The Illinois Consortium on Drug Policy

Through a Different Lens: Shifting the Focus on Illinois Drug Policy

An examination of states' solutions and applicability to Illinois

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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 just, 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.

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EXECUTIVE SUMMARY

Drug Policy Changes in Illinois

Over the past 25 years, the Illinois General Assembly has enacted nearly 20 laws that have created harsher penalties for drug offenses. Drug Free School Zones effectively doubled the penalty for any individual convicted of sales of an illicit substance within 1,000 feet of a school. Nine additional enhanced penalty zones were added from 1988 to 1999. These laws effectively place much of Chicago, particularly its West and South side neighborhoods, in a contiguous or overlapping enhanced penalty zone.

By the late 1980s, legislative changes mandated that some drug offenses were ineligible for probation. Legislative changes continually decreased the weight of the substance amount within the equivalent felony classification and charge, for both sales and possession offenses. Since the felony reclassification of drug offense weights, examples of current penalties include:

- The possession of one gram of cocaine or heroin, less than 1/8 of a teaspoon, carries the same sentence as stalking or possession of an illegal firearm.
- An individual convicted of possession of 15 grams of cocaine, about ½ a tablespoon, can now serve the same sentence (4 to 15 years) as a violent offender convicted of sexual assault.
- The current sentence imposed for sale of ½ of a gram of cocaine, less than 1/16 of a teaspoon, is equal to the sentence for arson, a prison sentence of 3 to 7 years.
- An individual convicted of sales of one gram of cocaine *in an enhanced penalty zone*, may face a Class X felony, a prison sentence of 6 to 30 years, which is equivalent to the penalty associated with aggravated criminal sexual assault.

Large Prison Increases: Drug Offenses Accountable

In 2005, drug offenders accounted for about one-third of the total Illinois prisoner population. Nearly 25 percent of individuals incarcerated in Illinois Department of Corrections were drug possession offenders. About 10 percent of inmates housed in Illinois prisons were convicted of sales offenses, and the majority of incarcerated sales offenders were lower-level offenders.

- In 2005, nearly one out of four inmates housed in the Illinois Department of Corrections was a drug possession offender.

- More than half (52 percent) of individuals released from Illinois prisons in 2002 had returned to state prisons by 2005.

Illinois prisons are increasingly comprised of non-violent drug offenders. According to analysis of the Department of Justice Prison Admissions data sets, from 1984 to the most current year (2002):

- In 1988, Illinois ranked 10th in the country for the number of individuals entering prison for drug offenses; in 2002, Illinois ranked 2nd in the nation for the number of individuals entering prison for drug offenses. This represented the highest percentage increase of any other state in the nation reporting over this period.

- In 1984, 628 individuals were incarcerated for a drug offense. In 1992, 5,165 individuals entered prison for a drug offense and by 2002, 12,985 individuals entered Illinois prisons for a drug offense, an increase of 1,968 percent.

- In 1984, drug offenders comprised 6 percent of total state prison admissions, by 2002, 38 percent of total prison admissions were drug offenders.

County and Region

In 2002, the vast majority of drug offenders—nearly 70 percent—sentenced to prison in Illinois were convicted in Cook County. However, the Collar Counties and the rest of the state also have experienced significant increases in the number and proportion of drug offenders sentenced to prison over the last two decades:

- In the Collar Counties in 1984, drug offenders comprised only 9 percent of those convicted and sentenced to prison within that area (68 individuals). In 2002, 30 percent of those convicted and sentenced to prison within the Collar Counties were drug offenders (1,184 individuals).

- From 1984 to 2002, the number of drug offenders sentenced to prison within Will County rose by 2,744 percent, greater than Cook County's increase of 2,246 percent.

- From 1984 to 2002, the number of drug offenders entering prison from McHenry County rose by 3,700 percent, greater than Cook County's percentage increase over the same time period.

