorders belong to a class of people who ought to receive punishment for their use. While the instinct to punish those who use drugs may be understandable, it is not cost effective and it does not reduce drug use.⁶ Many people are afraid to discuss the impact of a substance use disorder on families and communities. Misconceptions are abundant, but perhaps the most dangerous are the myths that *addiction is a choice* and *those who are addicted do not want to get well*.

While each story included here appears extraordinary, these stories are equally ordinary—ordinary because one million Illinoisans suffer from untreated substance use disorders. These stories demonstrate how drug policy and substance use disorders intersect with a number of seemingly unrelated social spheres. They also reveal that drug policies do indeed have an effect on Illinois residents across all spheres of life. Drug policies impact the lives of Illinois residents in significant ways. This project aims to encourage all Illinoisans to discuss and view substance use disorders in a new way: as a public health problem—a problem that does not discriminate based on age, gender, race, education, or income.

Methods

To fully demonstrate the expansive intersections of drug policy, the Illinois Consortium on Drug Policy's project, *Intersecting Voices*, uses both qualitative and quantitative research methodologies. Consortium members agreed that the use of both quantitative and qualitative case studies would best elucidate the intersection of drug policies with other social areas of life, and allow the Consortium to effectively "breathe life" into what can sometimes be perceived as dry, academic work.

The case studies were gathered from a variety of sources including housing and service providers, academics, advocacy organizations, as well individuals the researchers encountered while engaged in other drug-related fieldwork. Roosevelt University's Institutional Review Board approved the research design and the protection of human subjects. Each subject highlighted in the case study provided informed consent and the researchers changed each individual's name and other identifying characteristics to protect the subject's confidentiality.

Researchers initially met with each subject and collected his/her story by interviewing the subject using an open-ended instrument. The interviews often resulted in several meetings and most interviews lasted about three hours. Each story, or case study, was told to the researchers with one researcher providing the interview questions while the other researcher recorded verbatim what the subject stated during the interview. These notes were transcribed and edited by the researchers. The researchers then met again with each subject to ensure that the transcription and editing process had accurately reproduced the story. Often, the subjects would add a line or two or clarify another point during these meetings. Review of the contents of each case study occurred during these meetings.

In order to provide context for the case studies, researchers analyzed primary data sources like the Treatment Episode Data Set to illustrate the age Illinois youth with substance use disorders first began using drugs. Several data sets were analyzed for the project, including the National Corrections Reporting Program, the Youth Risk Behavior Survey, and other existing primary data sources. The researchers also examined and referred to a number of existing academic studies on each "intersection," as many of these areas have already been quite thoroughly researched and examined by other academics. The primary and secondary source materials following each case study present how drug policies intersect with other policies, and articulate the impact of drug policies on all Illinois residents.

CHAPTER 1:

“Like trying to hold back the ocean with a sword”

ENFORCEMENT, INCARCERATION, EDUCATION & RACE

Franklin is a 40 year-old, African-American male who grew up on the Southside of Chicago. Franklin's mother died when he was 12, leaving him without many resources. From a young age, Franklin watched the devastation that drugs brought to his neighborhood. Franklin has always wanted to make a difference in his community and he believed that he could do so by eradicating drugs from his neighborhood. He now works at a university full-time, and also teaches youth at a community college.

I knew I didn't want my life to end the way I saw so many others end. I didn't want to be like the walking dead, those folks strung out on alcohol and drugs, ones that I saw on the street everyday. My only route out: the military or college. Something deep inside me was really frightened; I didn't want to be jobless, strung out on dope.

I was on my own, living in a rough, poor neighborhood in Chicago when I decided to join the Marines in 1984. In 1988 I was sent to Colombia on assignment and was informed that I was a leader of the front line. I was to curtail the tide of drugs coming into our country. I thought this was it; after watching all the harm caused by drugs, this was my chance to do something about it. We were told that we were in Colombia at the request of their government and that we were to assist in the training of their soldiers to stop the coca trade.

I thought if I can end up keeping coke off of the Southside streets, then I was willing to do nearly anything. Then one day, I came upon a storage room that was about 10,000 square feet, two times the size of a basketball court. It was filled, top to bottom, side-to-side full of loose cocaine piled as far as I could see. The room was floor to ceiling full of packed kilos of cocaine, some bundled, some loosely piled as if it was rock salt on the side of a snow-filled street. This was one processing plant out of acres and acres of processing plants, let alone all the other stages and amounts of cocaine. Just to think, there were acres and acres just waiting to be harvested.

I remember seeing all of it, thinking, my God. Then I tried to do the math. Let's see, a dime bag is this, it costs this much for this, oh my golly, there was so much money to be made. I quickly felt the inevitable doom. It was like trying to hold back the ocean with a sword.

But then I came to understand that these are not bad people. They are just men and women from a third world country, so poor, just trying to make it, just trying to survive. For example, a man is paid \$500 to process coca leaves into powdered cocaine, which is enough for a man to feed his family for many years. Men stomp on coca leaves in vats and the process destroys their feet, actually eats away their flesh, leaving men handicapped for the rest of their lives. Still, many are eager to get that \$500, because they know that their families will be taken care of.

Prior to Colombia, I thought we as a people can change this, after my assignment I realized that the odds are stacked against us. This strategy was not going to end drug abuse or save my community. In Colombia, I realized the futility of drug interdiction. When I saw the amounts of drugs being produced by essentially a third world country, a fluid government, I knew that this was not going to end. The whole country seemed like a coca production plant. The scope was too large.

Shortly after the marines, I joined the Chicago police force because I needed to do something to help my people. I wanted to help in Colombia, but I couldn't. I felt that being a police officer, with all the knowledge of what was going on in the 'hood; I knew all the hide-outs, lookout patterns. I thought I could really do some good on the streets.

I watched and watched the task units take down dealers, the people on the same spot. I saw people get arrested and by the next week that same spot was hot again. It was on the street that I was reminded why these kids were selling; they weren't selling to be cool. I would meet these kids and find out that they were supporting younger siblings. These kids sell drugs to buy food, to pay rent, buy clothes for their younger brothers and sisters so they can go to school.

We can talk about alternatives, but what are these kids to do to survive? In a good night, these kids can make \$250, and this is a hot corner but remember your life is in danger. Most kids make around \$150. These are kids, thirteen, fourteen years old.

Once again, I had that epiphany. I had a realization, put two and two together. This is not going to stop. I was seeing how prevalent drug sales were, people's willingness to kill each other. It was a waste of my time; I had to get out. I saw that this wasn't the answer.

I thought that my life was a natural progression, but instead I got caught up in the neighborhood in a different way. I ended up right where I had left but now I was looking at my people—Black folks—in a skewed, negative, simplistic way. I knew the pain, I knew the reasons and I knew that my reactions were not right. I had started to blame people for what was essentially a systemic failure. It's not just about drugs. It's about race, class, and opportunity.

The people who use drugs are people, people in need. Drugs do horrible things to people, but when I enforced on the streets, that didn't seem to be working either. Prison hones the skills of young criminals; it solidifies the anger and their contempt for the police. Most drug users want a better world, a better life, but what options are open to them? Most people don't realize how difficult it is to get a job in a neighborhood where there are few, if any jobs. Educational opportunities are also sorely lacking. It's no wonder that with the lack of treatment, and so few options for employment, that folks get stuck. Once you have that felony conviction, it's hard to get good employment, even if you have an education.

We need to help those who are in need. The need is there, the demand is there, so what are we going to do about it?

ENFORCEMENT, INCARCERATION, EDUCATION & RACE

Drug Supply Reduction: Interdiction and Law Enforcement

Of all methods used to reduce the supply of drugs and limit the number of illicit drug users in the United States, supply reduction has received the most funding.^{7,8} Supply reduction strategies range from efforts to eradicate coca plant production in Colombia, to large-scale drug seizures, to arrests of drug consumers on the streets. These strategies aim to raise drug prices, reduce drug availability, demonstrate social disapproval, and hope to challenge drug suppliers' political influence. While enforcement efforts may contribute to the above drug-related goals, little or no empirical evidence exists to demonstrate the effectiveness of these efforts in the United States.⁹

The United States spends a great deal of money on supply reduction strategies. According to the Office of National Drug Control Policy, in 2002, a total of \$12.686 billion dollars was spent on interdiction and law enforcement strategies, while only \$6.136 billion was spent on treatment and prevention strategies. Law enforcement and interdiction received two-thirds of the entire federal budget spent on the drug war, while treatment and prevention received a mere 33 percent of those dollars. Supply reduction efforts continue to receive more funding than demand reduction efforts, despite the fact that demand reduction efforts, like treatment, have been demonstrated to be more effective, while the study of interdiction efforts has been almost entirely neglected.^{10,11}

Supply Reduction Effects in Illinois

The United States drug enforcement strategy, aimed at curbing availability, decreasing purity, and increasing drug prices, appears to have had little effect in Illinois. According to the National Drug and Intelligence Center, from 1992 to 2002 (the latest year data is available for Illinois) marijuana remained the most readily available drug and prices have remained relatively constant.¹² Powdered and crack cocaine have become increasingly available with prices declining slightly over the ten-year period and purity levels (60 to 70 percent) continue to remain high both in Chicago and statewide. The availability and production of methamphetamine has increased considerably and poses the primary drug threat in the rural areas of the state. Methamphetamine prices in Chicago range from \$7,300 to \$10,000 per pound, considerably less than the \$20,000 average in the East and Midwest of the United States. Nationally, MDMA (ecstasy) production has increased and prices have been dropping since 2001.¹³ Since 2003, an increase in MDMA lab production facilities has occurred in neighboring states like Indiana and Wisconsin.¹⁴

In 2001, while the price of a milligram of pure heroin in Chicago was at its lowest price in a decade, retail purity had risen dramatically from 2 to 4 percent in the early 80's to 25 to 30 percent in 1995 and availability had increased. Despite recent but modest price increases, in 2004, Chicago's price per milligram of pure South American heroin was the third lowest in the country, with prices lower than those New York City.¹⁵ Since 2005 in the Chicago area, mixes of heroin and fentanyl have become increasingly available, resulting in a more lethal product. This new 'heroin'—heroin combined with fentanyl—resulted in over 100 overdose deaths in less than one year.

Illinois and Drug Enforcement

The nation's current policies, which heavily favor interdiction and law enforcement, have had particularly racially disparate effects in Illinois. According to two ground-breaking studies "The Vicious Cycle: Race, Prison, Jobs, and Community in Chicago," and "Human Rights Watch: Race and Incarceration in the United States," utilizing data from 1996, Illinois ranked second (behind Maryland) in racial disparity for the incarceration of individuals for drug offenses.¹⁶ Illinois prison admissions for drug offenses were second in the nation,¹⁷ and Illinois led the nation in the percentage of black drug offenders (of all drug offenders) admitted to prison.¹⁸

Illinois now has the dubious distinction of leading the nation's drug enforcement efforts in several key areas (according to the latest year data was available for analysis: 2002): Illinois ranked first in the per capita rate of incarcerated African-Americans convicted of drug possession offenses; Illinois incarcerated more individuals for drug possession than any other state reporting other than California;¹⁹ Illinois again ranked second in black-to-white disparity in incarcerating individuals for all drug offenses;²⁰ Illinois prison admission for all drug offenses ranked second in the nation; Illinois' ratio of incarcerations of black-to-white prisoners for possession offenses was the second most disparate in the country; more blacks were incarcerated for possession than any other state aside from California; and Illinois is still one of the leading states in the nation in the percentage of black drug offenders (of all drug offenders) admitted to prison (see Appendix B for rankings).²¹

Incarceration and Drug Offenders: the Impact in Illinois

The number of individuals incarcerated for drug offenses has jumped dramatically over the past two decades, both for sales and possession offenses.²² In 1983, 456 persons or 4.8 percent of the individuals entering prison in

Illinois were incarcerated for a drug offense.²³ Ten years later in 1993, drug offenders admitted to prisons numbered 6,352 individuals or 30.3 percent of all prison admissions.²⁴ In 2002, 12,985 individuals, or 37.9 percent, of all admissions to Illinois prisons were for drug offenses.²⁵ From 1983 to 2002, the largest increases in the prison population by offense type occurred among drug offenders, the number of which increased by 2,748 percent (see Appendix B).²⁶

Changes in Incarceration Patterns: Possession and Sales

Illinois now incarcerates more individuals for possession of drugs than it does for drug sales. In 2002, 20 percent (5,597) of all prisoners were admitted for drug possession offenses, while 16 percent (4,406) of the total prisoners were admitted for drug sales violations. In 1993 less than 10 percent (1,976) of prisoners admitted to Illinois' prisons were convicted of drug possession violations, while over 20 percent or 4,336 individuals were admitted to Illinois' prisons for drug sales violations.²⁷ Trends in Illinois' incarceration rates over this nine-year period show the increase in the overall number of incarcerations, the increase in both the absolute number and the percentage of the prison population incarcerated for drug possession, and the decrease in the percentage of the prison population sentenced for drug sales.