- In 1984, drug offenders comprised just 16 percent of those convicted and sentenced to prison in Kane County (25 individuals). In 2002, 42 percent of all offenders convicted and sentenced to prison within Kane County were drug offenders (378 individuals).

- In 1984, in Downstate Illinois, drug offenders comprised just 6 percent of those sentenced to prison (179 individuals). But in 2002 drug offenders comprised 22 percent of those sentenced to prison from Downstate courts (2,849 individuals).

- In 1984, just 2 percent of those sentenced to prison in Champaign County were drug offenders, by 2002, 31 percent of those sentenced to prison within the County were drug offenders.

Race

Racial disparities in Illinois have increased over time according to analysis of the Department of Justice data from 1984 to 2002, particularly among African Americans. These changes coincide with drug policy changes, which occurred in the late 1980s and continue to the present day:

- In 1984, African Americans comprised 47 percent of drug offenders entering prison. By 2002, African Americans comprised 80 percent of drug offenders admitted to prison.

- From 1984 to 2002, the number of African Americans incarcerated for drug offenses rose by 3,293 percent, while Whites incarcerated for drug offenses rose 799 percent.

- In 1984, 297 African American individuals entered prison because of a drug offense. In 2002, more than 10,000 African Americans entered prison for a drug offense.

- In 2002, Illinois ranked first in the nation in the per capita rate of incarcerated African Americans convicted for drug possession offenses.

The proportion of Whites and Latinos admitted to prison for drug offenses has decreased dramatically:

- In 1984, White drug offenders comprised 37 percent of drug offenders entering prison, but in 2002, White drug offenders made up only 16 percent of incarcerated drug offenders.

- In 1984, Latinos made up 16 percent of drug offenders entering prison, but in 2002, only 6 percent of drug offenders entering prison were Latinos.

Drug Availability

If Illinois drug policy aims to curb availability, decrease purity, and increase drug prices, these policies appear to not work effectively. The availability of drugs has increased in Illinois, and the price of many drugs, like cocaine and methamphetamine, has dropped, while purity of drugs has 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 New York City.

Drug Treatment is More Cost-Effective than Incarceration

Drug treatment lowers criminal activity, decreases drug use and criminal recidivism and increases the number of taxpayers through employment. The average cost savings from each dollar invested in treatment yields approximately $8 returned to society.

- In 2005, it cost Illinois taxpayers $240 million to incarcerate drug offenders.

Other State Solutions: Lessons Learned Inform Policy Recommendations

Many states across the country, whether through public or legislative initiatives, have embraced a public health approach and have codified treatment for drug offenders or drug-involved offenders as an alternative to incarceration. At least 22 states across the country have enacted sentencing reform for drug offenders between 2004 and 2006. Examinations of 8 states' alternatives to incarceration programs lead to the following policy recommendations.

1. Create a statewide alternative to incarceration plan to treat non-violent drug offenders. Statewide alternatives to incarceration have been enacted in California, Washington, Arizona, Hawaii, Kansas, and Maryland**.** Ensure that policies and processes for providing treatment alternatives to incarceration are enacted in Illinois' laws and are reflected in any subsequent legislation.

- Build upon existing codified infrastructure to construct a larger capacity for a statewide diversion from incarceration program.

2. Create new revenues to establish the statewide alternative to incarceration plan, a lesson learned from Arizona and Washington. The statewide alternative to incarceration program in Illinois could be funded through taxes on the following dependency-causing substances and activities:

- Coffee beverages, fast food items, alcoholic beverages, energy drinks, tobacco and/or gambling establishments.

3. Re-evaluate sentencing guidelines to increase eligibility for probation or sentencing to community-based treatment in lieu of incarceration:

- Review the impact of particular sentencing enhancements like drug free zones, as these laws effectively include the majority of the city of Chicago. Consider reductions in the number of feet to reflect urban populations, or limit these provisions to areas directly adjacent to the affected area (e.g. schools and public walkways across from schools).

- Review the impact of lowered drug weights and equivalent felony penalty classifications for both possession and low-level sales offenses.