Over time, proportionally more individuals have been incarcerated for possession than sales. In 1993, sales convictions represented 68 percent of all drug offenders admitted to prison, while possession admissions comprised 31 percent of all drug offenders admitted to prison. In 2002, the proportion of sales-to-possession offenses was almost one-to-one, with nearly 54 percent of those admitted to prison for drug possession offenses, while about 45 percent were convicted for sales (see Appendix B).

Increasing Racial Disparity

Incarcerations for drug offenses have increased greatly from 1983 to 2002 for both blacks and whites, but African Americans have been impacted much more severely than whites. African American drug offense admissions to prison rose from 185 individuals in 1983 to 10,077 individuals in 2002, which represents an increase of 5,347 percent. The number of whites incarcerated for drug offenses grew too, but not as dramatically. In 1983, 270 whites entered to prison for drug law violations, while in 2002 the number of whites who entered prison for drug offenses was 2,067, an increase of 666 percent.²⁸

Disparities in prison admissions and incarcerations are consistent for both sales and possession offenses. The proportion of white to black drug offenders in Illinois is nearly 1:5 despite the fact African Americans' comprise only 15 percent of the population. In 2002, 55 percent of African Americans admissions to prison were for possession violations, while less than 48 percent of white prison admissions were for possession. Whites had the higher percentage of drug sales conviction, about 46 percent, while the percentage of blacks incarcerated for drug sales was lower, at 43.7 percent (see Appendix B).²⁹

Drug Use, Arrest, and Sentencing

Research indicates that there is virtually no difference in the prevalence of illegal drug use between blacks and whites.³⁰ Despite similar drug use rates in Illinois, in 1999 blacks comprised 15 percent of Illinois' population, but accounted for 72 percent of all arrests for Controlled Substances Act violations, and constituted more than 80 percent of all drug offenders admitted to prison.³¹ About 20 percent of those arrested for Controlled Substance Act use violations were white, but only 11 percent of whites arrested were remanded to prison.³² Thus, black arrestees are far more likely to face incarceration than white arrestees for violations of the Controlled Substance Act.

Funding for Prisons and Education in Illinois

The cost of incarcerating one adult in Illinois is approximately four and a half times the cost of one child's annual education.³³ The cost of imprisoning one individual is estimated to be between \$20,637 and \$25,900 per year.^{34,35} Meanwhile, Illinois mandates only \$5,164 per child per year for public education.³⁶ In 2005, \$1.21 billion were allocated for corrections, which represents a 221 percent, or more than three-fold, increase over 1990 figures.³⁷

In Illinois, more blacks are currently in prison for drug convictions than attend college.³⁸ In 1999, only 992 black males received a bachelor's degree, while the number of black males released solely on drug charges was estimated to be around 7,000.³⁹ In 2001, there were nearly 20,000 more black males behind bars than were enrolled in undergraduate programs in the State's university system.⁴⁰ Between 1985 and 2000 the State's budget for higher education increased by 30 percent, while the State's budget for corrections increased more than 100 percent.⁴¹

Incarceration Exacerbates Existing Inequalities

The use of incarceration as a means to control drug use has disproportionately affected the health and well being of racial and ethnic minority populations, particularly among African-American males.⁴² Incarceration creates additional barriers for economically disadvantaged populations. A felony drug conviction significantly decreases access to jobs and related health benefits, and military service. Felony drug convictions effectively eliminate access to public housing, food stamps, and most professional licensure.⁴³ These service and opportunity barriers that occur after the individual has served their prison sentence make it extremely difficult for the formerly incarcerated to effectively re-integrate into society.

CHAPTER 2:

“I can say now, I sure didn’t know what I was getting into”

YOUTH, DRUG USE, PREVENTION & EDUCATION

Josh is a 21-year-old Caucasian male, who grew up in Chicago’s western suburbs in a middle-class family. Josh is an only child who began using heroin at age 15, after an older neighbor introduced him to it. Josh soon began to steal to support his habit, and was later arrested and incarcerated for theft. After receiving treatment through a court-mandated program at age 18, Josh has been able to remain drug-free for several years and is now employed.

The only drug education I got was in the D.A.R.E. program. I think it was in 5th grade. An officer told us not to drink, or smoke pot or cigarettes. In 5th grade, I was sure that I would never do any of those things. The officer didn’t tell us about the effect of other drugs. And really, when you think about it, the most important time to really talk about drug education is in junior high and high school. By junior high, I had tried alcohol and marijuana. I thought that heroin was addictive in the way that marijuana was addictive. It wasn’t until I was around it—involved in it—that I realized the difference.

I am not saying that marijuana is a harmless drug. For me, it wasn’t harmless. I knew kids who could smoke pot on the weekends and still do their homework. But I wasn’t like that and when you learn or think that every drug is like pot, it’s hard to imagine the bad stuff that other drugs can do to you.

I was into hanging out with my friends and sort of escaping my feelings by using drugs. My neighbor was always talking about this drug that he called “blows.” I didn’t know that he was talking about heroin.

I wonder sometimes if my life would have been different if I had known then what I know now. The body, mind, and spirit become addicted. That addiction is powerful and it’s really hard to stop. That I would end up hurting my family, my friends, and myself by using and chasing after drugs like heroin and crack cocaine.

I mean, I thought that heroin was something I thought nobody really did, except for maybe rich people and maybe old rock ‘n’ rollers who stuck needles in their arms. I never thought that anyone in the suburbs used it. I didn’t know you could snort it. My neighbor told me that it was the best high. Even better than sex. I was fifteen. I didn’t know that my neighbor had a heroin habit or even that you could get a habit from doing heroin. I had no idea that heroin withdrawal felt like the worst flu in your life and that you couldn’t sleep and that you would do anything to end it. After I started using it, my life got bad really fast. I ended up riding with other guys in my neighborhood to the West side to get it.

I remember the day that I overdosed. Two of my “buddies” picked me up, and we went around for a few hours stealing, so that we could get money to feed our habit. We drove to the city, and on the way back the two of

them shot up. The whole way home I was basically steering the car from the passenger seat, because the driver was nodding off the whole time. I really thought I was going to crash on the way home, and I hadn't even gotten high yet.

We got back to my house, and I shot up two bags; the amount that I usually used every day. I got a very warm feeling all over my body and all I remember was looking into my friend's eyes, and I passed out.

I woke up to about four detectives and a countless amount of paramedics all over my kitchen and living room. They told me that I just overdosed on heroin. All I could worry about was that my parents don't find out, and where my friends were. They took me to the hospital, and my parents met me there. I acted like it wasn't a big deal, because inside, it wasn't. This was normal for heroin addicts to go through. It didn't affect me that my mother was bawling and my dad was depressed. None of it mattered. I laid in the hospital bed, dreaming of the next time I could use again.

None of this mattered. The fact that I was being put in the psych ward didn't matter. I knew when I got out, and all of this blew over, I was going to use again. It had control. I didn't care. Nothing mattered. The only thing on my mind was getting high.

I never thought that snorting heroin could cause you to overdose or that I would get addicted to it. During my sophomore year of high school I never thought I would overdose or shoot up heroin. But I did. I never thought that I would do the things I did to get money for drugs, stuff like stealing from my mother and selling baby formula on the West Side, but I did. I never thought I would steal from the people I considered my best friends, but I did.

Maybe if had gotten some better education about drugs, I wouldn't have snorted that first

line of heroin, I never would have gone to jail, and never would have overdosed. Maybe things would have been different for me.

I never thought that I would be sitting ducked down, scared to move in the back of a car while my neighbors copped drugs on the inner-city streets. I never thought I would end up in jail trading my shoes for the smallest amount of drugs that didn't even get me high. I never imagined that a drug dealer would tell me that I was too young to cop. I never saw myself as a crack-head or a junkie. But it is what I became. I thought that a drug like heroin was so far removed from my world, the suburbs, but it wasn't. I found out that crack cocaine was all around me, even easy to get in the suburbs, if you knew where to go.

I can say now, that I sure didn't know what I was getting into. I was leading a secret life that at first seemed "cool," but turned ugly real fast.

I went through numerous treatments, and even admitted into the psych-ward four times. None of them really worked for me, because I wasn't ready to stop on my own. I had already become an addict, and there was nobody that could stop me from getting high anymore. The only person that could truly help me was myself.

I didn't get treatment that worked for me until I was 18. If my mom was a lawyer and my dad was a doctor, then maybe we could have afforded treatment that helped me. My parents nearly went broke trying to get me into treatment. They even filed for bankruptcy.

I finally got treatment in an adult program. I was court mandated to the program, so finally nobody was throwing all of their money away to try and get me to stop. In treatment, the older people told me they were just like me at my age. That made me think about what my life had become. What I saw and heard changed me. I can picture a couple of those guys now; one guy limped because he got beaten up.

Another guy who told me I was just like him had no teeth. It was then that I decided that I couldn't be that way, I didn't see myself that way. When did this happen? I knew then that I had to change.

Today I know that I am blessed to be alive, to not have a disease like HIV from sharing needles. I now understand that I used drugs to escape or avoid feeling down or lost or alone. Now, I am trying to deal with how to cope better.

I just hope that other teenagers get a better shot at learning about how drugs can hurt you. I hope that they get to learn through school education programs instead of learning the hard way, like I did. Nobody deserves to go through a lot of the things that I did, and I don't think they need to. If there is any chance that we can help or prevent someone from getting into a life like that, than I am all for it. Too many people are dying, and the age that they are dying is getting younger everyday.

YOUTH, DRUG USE, PREVENTION & EDUCATION

National Perspectives

American youth use illicit drugs at alarming rates – making drug use the single greatest concern for youth ages twelve to seventeen. Fifty percent of youth ages twelve to seventeen report attending schools where drugs are sold, kept or used. Youth reporting drug-access at school use illegal drugs at rates more than double those for youth not reporting drug-access at school (41 percent vs. 20 percent).⁴⁴ Early drug use is associated with a variety of negative consequences, including lower grades in school, increased truancy, and a more negative self-appraisal.^{45,46} When substance use continues into adulthood, more significant consequences may arise. These social, physical, and psychological costs often include increased medical health care, mental health problems, economic insecurity, and involvement in crime.⁴⁷

Program and Policy Responses

Government programs and policies have developed preventative strategies for American youth because evidence suggests that, in general, people who do not abuse drugs before 25 years-of-age are unlikely to ever develop a serious drug addiction.^{48,49} The Drug Abuse Resistance Education (D.A.R.E.) program was initiated and funded over the past two decades as the primary federal drug prevention and education program in efforts to curtail youth drug use.^{50,51} Numerous studies, however, have found the D.A.R.E. program ineffective, including a General Accounting Office report in 2003, which found no difference in the rates of drug use between program participants and those who did not attend programs.^{52,53,54} The program was also expensive, averaging three quarters of a billion dollars annually in operat-

ing expenses, nationally.^{55,56} In 2004, Governor Blagojevich ended state funding for this program after former Governor Ryan cut the budget from \$1.3 million in 2002 to \$600,000 in 2003.^{57,58}