- Broaden probation eligibility for drug offenses, particularly for drug possession offenders.

Statewide Alternatives to Incarceration Save Money

All of the state models have demonstrated that cost-savings can be achieved through codified wide-scale alternatives to incarceration. For example:

- Arizona estimates its cost savings for the most recent fiscal year to be more than $11.7 million.

- Washington State's Drug Offender Sentencing Alternative (DOSA) demonstrated a return between $7.25 and $9.94 per dollar of treatment cost for drug offenders.

- Under California's Substance Abuse and Crime Prevention Act (SACPA), for every $1 invested, $2.50 in savings was incurred, despite limited sanctions and a participation rate of about 70 percent, and a completion rate of only 34 percent.

Using evaluation research from Washington and California cost-benefit analyses, if $20 million of Illinois state dollars were invested in the model alternative to incarceration program, Illinois taxpayers have the potential to save between $50 and $150 million per year.

INTRODUCTION

Illinois is at a unique juncture in the evolution of state drug policy. Over the past 25 years, Illinois has increasingly used the criminal justice system to "treat" drug offenders. Unfortunately, the criminal justice approach has done little to curb drug use and is extremely expensive to taxpayers. Currently, a widespread consensus has emerged among policymakers, community groups and researchers that Illinois must view drug offenders "through a different lens." A number of projects, initiated within the last year, demonstrate that Illinois is beginning to recognize the criminal justice system's limitations in addressing drug offenders.

- In August 2006, the Illinois Consortium on Drug Policy published its *Intersecting Voices* report, looking at the broader social impact of Illinois drug policies on issues related to youth and drug use, mental illness, education, employment, unique issues for women and the disproportionate impact on minority populations.

- In October 2006, Chicago Metropolis 2020 published its *2006 Crime and Justice Index*, the most comprehensive statistical presentation of the impact of crime and criminal justice policy in Illinois published to date.

- Early May 2007, The Center for Health and Justice at Treatment Alternatives for Safe Communities (TASC) published its *No Entry: Improving Public Safety through Cost-Effective Alternatives to Incarceration in Illinois*. This report called for a balanced and scientific application of public policy to the issue of drugs and crime, with the goal of keeping non-violent drug-involved offenders out of prison and on the path to restoration and recovery.

- In Spring 2007, the CLEAR Commission, a group of top Illinois policymakers and justice practitioners, offered its first set of recommendations related to its broad-based review of the Illinois Criminal Code in order to achieve clarity and equity in criminal justice laws and practice.

- During the Illinois Spring 2007 legislative session, bills were introduced to expand prosecutorial diversion programs for drug offenders, to increase funding for drug courts, and to expand treatment and case management for drug-involved probationers.

Illinois is not the only state in which such a broad-scale examination of drug policies and strategies is underway. Many states have initiated or are considering legislation promoting large-scale access to substance abuse treatment for drug-involved offenders. States, such as California and Arizona, have expanded treatment capacity to respond to the large population of offenders that require treatment for substance use disorders.

Illinois may not be the only state exploring options for dealing with this challenging population, but the state is uniquely positioned to promote treatment for drug offenders. Over the past 20 years, Illinois has developed an infrastructure of laws, licensure and practice designed to address the needs of non-violent, drug-involved offenders. These practices and policies ensure that all individuals comply with mandated criminal justice requirements. However, Illinois' system has never been truly brought to scale.

Efforts currently underway to re-evaluate the criminal justice approach to working with drug offenders could not be timelier. Illinois is struggling with the social, logistical and fiscal burden caused by drug offenders within the criminal justice population. Drug offenders—at both the local and state level—are the largest consumers of criminal justice resources. Illinois' prisons are filled to capacity with non-violent drug offenders that lack access to adequate drug treatment. Without treatment, drug offenders are at an increased risk of re-arrest. Our prisons are filled with a disproportionate number of minorities imprisoned for drug offenses, creating a devastating impact on minority communities. And Illinois taxpayers are paying for it all.