Initiation of Drug Use in Illinois

For many Illinois youth, substance use initiation begins at an early age. Analysis of the Treatment Episode Data Set (TEDS) in 2003, demonstrated that 56 percent of all Illinois publicly-funded heroin treatment participants first used heroin before the age of 18. Of those that used heroin before age 18, over 5 percent were aged 11 or younger, and over 21 percent were between 12 and 14 years of age. In Illinois, 72 percent of methamphetamine treatment participants first used methamphetamine before age 18. Of these, nearly 10 percent first used methamphetamine by age 11, nearly 29 percent first using between ages 12 and 14, and about 34 percent first using methamphetamines between 15 and 17 years of age. Of those treated for cocaine, the statistics demonstrate equally early first use: 65 percent used cocaine before age 18, with nearly 10 percent of first use earlier than age 12, 25 percent of treatment participants began using between ages 12 to 14, while about 30 percent used cocaine for the first time between ages 15 to 17. Nearly 90 percent of those treated in publicly funded treatment facilities first used marijuana before the age of 18.⁵⁹

Drug Availability in Illinois Schools

Despite federal legislation that outlawed drugs in schools (e.g., the 1989 *Drug Free Schools and Community Act*)⁶⁰ drugs appear to be easier to obtain in school in 2005 than in 1993. According to analysis of the 2005 Risk Youth Behavior Survey, children in Chicago are much more likely to report having been offered, sold or given an illegal drug on school property than in the past. In 2005, nearly 40 percent of

Chicago's children reported that they were offered drugs on school property, while in 1993 less than 17 percent of kids were offered drugs on school grounds.⁶¹

In 1993, the percentage of Illinois youth reporting that they were offered, sold or given drugs on school property was 18.5 percent, while in Chicago the percentage of kids reporting drug availability was 17 percent.⁶² By 1995, the percentage of children who indicated that drugs had been offered to them on school property rose to 31 percent in Illinois and 29 percent in Chicago.⁶³ In 2005, nearly 40 percent of Chicago-area kids reported drug availability.⁶⁴

Table 1: Percent of Youth Offered, Sold, or Using Drugs at School

Year	Chicago-area	Illinois
1993	17%	18.5%
1995	29%	31%
2005	40%	?

Unfortunately, Youth Risk Surveillance data in 2005 for Illinois as a whole is lacking, making it impossible to detect whether a change in the percentage of youth offered, sold or using drugs since 1995 has occurred within the state at-large. However, assuming that the trends for Illinois as a whole continued to mimic the trends for Chicago-area children into 2005, we hypothesize that more than one in three youth in Illinois has access to drugs on school grounds. We therefore hypothesize that Illinoisan youth have greater access to drugs on school grounds than they did 10 years ago.

Changing Drug Use Patterns

Greater availability of drugs within schools is not the only factor that has changed. Drug use patterns have changed. Drugs that are associated with urban areas are now found in suburban and rural areas (e.g. heroin⁶⁵ and crack cocaine). From 1995 to 2002, the number of collar county youth hospitalized for heroin rose over 450 percent, and suburban Cook county youth hospitalizations for heroin increased over 200 percent, while Chicago youth hospitalized for heroin decreased more than 20 percent over the same time period.⁶⁶ In 2002, more suburban youth (343) sought treatment for heroin use than did Chicago youth (85).⁶⁷ Parents, schools, and community members may not be aware that the availability of dangerous drugs, such as heroin, cocaine, and methamphetamine, might be increasing within their communities.

Drug Education Strategies

The highest risk for substance use occurs during difficult transition periods, like the transition from elementary to junior high school and also from junior high to senior high school, according to National Institute on Drug Abuse (NIDA) researchers.⁶⁸ These periods are optimal for reinforcing drug education messages and also clearly stating the harms that occur from each drug. NIDA research indicates that prevention programs that begin in elementary and junior high school have beneficial effects in lowering drug use, but that these effects are diminished if follow-up is not presented in high school programs.⁶⁹

While community-based programs and parental support help reduce youth drug use, an effective school-based drug education program is still necessary in youth drug use prevention.^{70,71} A 2004 Substance Abuse and Mental Health Services Administration (SAMHSA) study indicates reduced rates of illicit drug use for youth

exposed to drug education in schools.⁷² However, since the elimination of D.A.R.E. funding in Illinois, a comprehensive drug education strategy for Illinois youth has yet to be implemented. According to Public Act 92-0023 (passed in 2001), Illinois' State Board of Education is responsible for creating guidelines to assist schools in incorporating instructional materials on alcohol and drug use and abuse into existing curricula.⁷³ While the Illinois State Board of Education does state goals for drug education, no universal standards or strategies exist for systematic implementation of these goals into curricula.⁷⁴ That is, schools are given discretion to decide the amount time devoted to health education instruction so long as they cover all the required topics of instruction.^{75,76} Illinois students, who already have no specific health education requirement for graduation, receive inconsistent, and occasionally inadequate, levels of drug education dependent wholly on the place in which they live.

CHAPTER 3:

“I was nearly 50 before I was given the right diagnosis”

THE COST OF UNTREATED SUBSTANCE USE DISORDERS, TREATMENT BENEFITS & CO-OCCURRING DISORDERS

Lawrence is a 49 year old, African-American male, who grew up on the Westside of Chicago. Lawrence became immersed in the drug culture at an early age, after he left his family because of his father's physical abuse. Lawrence did not use drugs until his twenties, after which he quickly became addicted to heroin. His addiction continued, relatively unabated, for more than 20 years, when he finally received appropriate treatment and a diagnosis for a mental health disorder. Since his treatment, Lawrence now lives on the Southside of Chicago, in a supportive housing environment, and he has remained clean from drugs for nearly one year.

My father had been mentally and physically abusive all my life. He would call us horrible names, tell me I will never be anything, amount to anything. He said this to me for years. I felt like I wasn't worth anything. He beat me with his pistol, he beat me with a hose, he beat me with a bat. I was scared, terrified of him. When he told me not to tell anyone, I didn't. He injected his filth into the whole house, especially when he was drunk. He mostly got Mother. She was helpless and afraid. I was scared for her. I couldn't understand why she didn't leave him. I couldn't do anything to stop it. I tried a few times, but got

knocked straight on my butt. He was what you call a prolific alcohol user. He used to come home and jump my mom. Sometimes he would get his gun, flash it around the house. It was scary; I did know the fear of a gun.

As time went on, I started to not trust him or even talk to him. When I left, my mom cried, she understood. I had to leave. It all started when I was 13.

I was looking for a male role model, someone I could talk to, get answers from. This is how I got affiliated with drugs. I met a guy that gave me a proposition. If I sold his drugs, he would buy me my clothes and give me a place to live. I was 14 when I dropped out of school. I wasn't doing drugs at first. I was an athlete. When I dropped out, I started hanging out on corners, selling drugs, doing things grown people do. My new role model had cars, nice suits, money. He took me places and bought me things. I stayed with him and he took care of me. His house was always full of women. I was a just a kid, so this was so new to me. He had a lot of money, a lot of power. I didn't know about his power when I first got involved with him, but I learned quick though, after I moved in with him.

Then he got a dope house and he wanted me to run it. It hit me so fast that I had to be a grown man, the whole nine yards. He was paying me big money. I went over there and the place had everything I could have wanted, everything I needed was in the house. All I had to do was watch the workers.

I remember one night watching people sitting around the table mixing dope. There was a scale, a blender, and naked women sitting at the table. I had never seen so many drugs. The table was completely full of coke and dope. He said, "Come over here man, I want you to mix this." There were all these people: one was bagging, one blending, one testing, one cooking, and another tester. It was something I never dreamed of.

He showed me the ropes. As time went by I was making tons of money. I went to my mom and picked her up in my Cadillac. I handed her \$10,000 and she started to cry. I told her I gotta survive. I was 17.

She went home and told my dad. He yelled at her and screamed that it was all her fault, he jumped her and beat her up real bad. I thought, now I finally got the power to retaliate, I got guys, but I never did.

One day the police raided the house. They took everyone to jail. I was bonded out. I was terrified, it was all new to me, I was a kid. I didn't get much because I was a minor but they called my parents. I had to go back home. Me and him got into it. Now I was grown, big, I wasn't takin' a whoopin' from him. From all my experiences, all that I had seen, so I left. I was on the streets, wasn't going back to the smoke house, it scared me that bad. So I thought I would hustle the streets. I still hadn't put a drug in my body.

Some years went by and my guy came back. He took me shopping, gave me a lot of money. He was like a god to me; whatever he did was cool. One day we were sitting at the table where we cut drugs and I said come on man, give me some of that stuff. He said no, and we went back and forth. Finally I got it and tooted it. My nose started bleeding and I threw up. From that day on, I started using everyday.

The day I started using heroin, I had no knowledge that it would almost be my death. I had daily access to it. I was 21, working for him again. He knew I was honest, I would have never stole from him. He treated me like I was his little brother or son. I was loyal to him. Most things I did then were through him.

I had a lot of pain. Thinking about my problems felt like someone was ripping my insides out. Heroin took away that pain. It killed those feelings. It did it for me. It put me in the zone. If I didn't reach the zone, everything would be wrong. Once there, I felt so damn good and that's what made me an addict. Not because it was the thing to do or because it was popular, it was because I enjoyed it, and it took away my pain. I did it over and over again and never thought it was a habit, until it—the heroin—started making decisions for me. I felt like it was saying, look you need me, go steal out of that store. I had a huge fear of being sick. I didn't wanna ever come down because I knew I was gonna get sick. I had a table habit—a dealer's habit. It got to a point where the dope and friends ran out, couldn't keep a job because I would get sick. I was out on the streets scrapping, collecting cans to support my habit. Heroin can take you so damned high and so damned low.

I realized I had a habit when even if it meant taking from my own mother, I would have. All through the 80's I was in and out of treatment centers trying to figure out what was wrong with me. I couldn't stay out of the penitentiary. This was happening for years.

If I had a second chance, I would have never left home and I would have stayed in school.

I finally admitted to myself I couldn't do it anymore. It took too much energy. I had lost all my friends.

Life didn't mean nothing to me. Then I met Big Al. I used to use drugs with Big Al but he had been clean for a long time by then. He was my connection into therapy. Without him, I was not able to access treatment that I needed to get clean and stay clean. It was hard, but I have been clean since November. Without a medical card or insurance it is almost impossible to get into a 30-day treatment.

Believe me, I had issues. Six months ago I finally was diagnosed with bi-polar disorder. It was a relief. It made me aware of my other issues. Now that I know my diagnosis, I know my symptoms; I know what to do to keep my symptoms down. I know what I have to do to reintegrate back into society. People helping me now have patience, patience to deal. I wanted and needed a helping hand and I got it. I am being prepared for transitions. I owe them my life. I was about to take my life. My life might not have turned out the way that I wanted, but they cared enough to help me and keep me alive. That was all I needed to hear. I want to come back and help someone the way that Big Al helped me. Maybe then, my life has purpose then, to show that it isn't easy to get help, to get the right help.

But the right help makes all the difference in the world. It kept me alive, well and clean so that I could tell my story. Maybe my story will help someone else; maybe I will make a difference. I was nearly 50 before I was given the right diagnosis and having that knowledge is a relief. A godsend.

THE COSTS OF UNTREATED SUBSTANCE USE DISORDERS, TREATMENT BENEFITS & CO-OCCURRING DISORDERS

Treatment: The Societal Benefits

Treatment has been found to reduce the individual demand for substances.⁷⁷ Research has demonstrated that treatment effectively reduces drug use, improves health, improves employment outcomes, reduces criminal offense rates, brings increased self-monitoring, and reduces serious health harms.⁷⁸ Treatment has also been shown to reduce crime.⁷⁹

Costs of Untreated Substance Use Disorders

There are numerous other expenses associated with untreated substance use disorders. Most costs from untreated substance use disorders are related to medical costs including hospital visits (e.g., emergency room visits for accidents, overdoses or other health problems), medicines, and drug-related chronic conditions. Additionally, there are a number of peripheral costs to allowing substance use disorder to go untreated, including the increased risk of injury, Medicaid services, and untreated long-standing health illnesses (e.g., heart disease, diabetes). Other substance-related factors that increase the costs of untreated substance use disorders include increased domestic violence, greater need for mental health services, lower worker productivity, and increased homelessness and poverty, increased unemployment, and higher incarceration rates (including the costs of construction and maintenance of prisons).⁸⁰

Treatment: Social and Financial Benefits

Treatment is cost-effective in a number of ways. First, treatment reduces further substance use among those who use drugs and the health costs associated with the individuals' drug use. Second, treatment lowers criminal activity and criminal recidivism (e.g., incarceration costs, criminal prosecution costs, and costs of drug-related crime), and increases the number of taxpayers through employment. Third, treatment helps to lower the number of drug users overall and the costs resulting from substance use disorders.⁸¹

Numerous studies that have analyzed the cost savings of treatment demonstrate positive financial outcomes. The most conservative studies indicated \$1 saved on every \$1 invested in treatment of substance use disorders to upwards of \$18 saved on every \$1 invested.^{82,83} The average cost savings from each dollar invested in treatment yields approximately \$8 returned to society. Currently treatment availability is limited. So while treatment creates both social and financial benefits that are returned to taxpayers, treatment is only as effective as it is accessible.⁸⁴

Definition of Co-Occurring Disorders

Co-occurring disorders, or co-morbidity, refers to those individuals diagnosed as having a substance use disorder combined with a mental health disorder. This type of dual disorder is extremely prevalent in the United States. According to the Substance Abuse and Mental Health Services Administration, in 2002, 4 million American adults suffered from both a serious mental illness and a substance use disorder. In 2002, 25 percent of adults with a substance use disorder were also diagnosed with a serious mental illness.⁸⁵

Prevalence of Co-occurring Disorders

More than 50 percent of individuals who have ever been diagnosed with alcohol or other drug abuse or dependence have also experienced a mental disorder.^{86,87} Depression, anxiety and other mental health disorders may cause individuals who are not effectively treated to self-medicate, which may then lead to a co-occurring substance use disorder in combination with the original mental health problem.⁸⁸ Those individuals with substance use disorders are often treated by the community as a stigmatized population, as individuals who lack "will" or "self-control," despite the fact that research indicates that substance use disorders are neurological in origin.⁸⁹ Individuals may use a substance in order to alleviate mood disorders like depression, anxiety, and bipolar I disorder.

Rates of co-occurring disorders vary according to type of disorder, drug, and gender of the individual. A mood disorder, such as major depression, has been found to be dually diagnosed with substance use disorders in 27 percent of the diagnosed individuals, while 56 percent of those individuals diagnosed with bipolar disorder met criteria for an alcohol or drug disorder.⁹⁰ According to The Epidemiological Catchment Area (ECA) survey, an individual meeting the criteria for anxiety disorder had a 50 percent increase in the odds of being diagnosed with a lifetime alcohol use disorder.⁹¹

Gender Differences

Women experience co-occurring disorders at significantly higher rates than men. Serious mental illnesses were found to be more prevalent in women than in men (30.3% versus 15.7%) among adults with substance dependence or abuse (illicit drug or alcohol).⁹² About one-half of all women who misuse alcohol also meet the criteria to be diagnosed with major depression, while only one-fourth of men meet the criteria for both alcohol use disorder and depression.⁹³

Treatment of Co-Occurring Disorders

Most of those individuals with co-occurring disorders do not receive treatment for either condition and very few receive treatment that adequately addresses both mental health and substance use.⁹⁴ According to the U.S. Department of Health and Human Services, more than half (52%) of adults with serious mental illness and a substance use disorder received no treatment for either of these problems. Among the individuals who received treatment, only 6 percent received treatment for both mental health and substance use problems, and about 2 percent received treatment for the substance use disorder alone.⁹⁵

Prevalence of Co-Occurring Disorders in Illinois

In 2004, over 1.2 million Illinois residents suffered from a substance use disorder (including alcohol). Of these individuals, only about 10 percent received treatment.⁹⁶ Projecting from SAMHSA survey data, approximately one-quarter of these 1.2 million residents likely had co-occurring disorders—about 266,000 individuals had both a substance use disorder and another mental health disorder. Since treatment rates for dually diagnosed individuals are low, about 250,000 (or 94 percent) of those dually diagnosed individuals did not receive proper care—for both the mental health issue and the substance use disorder.⁹⁷

CHAPTER 4:

“To see how people look at you, like trash”

HOMELESSNESS & SUBSTANCE USE DISORDERS

Lauren is a 48 year old, African-American woman, who currently lives alone in an apartment on the Northside of Chicago. Despite growing up in Chicago's tough Cabrini Green neighborhood, a housing project, Lauren did not use drugs until her 40's. Lauren's mother, a nurse, raised Lauren and her three brothers without help, after a car hit and killed Lauren's father while he crossed the street. Before her recent five-year struggle with homelessness and addiction, Lauren was regularly employed, and was extremely close to her mother, family, and friends. After her addiction spiraled quickly out of control, Lauren found herself, for the first time, without a place to stay, except for the streets and an apartment inhabited by crack users. During her struggle with homelessness and addiction, she ended up in a women's shelter on and off for three years and was then transferred to transitional housing. Lauren sought help for her addiction, got a job, and was able to get clean. Lauren feels strongly that without housing, she would not be drug-free and alive today.

I didn't get in trouble with the police or cocaine until my forties. Before, I didn't know about drugs, didn't know anything about crack cocaine. Addiction came quick.

My issues were homelessness and drugs. I needed drugs, I had no housing. Without drugs I would have been in a deep depression. My mother was sick with cancer. I knew that she would die soon.

I was working full time for a company for 12 years when they moved locations. I wasn't able to transfer. I lost my job and received profit sharing. I invested with my brother in property, but I also had a lot left. It was gone before I knew it. I made a wrong turn. I was following my partner's steps. It was too easy; my partner's family was selling it. My mom was dying. It made it so hard.

I was on the street everyday. Three hundred and sixty-five days I was on the street. Was hustling, smoking. I was smaller than my finger. I would go to sleep at 6 in the morning, wake up two hours later. There were people making noise, walking over me, bugs crawling on me. 'Cause I was homeless, I had no food.

On the street, places I stayed were terrible. There were roaches running around. It was hard. Sleeping on dirty stuff, on the floor, maybe a couch or chair if I was lucky. Sometimes I didn't sleep at all. People would come over, all day, all night and be smoking. Smoking out front, out back, in the kitchen. Was on the streets trying to get money for food, for drugs. I would buy a bar of soap and take it with me. I would carry bags all day long. I refuse to carry a bag anymore.

I would get up, didn't want drugs first, needed food to get some energy. I would start pan-handling on the streets. I would get \$1, buy a can of soup. I would get \$10, go get a rock, go back to the [crack] house, smoke it, then I'm charged. When I get \$10, or close to it, all I can think about is that rock. Do it and then

come down. I must have it, even if I'm really, really hungry. Wasn't thinking about eating for the rest of the day. This would go on and on for two, three days and then I would crash. Did this in the cold, didn't matter. I didn't realize it then, but that was degrading. Today I couldn't see myself doing it. To see how people look at you, like trash.

I was my mom's only daughter and we were real close. My mother was ill. I think I kept doing drugs to keep from getting sad. From getting depressed. As long as I was getting high, I wouldn't have to think about my mother being sick and be sad. It is complicated; no one knows what one has gone through.

When she passed, I was out of control. Things got worse. I was filled with sadness. After a time, her passing woke me up. I couldn't keep going the way I was goin.' Five years of homelessness was enough for me, I'm done with that. Five years of holding me down.

Couldn't get clean, I just needed to use. Had to get out, wanted to get out. Had to get somewhere where there was no cocaine; I knew I'd lick it.

One day everyone was asleep. I had to step over the people sleeping and went to a shelter to get help. They told me to call the next morning. I got up, showered, ate real good, and called. I was tired. I was tired of fighting. More tired of the drugs, not eating, the whole way of living.

I had family; I couldn't admit it to them. I remember crying and crying outside in the hall of my brother's apartment. My family is real close, but I can't be with them, not unless I am clean.

Getting clean took time and some slip-ups, but that's part of recovery. I went from a shelter to transitional housing to where I am now. I have my own apartment and am clean. If Deborah's Place would have kicked me out for my mistakes, I would have never had a steady job. I would not have been able to kick.

There is no way I would be clean, or I would be here without housing. Without housing, to stay clean would have been impossible. Without housing I would have missed out on everything. Without housing, as soon as I got out of rehab, I hit the door and was out back to the same people, places, and things. With no place to go, how could I not go straight back to those people, places, and things?

Today I see the same three people out there. I see myself. Today my focus is to keep going forward. People have to find their own way, just like me. But people need the basics first. How can someone kick if they don't have a place to stay? I didn't realize it at first, but I was lucky. The housing I have, the staff was great. They were there to help me, they cared, knew what I was going through, accepted my slip-ups. Didn't kick me out to the streets, back to the drugs.

Just because someone uses drugs, don't mean they don't deserve decent housing and help. I want to help. I want to do all that I can do to help homeless people. Every night when I lay down my head, I pray. I pray because I finally got my own apartment even with the struggle. I pray because I was given a chance. A place to stay. Time to get my life back, people that helped me. My mother is looking down on me and smiling.

Homelessness and Substance Use Disorders

It is estimated that anywhere between 30 percent and 50 percent of homeless individuals have a substance use disorder.^{98,99,100,101} This is a much higher rate than among domiciled individuals,¹⁰² with approximately 9 percent of the general population having a substance use disorder.^{103,104} Forty-three percent of homeless individuals cite drug or alcohol problems as one of the factors that contributed to their homelessness.¹⁰⁵ Although extreme poverty is the greatest predictor of homelessness, secondary characteristics – such as substance use disorders – are also strong predictors of homelessness.¹⁰⁶

The Cost of Homelessness

Chicago's emergency shelters alone served 13,108 unduplicated clients in 2004, up from 11,050 in 2003.¹⁰⁷ For each homeless individual housed, the costs are approximately \$22 per day at a shelter, \$60 per day in jail, \$61.99 per day in prison, \$437 per day in a mental hospital, and \$1,201 per day in a hospital. However, it only costs \$20.55 per day to house an individual in permanent supportive housing.¹⁰⁸ Based on these estimates and additional research, one of the most cost-effective approaches to addressing homelessness is through supportive housing arrangements.¹⁰⁹

The “Continuum of Care” Housing Model

Nationally, the most widely used housing model for addressing the needs of the chronically homeless is the “Continuum of Care” housing model. This model begins with outreach to the chronically homeless, followed by treatment and transitional housing, and concludes with permanent supportive housing. It recognizes the aforementioned prevalence of substance use disorders and mental illnesses in the chronically homeless, and seeks to prepare these

individuals for independent housing by first requiring sobriety and stabilizing psychiatric disabilities through institutionalized services.¹¹⁰

However, research has shown substantial limitations to this housing model. Besides entrance barriers associated with behavioral expectations and responsibilities (sobriety, receiving psychiatric services as needed, etc.),¹¹¹ service providers using this housing model have reported difficulties engaging homeless individuals with mental illnesses in their programs.¹¹² Additionally, residents of this program typically live in congregate housing during the transitional housing phase – one condition that may make them less prepared to live independently upon exiting the program.¹¹³ Most notably, however, the philosophy behind this housing model hinges upon the conformity of residents to set program requirements, not tailored, case-specific goals. Therefore, a relapsing resident with substance use disorder could be expelled from the housing as a means of implementing a zero-tolerance, abstinence-based housing solution.

The practices of this approach fail to meet the National Institute on Drug Abuse's “Principles of Drug Addiction Treatment” criteria for an effective treatment method by not attending to multiple needs of homeless individuals through the enforcement of an abstinence-only policy.¹¹⁴

Excessive and stigmatizing admissions procedures and program requirements are barriers to housing the homeless.¹¹⁵ Despite popular belief, service individuals can successfully be moved directly from the streets or shelters into permanent supportive housing.¹¹⁶ Research demonstrates that homeless providers for the homeless should implement a Housing First, or similar model which has low demands and flexible program rules and admission requirements¹¹⁷ as the primary way to address homelessness when prevention is no longer an option.¹¹⁸

Defining a “Low-Demand” Housing Model

The “Housing First” approach to ending homelessness is guided by the philosophy that providing permanent housing should be of foremost importance. Then, services are provided, as needed, once housing is obtained. The goal is to move homeless individuals and families into permanent housing as quickly as possible. Once the basic human need of housing is secured, the individual or family can be engaged in various services that further promote housing stability, such as programs to decrease substance use and provide psychiatric stability. Residential programs that use the Housing First model do not make the housing contingent on compliance with traditional treatment approaches. Rather, individualized service plans are developed that build on the resident’s strengths while matching his or her readiness to engage in change. Further, the safety of both the individual and the community is addressed through behavior expectations and residential responsibilities that are developed collaboratively by staff and residents. The staff works closely with residents to ensure that they have the resources, skills, and support to meet these expectations and fulfill these responsibilities. Often referred to as low-demand housing, housing with limited demands facilitates ease of entry and provides services that are tailored to the needs of each resident. Residents are invited to “come as they are” and the supportive service staff focuses on efforts to help clients remain housed. Low-demand housing, based on the Housing First model, is an effective way to bridge the gap between a life on the streets and one filled with promise and dignity.^{119,120,121,122,123}

Cost Benefits for Low-Demand Housing

According to recent research, residents of supportive housing increased their earned income by 50 percent and increased participation in employment by 40 percent.¹²⁴ Beyond Shelter’s Housing First Program in Los Angeles, CA, served approximately 2,800 primarily high-risk and multi-problem homeless families from 1989 through 2003. More than 85 percent of those families stabilized in permanent housing within one year.¹²⁵ According to a study of a segment of Beyond Shelter’s Housing First participants, done by the University of Southern California, in conjunction with the Center for Urban Policy at Rutgers University, 87 percent of participants with at least one parent who had a history of substance abuse were living drug and alcohol free after six months in housing.¹²⁶

CHAPTER 5:

“I lost my kids, I lost my hope”

WOMEN, TRAUMATIC HISTORY, SUBSTANCE USE DISORDERS & THE IMPACT OF INCARCERATION

Zoë is a 33-year-old Caucasian woman who grew up in Chicago. Zoë was surrounded by drug use, physical violence, and sexual abuse from the day she was born. At the age of 15, she moved in with a 25-year old man, who later fathered her three children. He encouraged her to use drugs and he physically abused her. Later, after relocating to Wisconsin, she left her common-law husband. Zoë was able to get counseling for herself and her children, a job, and housing. After a series of events, she lost custody of her children after leaving them in her in-laws' care. After this point, her addiction escalated, and she found herself without a place to stay, without means of support, and she turned to prostitution. She was arrested and sentenced to prison. While she was in prison for prostitution, she was encouraged to sign away her parental rights.

Between the ages of 4 and 10, I was sexually abused by four men. I've been through so much trauma. For me, my story starts when I was four years old. My mother's boyfriend was the first man to sexually molest me. Being 4 and 5 years old, I know I blocked a lot of this out, but I still have memories of him taking me to this parking lot. I remember being really scared and telling him no once, that I wouldn't do it. I'm not sure how many times it happened. The next time was a young boy that lived next door

to my grandma. He was in his early to mid teens. I was seven or eight. I later found out he molested me and my brother. Then it was my uncle. He was a deaf mute who never left the small room he lived in. He would grab me and do those sorts of things. He was the one who first gave me pot.

My whole life, practically since I was born, has been about sex.

My mom married a Chicago cop who was very physically and mentally abusive to all of us. I remember being hit with belts, being choked. He left dents with his ring in my brother's forehead. He was nastiest to my brother. I couldn't stop him. He would handcuff him to a table, take off all his clothes, open all the windows in the middle of winter and leave him to freeze for hours. He would leave him a cup to pee in. He tortured him; he was a very sick man. I remember him holding a knife to his penis, threatening to cut it off if he peed the bed again. He was six.

I would remember them coming home and her face would be all bloody from being beaten. It was sick. He would throw his gun at her and say, “Why don't you just kill me?” He was so hateful and he terrorized us, his own family.

I was living house to house when my mom finally left. I was 11 or 12 and I went to live by my grandma. I started getting high at eleven. Everyone I knew did drugs. During my childhood, I didn't know anyone, except my grandma, who didn't get high. If you didn't get high, you weren't normal.

I was drinking heavily as a teenager and tried sniffing cocaine when I was 13. I was snorting coke with my mom when I was fifteen. She was an addict too. At that point, I met a man who was 25 years old, ten years older than me. He turned me on to cocaine, really got me into it. He had a good job, made a lot of money and he was really into it. At fifteen, I was living with him in his parents' basement.

At sixteen my mom put me in rehab. My stepfather found out and cut off my insurance so I only stayed for 5 days. I had to leave, so I had to go back to a man I called my boyfriend, a man that was severely beating me everyday. What I really needed was treatment for all the trauma I had and was enduring. I got pregnant later that year.

He continued to severely beat me through all of my pregnancies. I lost a baby because of him beating me. I just couldn't leave him. When I was nineteen he moved me and the kids up to Wisconsin. He was still beating on me everyday. Everyone knew he was doing it from the beginning. He had brainwashed me. He constantly told me everyday how fat I was, how ugly I was, how no other man would want to be with me. He degraded me so much, I believed him. He had total control over me; I was up in the middle of nowhere.

I was stuck and needed help; he threatened to kill me if I left him. He taunted me by saying he would cut my body up into little pieces and that no one would ever find me. I always tried to leave him, but I felt like it was impossible. I was barely surviving. I've had a couple of restraining orders on him. I went to 3 different battered shelters, five different times. It's hard with three kids. I finally left him, almost ten years later. He stalked me for many years.

I was doing much better for the next few years after that. My cocaine use had slowed down a lot, maybe to a few times in a year. I had my

own house, my own car. I was taking care of the kids on my own and was working in home healthcare. I was a Certified Nurse Assistant (CNA) for 5 years and finally had my life together. I was seeing a therapist, and so were the kids. I was getting parenting help, and being taught parenting skills. I was put on medicine and was slowly working through my traumatic history. I was dually diagnosed with depression, Attention Deficit Hyperactivity Disorder (ADHD), Post Traumatic Stress Disorder (PTSD), dysthymia [chronic depression] and a substance use disorder. I was doing the best I could and was reaching out for help. Life seemed good.

I was having intense flashbacks and was startled very easily. I don't know what was wrong with me, but I knew I needed a break. It was just me and the kids and it had been that way for awhile now. I decided to drive to Chicago and take the kids over to their father at their grandparents' place. I just needed a short break, I thought. I started smoking crack again. I just couldn't stop, I just couldn't quit. My mother-in-law decided to call Department of Child and Family Services (DCFS) and the children were put under their custody. Shortly after, the children's father threatened his parents which led to a second call to DCFS. This is when my world ended.

I was still seeing my caseworker. I asked the DCFS caseworker to mandate me to treatment. She told me "No," they can't do that.

When my kids were taken, I pretty much gave up right then and there. I hated everybody. I was going every week to see them, but for some reason I couldn't do what they wanted me to do. I was out on the streets; I had left everything behind in Wisconsin. That is when I started prostituting myself. I remember telling myself that I didn't deserve to be happy again. I didn't deserve to smile. I didn't know how to protect them. I couldn't stop getting high. I

had to cover the pain. I wanted to try to quit. I didn't know how. I didn't have the knowledge or the understanding that I could. It just, was always there.

My mom, now clean, tried to fight for my kids. They told her all this stuff to do and she did it. DCFS then came in and told her that she needed to register as a foster parent, but it turned out that interstate laws stopped her from being able to get custody of the kids. The kids were 7, 9, and 10. This made no sense. She fought so hard and was devastated, she wanted them so bad. If only my in-laws would have called my mom or dad, so much could have been avoided.

The day that I was pressured into signing away my babies was the worst day of my life. It was the first time I was in prison. Some man kept pressuring and pressuring me, telling me that this was best for the kids. I knew I didn't want to give them away. They were my babies, I loved them so much. I was scared, confused, out of it. I asked to speak to my mom and he wouldn't let me. I tried to fight, but he bullied me into it. He kept pushing and pushing. I just wanted what was best for my kids. I was really messed up. I finally thought, you say this is best, then I believe you.

After that I pretty much wanted to die. There were plenty of times when I was on the streets and I had wished that someone would just kill me. I know my use was masking my pain for all of the abuse I'd been through. I wanted to forget. It came to a point where crack wasn't helping me forget. If I knew how to help myself, if I knew what I needed, I would have done it a long time ago.

The man who told me that I was doing the best for my babies was wrong. I recently found out from my mother that my one of my boys was physically abused while in foster care. A report stated that there were bruises, welts and cuts on his butt. I was so angry and devastated. All of

this could have been prevented. Why didn't the state try to place them with my family?

Why didn't anyone actually take the time to sit down with me and explain to me the situation? I wasn't encouraged to get help. When they came to my house to steal my babies all they did was hand me a piece of paper with a bunch of phone numbers on it to call. No explanation. Maybe things could have been different if they'd given me the help when I asked them to. Maybe then I wouldn't have had to go back to the streets.

I lost my kids, I lost my hope. It felt hopeless. I had nowhere to live. No help was offered. There should have been an option. We need options. Why are there not more options for us women? They take our kids and what happens to them—it's crazy.

I just want my kids to be treated good. I always thought I would be able to protect them. I am so angry about my children being abused. I want to turn my anger into something positive. Maybe I can help.

GENDER, TRAUMATIC HISTORY, SUBSTANCE USE DISORDERS & THE IMPACT OF INCARCERATION

Women, Trauma, and Substance Use Disorders

Individuals with substance use disorders report high rates of physical, sexual, and emotional abuse and neglect during their childhood.¹²⁷ Women, as compared to men, report higher rates of sexual abuse.¹²⁸ The rate of childhood sexual abuse among females with substance use disorders is twice as high as that found in the general female population.¹²⁹

While studies vary due to definitions of abuse and the way they are conducted (e.g., sampling procedures), an average of about 55 percent of all women with substance use disorders experienced childhood sexual abuse.¹³⁰ Childhood sexual abuse has wide-ranging and long-term effects—it can result in disorders like post-traumatic stress, depression, and anxiety. Women who have been abused as children may later use alcohol or drugs to self-medicate and to reduce negative feelings.¹³¹

Research demonstrates that women who experience abuse during childhood are likely to experience substance use disorders and are more likely to be involved in abusive and violent relationships in adulthood.¹³² This link between physical/sexual abuse history and problematic drug use among women includes earlier age of first use of drugs, more types of drugs used (e.g., polysubstance use), greater problematic use (e.g., larger number of blackouts reported), more family members with substance use disorders, and greater psychological problems.¹³³

Beyond problematic drug use, the impact of abuse on women is extensive. Individuals with traumatic backgrounds are at greater risk for

psychiatric problems, may lack proper support and may experience greater difficulty trusting a treatment provider.¹³⁴ Traumatized women have also been found to report poorer psychosocial functioning, more health-related issues and more family problems.¹³⁵

A 2001 study of Minnesota children whose parents had their parental rights terminated found that 80 percent of mothers had dual or multiple disorders and over half either currently or previously had a substance use disorder.¹³⁶

Treatment Barriers for Women

Gender-specific barriers include childcare, family responsibilities and co-morbidity issues. Many females with a substance use problem also are faced with living well below the poverty line, are more likely to be unemployed, and have low levels of education.^{137,138,139,140,141,142} Furthermore, many substance using women report having a spouse who has a substance use disorder, are more likely to live with a current or previous drug user, and seldom use drugs alone.^{143,144,145}

Men and women also differ in how they seek help for substance use disorders; women tend to go to their physician, while men go directly to an abuse center.¹⁴⁶ Men are over-represented in alcohol and drug treatment centers while women are over-represented in mental health and primary health care clinics.¹⁴⁷

Women are more likely than men to have children in their care and living with them.¹⁴⁸ Childcare is a barrier to entering treatment for women. Most treatment centers do not offer accommodations for mothers. While men most often enter treatment due to career difficulties, women most often enter treatment due to family problems.¹⁴⁹ Early research has recognized that women generally have a better prognosis if their treatment offers childcare, assessment of comorbid disorders, and training in coping skills.¹⁵⁰

The Impact of Women in Prison in Illinois

Incarceration rates for women have increased sharply over the past decade, even exceeding the growing male incarceration rates. The total number of females admitted to prisons in Illinois in 1983 was 456 individuals; but by 2002, the number of women admitted had reached 3,483 women, a 664 percent increase.¹⁵¹

In 2002, of all women who were admitted into Illinois prisons, over 90 percent were incarcerated for non-violent crimes.¹⁵² In the same year, about 38 percent of all women were admitted for a drug offense.¹⁵³

The number of women who have experienced incarceration because of a drug law violation has increased dramatically over the past two decades. In 1983, 32 women were admitted into Illinois prisons on a drug charge. In 1993, 457 women were admitted and by 2002, 1,325 women were admitted into Illinois prisons on a drug charge, a 4,041 percent increase over the 19-year period.

From 1993 to 2002, the number of women admitted to prison for drug possession increased more than fourfold, from 178 women to 797 women.¹⁵⁴ In 1992, the majority of females admitted to prison on drug charges were convicted of sales or distribution of an illicit substance, but today, surprisingly, the majority of women admitted to prison for drug offenses (60 percent) were convicted of possession of a drug, not distribution of a drug.¹⁵⁵

It is estimated that nearly 80 percent of incarcerated women suffer from substance use disorders. Despite the growth in the number of female drug offenders in Illinois' prison population, fewer than 20 percent of all incarcerated women are able to access substance abuse treatment programs while incarcerated.¹⁵⁶

Eighty-five percent of incarcerated women in Illinois are mothers^{157,158} and almost 50 percent of those women have children under five years old.¹⁵⁹ Each year at least 25,000 Illinois children are impacted by maternal incarceration and at least 60,000 children will have their mothers spend time in a state prison while they are growing up.¹⁶⁰

Termination of Parental Rights

Most of the federal government's annual \$5 billion expenditure on child welfare programs supports children in foster care.¹⁶¹ Since Congress passed the Adoption and Safe Families Act in 1997, states now have an incentive to encourage adoption of children in foster care. Under this law, states receive \$4,000 to \$6,000 in federal money for each foster care adoption that exceeds the number of the previous year's total adoptions. The federal law requires states to petition to terminate parental rights when a child has been in foster care for 15 of the last 22 months, except if the children are placed with relatives, if the family has not received reunification services, or if there is a compelling reason why it is not in the children's best interest to have the relationship with the parent severed.¹⁶²

Incarcerated parents, who are often sent many miles away, represent a growing percentage of those unable to meet the demands of the state. As a result, the parent is unable to keep legal parental rights to their own children while purportedly receiving rehabilitation in prison. Many incarcerated mothers lose their parental rights because of their incarceration and the short time-frame for reunification imposed by the Adoption and Safe Families Act. These mothers lose all legal rights to visit their own children upon returning to society (adoptive parents may permit visitation, but all parent-child contact has been legally severed).¹⁶³

In Illinois, the number of children in substitute care (a foster home, group home, or institution) has steadily decreased from its 1997 high of 51,331 children to 17,415 children in February of 2006.¹⁶⁴ Not surprisingly, after these new federal mandates and incentives, the U.S. Department of Health and Human Services reported a 78 percent increase in adoptions spanning the years from 1996 to 2000. More than \$192 million in adoption incentives have been awarded to states since fiscal year 1998, when the first bonuses were instituted.¹⁶⁵

Since the 1997 Adoption and Safe Families Act, grounds for terminating parental rights of incarcerated parents have expanded.¹⁶⁶ Incarcerated parents wanting to keep their parental rights are expected to “discharge parental responsibilities” while incarcerated. However, numerous barriers frequently prevent parents from fulfilling the requirements of the state. Parents have noted some of the following issues: lack of or inadequate communication from the foster care case worker of requirements and procedures, treatment availability, financial support, caregiver support and training and employment opportunities. Since 64.3 percent of women in state prisons and 84 percent of women in federal prisons reported living with their children prior to incarceration, many mothers confined to prison find themselves detained too far away from their children to maintain a close mother-child bond.¹⁶⁷ The majority of incarcerated parents were detained more than 100 miles from their last place of residence.¹⁶⁸

CHAPTER 6:

“Thank God I was Incarcerated in 1992”

INCARCERATION, EDUCATION & EMPLOYMENT

Michael is a 52 year old, white male who grew up in an Italian-American family in the Chicago area. When Michael was in his 30's, he started using cocaine, and soon found himself in a situation that he never anticipated: prison. Michael now works for a large non-profit, and is the director of community relations under the transitional jobs program for ex-offenders.

By the time I had sold to an undercover informant I was using cocaine in the morning like most other people use coffee. A mutual friend asked me to get some cocaine for her. I didn't know then that she had been arrested and had bargained with the police when she introduced me to someone who “needed a favor.”

Soon after that, my wife and I had moved out of the city to get away from the drug scene, the city, all of it, to make a change. I was working a full-time job, making a great wage and helping my father out with his business on the weekends. I came from a close knit, upper-middle class, and traditional Italian family.

A year after the “favor,” I was sleeping in my bed at home when I heard a noise that suddenly woke me up. Someone was in my apartment. I threw on a pair of pants and grabbed a golf club. The next thing I saw were flashlights in my living room. My heart leapt into my throat. Then I heard a voice yell, “This is the police! Come out of the room with your hands in plain view!” I was shocked, stunned, scared. They

handcuffed and arrested me and took me to the county jail.

My thoughts raced. “What is going to happen next? I can't do time, my father's had several heart operations, and he may die before I get released! What is my family going to think? What will my boss think? What am I going to tell everyone?”

I was locked up in a 12' by 12' square cage and slept on the floor with a gym shoe as a pillow. They wrote a number, my number, my inmate number, on my arm in permanent black ink. I was in my thirties; what the hell was I doing in jail, what would my family think, what is going to happen to me, to us?

When the judge read the verdict, I didn't even understand what he meant. I was sentenced to six and four years, concurrent. I knew that this would kill my father and erase any level of trust my parents had for me. I was the only one in my family to go to prison. Or even to have been in trouble with the law.

In the county jail, I was lined up with 20 other guys against a long wall, and then they told us to strip off our clothes. They said to face the wall and not to move. One guy couldn't stand still, he was obviously sick from drug withdrawal. He just couldn't stand still. Three cops hit him with billy clubs because he wouldn't stop moving. I will never forget how it felt to watch that. I thought that it couldn't be real, that this kind of stuff only happens in movies. I was horrified. My mind was spinning.

I was led to my 8' by 6' cell. Once that gate slammed shut, the reality hit me hard. The

clank of iron slamming into iron still echoes through my mind. It had a sound of inevitability, of finality. This was definitely the end of the road, the end of my life. I had a new life now. Prison. I had to live this way for some time.

By the time I was transferred to another correctional center, a state penitentiary, my options then were simple and few. My appointed counselor informed me that I could scrub and wax the floors, work in the kitchen, or get an education. Since I was going to stay there for a while, there was no question in my mind. Education would be the valuable choice. I started taking college classes. And it ended up changing my life and the lives of others.

I quickly learned about a GED tutoring program. I received a tutoring certificate, and by the time I was transferred to two additional prisons over two years, I had personally tutored about fifteen inmates in six months. I freely talked to anyone and rubbed elbows with inmates from multiple gangs. The guys I tutored began to realize the importance of education and those guys watched my back. The average age at the prison, excluding the lifers, was between 18 and 30 years of age. Most young guys didn't understand that getting an education could turn their lives around, from lives often riddled with violence and poverty to a life of opportunity. It took an experience with someone like me to show them that education was useful, both inside and outside the prison.

This kind of rehabilitation could not happen today. Those cast into the criminal justice system today are not afforded the same educational opportunities I received. Now, there's a slim chance one will receive GED classes while incarcerated, but virtually no chance to receive a post-secondary education.

I am now a criminal justice advocate who has used my prison experience to help address important issues in our criminal justice system, such as the lack of education for those

who most need it. If I hadn't been hired by an understanding organization during my time on parole, my life on the "outside" would have been quite different. My first employment position after being locked-up played a key role in the development of who I am today. Employers must give every person, including the formerly incarcerated, a chance to succeed. I am an example of how education and employment can make the critical difference for success and personal achievement.

Mistakes individuals make should not trump access to education or employment. Without these tools, individuals are likely to return to a life of crime.

I was very fortunate in my experience. Educational opportunities redirected my life. Thank God I was incarcerated in 1992. If I had been incarcerated four years later, a post-secondary education would not have been readily available, I would not have graduated college, I would not be an advocate for change, I would not hold the position of director for a large non-profit in Chicago, and I would not be able to tell my story. I would have simply been another statistic, someone who failed the system, without really being given the chance to change.

INCARCERATION, EDUCATION, AND EMPLOYMENT

A Brief History of Higher Education in Prisons

In 1965 Congress, for the first time, allowed incarcerated individuals to apply for Pell Grants to receive a college education with the passage of Title IV of the Higher Education Act. Support of higher education in prisons grew throughout the 1970's. Evidence suggests that incarcerated individuals began to desire post-secondary education.¹⁶⁹ By 1982, more than 350 college-degree programs for inmates flourished in 45 states.¹⁷⁰ Within a few years, nearly 10 percent of the total prison population received post-secondary education. Consistent with today's research, early studies demonstrated the success of such programs in reducing recidivism rates and in helping individuals find and maintain employment.¹⁷¹

Prison education has repeatedly been shown to be one of the most effective forms of crime prevention. Education that allows individuals to acquire skills is shown to greatly decrease the likelihood of criminal behavior after release from prison.¹⁷² There are clear financial and social benefits: education provides incarcerated individuals with future earning power, creates future taxpayers, and saves current taxpayers' dollars by lessening recidivism. According to a three-state study of education for the incarcerated, every dollar spent on education returns more than two dollars to the public in reduced prison costs because of decreased recidivism.¹⁷³

Recidivism Rates

Recidivism rates differ greatly between those incarcerated individuals who participate in education programs and those who do not.¹⁷⁴ The more education received, the lower the rate of returning to prison; a bachelor's degree has a substantially stronger impact on recidivism rates than do other forms of education (e.g., General Education Degrees, vocational education).^{175,176} A 2002 study demonstrated that inmates taking college courses were four times less likely to return to prison than those inmates not receiving a college-level education while in prison.¹⁷⁷ In comparison to inmates not receiving education while incarcerated, post-secondary/college education programs in prisons reduce recidivism rates by 62 percent, which is to say that more than 90 percent of those receiving post-secondary education will not return to prison.^{178,179}

Elimination of Federal Funding

Despite the overwhelming supporting evidence indicating post-secondary educational benefits, federal funding was completely eliminated in 1994 when Congress amended the Higher Education Act with the passage of the Violent Crime Control and Law Enforcement Act, eliminating Pell Grants for both federal and state prisons. By 1997, only 8 college-degree programs continued operations in American prisons.^{180,181} The number of college courses offered at state prisons began dropping in January of 2001 when Illinois eliminated all higher education funding as a part of state cutbacks due to the large budget deficit.¹⁸²

Recidivism on the Rise; Financial Benefits Lost

The recidivism rate in Illinois equaled 51.8 percent in 2002, a notable increase over the annual recidivism rates from the Illinois Department of Corrections' earliest accessible department data of recidivism rates during the period when higher education was funded (1996, 1997, and 1998: 40.4%, 43.7%, and 44.1%, respectively).^{183,184,185,186} The average per capita cost of keeping each inmate in prison was \$21,124 over the past five years of available data (2001-2005), while the average cost of providing post-secondary education was approximately \$1,600 per individual per year.^{187,188,189,190,191,192} Analysis of the hypothetical savings Illinois could have enjoyed if higher education in prisons had continued into fiscal year 2002 demonstrates that Illinois would have saved between \$11.8 million and \$47.3 million, in this year alone, from the reduced recidivism associated with higher education programs for the incarcerated.^{193,194,195,196*} The sales, income and social security tax revenue generated by the employment of these educated ex-inmates would contribute an extra \$10.5 million per year to Illinois' economy.^{197,198}

* Methodology for these calculations may be obtained from The Institute for Metropolitan Affairs, upon request.

POLICY RECOMMENDATIONS

Non-Violent Drug Offenders and Incarceration

There are considerable gains for offering non-violent drug possession offenders treatment as an alternative to prison. Abstinence in prison does not address the underlying causes of addiction, so while an incarcerated drug offender might be able to achieve a period of abstinence while in prison, the individual's brain chemistry has not changed, nor has the individual learned the skills needed to maintain sobriety.¹⁹⁹ Research has demonstrated that the option of treatment over incarceration for non-violent drug offenders reduces recidivism rates and provides rehabilitation for those convicted of a drug offense. Numerous studies have documented the cost-saving and reduced recidivism rates for those who complete drug court programs.²⁰⁰ Drug courts, however, may be overburdened and are inaccessible in some areas of the state.

- Increase drug court programs to service more individuals, or provide a mechanism for drug possession offenders to receive time in treatment instead of time in prison.

Alternatives to current policies, particularly for offenses such as possession or other non-violent drug offenses, are necessary to battle the rising costs of incarceration for non-violent drug offenders. Illinois requires the appointment of a sentencing commission to review current legislation and regulation. Below are recommendations the commission should review, in addition to expansion of drug courts or other diversion programs:²⁰¹

- Increase incarcerated individuals' access to treatment, education, job training, and parenting classes.

- Provide services that help the formerly incarcerated re-integrate into society. These services should include: housing services, childcare, employment and job training, and education.
- Expand the Fair Employment Regulation to end employment discrimination.
- Allow judges to determine appropriate sentencing for the offender.
- Eliminate “habitual offender” legislation for non-violent drug-dependent individuals.
- Incorporate alternatives to drug-use parole violations; provide an option for mandated treatment or a return to prison.

Youth Drug Education in Public Schools

Illinois’ early average age of first drug use among youth, suggests that drug education should become required curriculum for elementary schools. At the same time, drug education must be comprehensive in its scope—to be effective in preventing early drug use. It is important that the curriculum stress the effects of drugs like marijuana, heroin, cocaine, and methamphetamine early and educational efforts should continue throughout junior high and high school.

While it is important to teach children refusal strategies in dealing with peers, children should also learn the possible health, social, psychological, and physical consequences of using drugs. Severities of consequences naturally differ among drugs and youth must receive sufficient education on the continuum of harms associated with popular and emerging drugs of use and abuse. It is important, therefore, to clearly state and differentiate in curricula for youth the harms associated with all classes of drugs of abuse, not just alcohol, tobacco, and marijuana.

- Establish a Drug Education Commission to focus on the development and implementation of a comprehensive, statewide curriculum, with guidelines for the amount of time devoted to drug education in Illinois.

Once implemented, these drug education curriculum standards will help to ensure that all public school children receive adequate drug education, which should help to lower youth drug use rates across Illinois.²⁰²

Treatment: Addressing Need

In order to best serve Illinois’ social and economic needs, Illinois legislators should consider introducing legislation that would make effective treatment more accessible for Illinois residents. The number of persons in Illinois who needed, but did not receive, treatment has been estimated to be about one million residents. Illinois leads the nation in drug-related or induced mortality for heroin, has extensive treatment waiting lists, and has soaring incarceration rates. Incarcerating these individuals has been expensive. In 2002, Illinois taxpayers spent approximately \$280 million to incarcerate drug offenders.

Treatment must be available. Because of the proven nature of substance use disorders, opportunity for treatment must be readily accessible when requested. Unfortunately many drug offenders face incarceration because treatment is not available when they need it.

An advisory referendum for “Treatment on Demand” passed overwhelmingly in Cook County, by a 3-to-1 margin of voters, but it remains unfunded by the state, despite the fact that 85 percent of registered voters in Illinois say they would support such legislation.

- Treatment on Demand should be funded by the State of Illinois, as treatment will lessen the number of individuals with active substance use disorders.
- If \$2.3 million were spent on treatment, the state would save taxpayers approximately \$40 million dollars per year.²⁰³

Co-occurring Disorders

Treatment that focuses on one disorder at a time frequently fails to effectively treat the individual's underlying problems and may not effectively address either the mental health or substance use disorder.²⁰⁴ Research overwhelmingly emphasizes the need for simultaneous treatment and for more comprehensive services for those who have a substance use disorder.

- Illinois should implement, utilize, and fund comprehensive screening procedures for individuals with substance use disorders so that they may be referred for proper treatment.
- Treatment of co-occurring disorders should be integrative in nature, that is, treatment providers need to develop treatment plans that address the substance use disorder and any other mental health issue(s) at the same time.²⁰⁵

Principals of Effective Treatment

According to the National Institute on Drug Abuse (NIDA), specific principles are necessary for treatment to be effective. NIDA released a research-based guide, which highlights these principles. For treatment of substance use disorders, "One size does not fit all." Successful treatment should be geared towards the individual's particular barriers, needs, age, gender, ethnicity, and culture. Policymakers should be aware of these principles when allocating funding for treatment:

- Treatment requires time. Substance use disorders, categorized as chronic disorders, often require multiple episodes of treatment.
- Use varying treatment approaches including counseling in group and individual and behavioral therapy.
- Continually assess and modify treatment plans.
- Utilize medications if needed, including substitution therapy, such as methadone maintenance.
- Medical detoxification provides an important first step toward recovery, but it is not comprehensive enough to transition an individual to recovery, unless detoxification is part of an integrative treatment plan.

Homelessness and Housing

Homeless prevention strategies have been identified as the most cost effective and beneficial way to end homelessness. However, when prevention is no longer an option, a model that moves the homeless into permanent housing as quickly as possible should be used (i.e., the Housing First Model).²⁰⁶

Eighty percent of Chicago housing providers currently use a traditional "Continuum of Care" model, which requires that all residents provide evidence of sobriety for a period of time before residency services can be initiated. These guidelines create barriers to adequate housing for individuals who do not have a residence and who suffer from addiction. In 2003, Mayor Daley signed into law an innovative plan to end homelessness in Chicago. The plan requires housing providers to shift from traditional residency models to low-demand housing models, in which barriers to housing are eliminated and the client works towards goals with the case-worker and the supportive housing community.

- Illinois legislators should extend and fund “Housing First” policies for all of Illinois’ supportive housing providers.
- The ideal housing program should offer services and supports, including ones that address the individual’s substance use, but keep housing as the priority.²⁰⁷
- Technical assistance needs to be provided to supportive housing agencies in Chicago that use a “Continuum of Care” approach in order to transition from the traditional model to the “Housing First” or low-demand approach.

Non-Violent Drug Offenders: Community-Based Sentencing for Women

Removing mothers from families and the community to sentence them to prison—often far from home, support, and family—separates caregivers from children and often causes permanent family disruption. Community-based alternatives—focusing on comprehensive programs including mental health, substance use, domestic violence, education, job training, job placement, safe housing, and parenting classes—would lessen the likelihood of additional offenses and give mothers the necessary skills to re-enter society as tax-paying citizens.²⁰⁸

Community-based sentencing is cost effective and enables children to stay with their mothers while appropriate treatment is given. Preserving the mother-child bond while the mother receives help, will also decrease the chance that children of drug offenders would become the next generation of incarcerated individuals.²⁰⁹ Displacement of mothers seems to aid in a cycle of hopelessness and despair for women who often suffer from addiction. These women need comprehensive treatment and support, not incarceration, displacement and isolation from their families. Community-based sentencing, instead of prison sentences, for non-violent female drug offenders, particularly primary-

caregivers, is necessary to preserve communities and families.

Four years ago, the Women’s Residential Treatment and Transition Pilot was signed into law, which established community-based residential and day pilot programs. This pilot was never funded.

- Fund the Women’s Residential Treatment and Transitional Pilot Program, which requires only \$155,000 in matching funds from the State of Illinois. Ninety percent of the program’s costs would be paid for with federal dollars.

Protecting Parental Rights

Since the 1997 Adoption and Safe Families Act, grounds for terminating parental rights of incarcerated parents have expanded.²¹⁰ Incarcerated parents wanting to keep their parental rights are expected to “discharge parental responsibilities” while incarcerated. However, numerous barriers frequently prevent parents from fulfilling requirements of the state. Parents have noted some of the following deficiencies: lack of communication from foster care worker of requirements and procedures, treatment availability, financial support, caregiver support and training, and employment opportunities.

- Foster care agencies and correctional facilities should collaborate to provide access to substance use treatment programs, which help mothers become healthier to aid in the reunification process.
- Fund programs for incarcerated mothers that help them to fulfill mandated parental responsibilities, such as parenting classes, substance use treatment, job training, education, counseling, and other services required under most DCFS service plans.
- Foster care agencies should provide re-unification services for incarcerated parents.

Incarceration and Education: Reconsidering Education

Higher education is one of the most effective tools for increasing social benefits and lowering recidivism, and *is also highly cost effective*.²¹¹ Illinois should allocate funds from the state budget to prioritize the provision of higher education for prisoners as a means of preparing incarcerated individuals to become stable economic contributors to society.

Analysis of the hypothetical savings Illinois could have enjoyed if higher education in prisons had continued into fiscal year 2002 demonstrates that Illinois would have saved between \$11.8 million and \$47.3 million, in this year alone, from the reduced recidivism associated with higher education programs for the incarcerated.^{212,213,214} Consideration of the sales, income, and social security tax revenue generated by the employment of these educated ex-inmates would contribute an extra \$10.5 million per year to Illinois' economy.²¹⁵

- Reinstating higher education in Illinois for incarcerated individuals.
- Reinstating higher education for 185 incarcerated individuals would cost approximately \$296,000 for one year, but it would save Illinois taxpayers between \$575,200 to \$2,317,500 in lowered recidivism rates alone.
- Illinois policymakers should be encouraged to propose legislation to reinstate federal Pell grants to restore higher education for incarcerated individuals.

APPENDIX A

**Table 1: Treatment Episode Data Set, 2003:
Age of First Use by Primary Substance Used**

Age of First Use	Cocaine (n=16,333)	Marijuana (n=18,670)	Heroin (n=14,236)	Methamphetamine (n=1,745)
11 and Under	9.5%	15.2%	5.6%	9.6%
12-14	25.9%	48.1%	21.6%	28.9%
15-17	30.6%	28.8%	29.4%	33.8%
18-20	13.7%	5.6%	17.3%	13.2%
21-24	8.2%	1.6%	10.3%	5.8%
25-29	6.1%	0.5%	8.5%	3.8%
30-34	3.0%	0.1%	3.9%	2.3%
35-39	1.8%	0.1%	2.1%	1.3%
40-44	0.7%	0.0%	0.8%	0.9%
45-49	0.3%	0.0%	0.4%	0.4%
50-54	0.1%	0.0%	0.1%	0.0%
55 and Over	0.1%	0.0%	0.0%	0.0%
Total	100.0%	100.0%	100.0%	100.0%

APPENDIX B

Table 1: Total Number of Admitted Drug Offenders in 2002, by State Rank

Rank	State	Total Number
1	California	39,878
2	Illinois	12,985
3	New York	11,610
4	Texas	11,425
5	Ohio	9,077
6	Florida	7,942
7	New Jersey	6,836
8	Louisiana	6,130
9	Georgia	5,995
10	Missouri	5,955
11	Maryland	5,126
12	North Carolina	4,852
13	Pennsylvania	4,410
14	Mississippi	3,365
15	Oklahoma	3,354
16	South Carolina	3,244
17	Virginia	3,204
18	Kentucky	3,127
19	Arkansas	3,017
20	Tennessee	2,853
21	Michigan	2,750
22	Washington	2,656
23	Alabama	2,338
24	Colorado	2,225
25	Wisconsin	1,953

The following states reported insufficient data and were therefore not included in the rankings: Arizona, Connecticut, Delaware, Idaho, Indiana, Kansas, Massachusetts, Montana, New Mexico, Rhode Island, Vermont, and Wyoming. States with a general population of less than 1,000,000 people were excluded because of their low *N* (Alaska, North Dakota and South Dakota).

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Table 2: Total Number of Individuals Admitted to Prison for Drug Possession Convictions in 2002, by State Rank

Rank	State	Total Number
1	California	10,366
2	Illinois	6,999
2	Ohio	5,278
3	Georgia	3,712
4	New York	3,471
5	Florida	3,388
6	Missouri	2,956
7	Maryland	2,347
8	Mississippi	2,081
9	New Jersey	2,003
10	Texas	1,962
11	Virginia	1,794
12	Oklahoma	1,706
13	Alabama	1,599
14	North Carolina	1,431
15	Colorado	1,380
16	South Carolina	1,243
17	Kentucky	1,195
18	Tennessee	965
19	Minnesota	745
20	Utah	641
21	Michigan	574
22	Nevada	485
23	Iowa	346
24	Nebraska	322

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Table 3: Rate of Incarcerated Individuals for Drug Possession Convictions per 100,000 Persons in 2002, by State Rank

Rank	State	Total Number of Possessions	Total State Populace	Rate per 100,000
1	Mississippi	2,081	2,844,658	73.2
2	Illinois	6,999	12,419,293	56.4
3	Missouri	2,956	5,595,211	52.8
4	Oklahoma	1,706	3,450,654	49.4
5	Ohio	5,278	11,353,140	46.5
6	Georgia	3,712	8,186,453	45.3
7	Maryland	2,347	5,296,486	44.3
8	Alabama	1,599	4,447,100	36.0
9	Colorado	1,380	4,301,261	32.1
10	South Carolina	1,243	4,012,012	31.0
11	California	10,366	33,871,648	30.6
12	Kentucky	1,195	4,041,769	29.6
13	Utah	641	2,233,169	28.7
14	Virginia	1,780	7,078,515	25.3
15	Nevada	485	1,998,257	24.3
16	New Jersey	2,003	8,414,350	23.8
17	Florida	3,388	15,982,378	21.2
18	Nebraska	322	1,711,263	18.8
19	New York	3,471	18,976,457	18.3
20	North Carolina	1,431	8,049,313	17.8
21	Tennessee	965	5,689,283	17.0
22	Minnesota	745	4,919,479	15.1
23	Iowa	346	2,926,324	11.8
24	Texas	1,962	20,851,820	9.4
25	Michigan	574	9,938,444	5.8

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Table 4: Black to White Ratio of Individuals Admitted to Prison for Drug Offenses in 2002, by State Rank

Rank	State	Number of Blacks to Number of Whites
1	Maryland	8.01:1
2	Illinois	4.88:1
3	South Carolina	4.52:1
4	Virginia	3.70:1
5	North Carolina	3.57:1
6	New Jersey	3.51:1
7	Louisiana	3:49:1
8	New York	3.18:1
9	Michigan	3.00:1
10	Ohio	2.29:1
11	Wisconsin	2.20:1
12	Georgia	2.12:1
13	Tennessee	2.10:1
14	Florida	2.04:1
15	Texas	1.83:1
16	Mississippi	1.78:1
17	Alabama	1.59:1
18	Pennsylvania	1.57:1
19	California	1:00:1
20	Colorado	0.77:1
21	Missouri	0.70:1
22	Kentucky	0.67:1
23	Arkansas	0.64:1
24	Minnesota	0.59:1
25	Nevada	0.59:1

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Table 5: Disparity in the Proportion of Blacks to Whites Admitted to Prison for Drug Possession Convictions in 2002, by State Rank

Rank	State	Number White**	Number Black**	Proportion Blacks to Whites
1	Tennessee	118	834	7.07:1
2	Illinois	979	5,597	5.72:1
3	Maryland	349	1,972	5.65:1
4	South Carolina	226	1,016	4.50:1
5	Virginia	335	1,445	4.37:1
6	New York	615	2,160	3.51:1
7	North Carolina	342	1,063	3.11:1
8	Ohio	1,332	3,903	2.93:1
9	New Jersey	591	1,275	2.16:1
10	Michigan	186	385	2.07:1
11	Texas	409	819	2.00:1
12	Georgia	1,285	2,409	1.87:1
13	Wisconsin	39	61	1.56:1
14	Florida	1,308	2,027	1.55:1
15	Alabama	630	965	1.53:1
16	Pennsylvania	43	59	1.37:1
17	Mississippi	894	1,179	1.32:1
18	Louisiana	19	24	1.26:1
19	Colorado	522	484	0.93:1
20	Kentucky	671	520	0.77:1
21	Nevada	274	159	0.58:1
22	Hawaii	14	8	0.57:1
23	Missouri	1,886	1,056	0.56:1
24	Minnesota	455	253	0.56:1
25	Arkansas	53	21	0.40:1

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**The number of “black” individuals refers to persons reporting their race as “black.” The number of “white” individuals refers to both persons reporting their race as only “white” and those reporting their ethnicity as “Hispanic.” Therefore, the observed disparities are underestimated and would be starker if a true black-to-white comparison were performed. No other racial categories are included in these figures for simplicity of comparison.

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Table 6: Rate of Black Individuals Incarcerated for Drug Possession per 100,000 Black Individuals in the State's Populace in 2002, by State Rank

Rank	State	Rate of White** Individuals Incarcerated per 100,000 White Individuals in the State's Populace	Rate of Black** Individuals Incarcerated per 100,000 Black Individuals in the State's Populace
1	Ohio	13.8	298.9
2	Illinois	10.7	298.5
3	Colorado	14.7	223.9
4	Utah	29.2	218.3
5	Kentucky	18.4	176.2
6	Missouri	39.7	168.5
7	Oklahoma	42.1	164.3
8	Minnesota	10.3	146.9
9	Maryland	10.3	133.4
10	Nevada	18.2	117.0
11	Mississippi	51.2	114.2
12	New Jersey	9.7	111.4
13	Virginia	6.5	104.2
14	Georgia	24.1	102.5
15	Nebraska	16.1	93.5
16	Tennessee	2.6	89.4
17	Florida	10.5	86.9
18	South Carolina	8.4	85.8
19	Iowa	10.5	84.6
20	Alabama	19.9	83.5
21	New York	4.8	71.6
22	North Carolina	5.9	61.1
23	Hawaii	4.8	36.7
24	Texas	2.8	34.2
25	Michigan	2.3	27.3

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Table 7: Rate of Black Individuals Incarcerated for Drug Possession per 100,000 People in 2002, by State Rank

Rank	State	Rate of White** Individuals Incarcerated per 100,000 Individuals in the State's Overall Populace	Rate of Black** Individuals Incarcerated per 100,000 Individuals in the State's Overall Populace
1	Illinois	7.9	45.1
2	Mississippi	31.4	41.4
3	Maryland	6.6	37.2
4	Ohio	11.7	34.4
5	Georgia	15.7	29.4
6	South Carolina	5.6	25.3
7	Alabama	14.2	21.5
8	Virginia	4.7	20.3
9	Missouri	33.7	18.9
10	New Jersey	7.0	15.2
11	Tennessee	2.1	14.7
12	North Carolina	4.2	13.2
13	Kentucky	16.6	12.9
14	Florida	8.2	12.7
15	Oklahoma	32.1	12.5
16	New York	3.2	11.4
17	Colorado	12.1	11.3
18	Nevada	13.7	8.0
19	Minnesota	9.2	5.1
20	Texas	2.0	3.9
21	Michigan	1.9	3.9
22	California	17.2	2.2
23	Utah	26.0	1.8
24	Iowa	9.9	1.8
25	Wisconsin	0.7	1.1

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Table 8: Drug Offenders Admitted to Illinois' Prison by Type and Percent Increase, 1983-2002

Offense	1983	1993	2002	Increase
Sales	264	4,336	5,761	2,082%
Possession	180	1,976	6,999	3,788%
Other Drug Offense	12	40	225	1,775%
Total Number Drug Offenders	456	6,352	12,985	2,748%
All Other Offenses (non-drug offenses)	8,918	14,583	21,242	138%
Total Incarcerated	9,374	20,935	34,227	265%

Table 9: Type and Percentage of Drug Offenders Admitted to Illinois' Prisons, 1983-2002

Offense	1983	1993	2002
Sales	2.8%	20.7%	16.8%
Possession	1.9%	9.4%	20.4%
Other Drug Offense	0.1%	0.2%	0.7%
Total Number	4.9%	30.3%	37.9%

Table 10: Drug Offense by Type and Percentage of the Total Number of Drug Offenders Admitted to Illinois' Prisons, 1983-2002

Offense	1983	1993	2002
Sales	57.9%	68.3%	44.4%
Possession	39.5%	31.1%	53.9%
Other Drug Offense	2.6%	0.6%	1.7%

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Table 11: Prison Composition by Offense Type for Incarcerated Caucasians: Drug Offenses by Type and Percent Increases for Illinois' Prisons, 1983-2002

Offense	1983	1993	2002	Percent Increase
Sales	178	522	946	431%
Possession	85	240	979	1,052%
Other Drug Offense	7	17	142	1,929%
Total Number Drug Offenders	270	779	2,067	666%
All Other Offenses (non-drug related)	3,256	4,231	7,340	125%
Total Incarcerated	3,526	5,010	9,407	167%

Table 12: Prison Composition by Offense Type for Incarcerated African Americans: Drug Offenses by Type and Percent Increases for Illinois' Prisons, 1983-2002

Offense	1983	1993	2002	Percent Increase
Sales	86	3,384	4,406	5,023%
Possession	94	1,576	5,597	5,854%
Other Drug Offense	5	21	74	1,380%
Total Number Drug Offenders	185	4,981	10,077	5,347%
All Other Offenses (non-drug related)	5,645	9,066	11,597	105%
Total Incarcerated	5,830	14,047	21,674	272%

Table 13: Drug Offense by Type as a Percentage of the Total Prison Population for Incarcerated Caucasians for Illinois' Prisons, 1983-2002

Offense	1983	1993	2002
Sales	1.9%	2.5%	2.8%
Possession	0.9%	1.1%	2.9%
Other Drug Offense	0.1%	0.1%	0.4%
Total Number	2.9%	3.7%	6.0%

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Table 14: Drug Offense by Type as a Percentage of the Total Prison Population for Incarcerated African Americans for Illinois' Prisons, 1983-2002

Offense	1983	1993	2002
Sales	0.9%	16.2%	12.9%
Possession	1.0%	7.5%	16.4%
Other Drug Offense	0.1%	0.1%	0.2%
Total Number	2.0%	23.8%	29.4%

Table 15: Drug Offense by Type as a Percentage of the Total Drug Offenders Prison Population for Incarcerated Caucasians for Illinois' Prisons, 1983-2002

Offense	1983	1993	2002
Sales	65.9%	67.0%	45.8%
Possession	31.5%	30.8%	47.4%
Other Drug Offense	2.6%	2.2%	6.9%

Table 16: Drug Offense by Type as a Percentage of the Total Drug Offenders Prison Population for Incarcerated African Americans for Illinois' Prisons, 1983-2002

Offense	1983	1993	2002
Sales	46.5%	67.9%	43.7%
Possession	50.8%	31.6%	55.5%
Other Drug Offense	2.7%	0.4%	0.7%

All presented data was obtained from the following source:

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APPENDIX C

**Table 1: Number of Female Drug Offenders Admitted to Illinois Prisons, By Drug Offense Type: 1983, 1993, 2002
Percent Change 1983 to 2002**

Drug Offense	1983	1993	2002	Percent Change
Possession	15	178	797	5,213%
Sales	17	274	504	2,865%
Other	0	5	24	*
Total	32	457	1,325	4,041%

Table 2: Percentage of Female Drug Offenders Admitted to Illinois Prisons, By Drug Offense Type: 1983, 1993, 2002

Drug Offense	1983 (N=32)	1993 (N=457)	2002 (N=1325)
Possession	47%	39%	60%
Sales	53%	60%	38%
Other	0%	1%	2%
Total	100%	100%	100%

Table 3: Number of Females Admitted to Illinois Prisons by Offense: 1983, 1993, 2002

Reason for Admittance	1983	1993	2002	Percent Change
Drug Offense	32	457	1325	4,041%
Non-Drug Offense	424	985	2158	409%
Total Women Admitted	456	1442	3483	664%

APPENDIX D

Endnotes

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