This report builds on the activities mentioned above, by incorporating an essential review of the "lessons learned" from other states that have enacted broad-scale legislation for drug offenders. This report explores these initiatives and distills recommendations for Illinois policymakers, to assist legislators as they consider the needs of the criminal justice and treatment systems. This report presents the framework to provide cost-effective solutions that effectively address substance use disorders for non-violent drug offenders in Illinois.

Report Structure

Section I presents the historical evolution of drug policy, both nationally and within Illinois. This section highlights the basic foundation of current Illinois drug policy. .

Illinois' prisons are filled to capacity with non-violent drug offenders that lack access to adequate drug treatment.

Section II details the implications of Illinois drug policy, including the changes in incarceration patterns for non-violent drug offenders. The section also examines changes in the racial composition of drug offenders, as well as demonstrating the impact of drug policies on different regions throughout the state. This section briefly examines whether increased penalties have effectively reduced the availability of drugs in Illinois. The impact of a felony conviction, recidivism, costs of incarceration, costs of untreated substance use disorders, as well as the cost effectiveness of treatment, are discussed in section II.

A timeline juxtaposes historical drug policy changes alongside the increasing number of individuals admitted to prison for drug offenses from 1984 to 2002.

Section III summarizes Illinois' current diversion infrastructure for drug-involved offenders, as well as other large-scale diversion initiatives across the country. A "quick glance" section allows for easy comparison across 12 areas of program infrastructure, such as funding, treatment options and participant accountability standards. State narratives provide further information about the process and implementation of states' alternatives to incarceration programs. A comparison of successes and challenges in other states' implementation processes help to inform policy recommendations.

SECTION I

Evolution of Drug Policy in the United States and Illinois

Evolution of Drug Policy in the United States

The United States' conception of drug regulation or "drug policy" has its origins in the early 1900s. Substances such as opium and cocaine were commonplace in medicine. These substances were considered to have beneficial properties to health and well-being, and were widely advertised as such.[1] Opiate dependency was a common phenomenon prior to the 20th century in the United States and occurred primarily among white, middle-class women.[2]

One of the first federal drug policies, enacted in 1906, was the Pure Food and Drugs Act, prompted by public attention to food contamination highlighted in Upton Sinclair's novel *The Jungle*.[3] The Pure Food and Drugs Act was also a response to patent medicines or "cure-alls" that contained such drugs as cocaine and heroin. The Act regulated food production and instituted content labeling of all medicines, many of which contained high concentrations of heroin, morphine, cocaine, cannabis and other drugs.[4]

During the late nineteenth and early twentieth century, drug use became associated with social transformations like urbanization, industrialization, and patterns of immigration. Consequently, people began to associate drug use with immigrant and minority groups—specifically males of color.[5] The first state restrictions prohibiting drug use occurred in California in 1909, and banned the importation of smoking opium.[6] Newspapers published fictional and sensationalized stories that played on American fears about the so-called "crazed behavior" of immigrant opium smokers and the supposed dangers posed by their potential fraternization with white women. For example, stories portrayed Chinese immigrants who lured "innocent" white women into addiction, sexual slavery and prostitution. "Yellow journalism" created the fictional image of the African American male as the "cocaine crazed Negro," who allegedly raped white women and under the influence of cocaine could withstand the assault of a .38 caliber bullet. These newspaper stories stirred up

Drugs like cocaine and heroin were commonplace in medicine in the early 20th Century.

public sentiment against drugs like opium and cocaine, and helped lead to passage of the Harrison Narcotics Act of 1914. [7]

The Harrison Narcotics Act of 1914 regulated the prescription, sale, and importation of cocaine and opiates. The Harrison Act was then followed by a series of Supreme Court decisions that, in effect, initiated the first instances of the "criminalization" of drug use. At this point, the condition of being physically dependent on or "addicted" to substances became a criminal and law enforcement concern, rather than a public health or a medical matter.[8]

In the 1930s, the viewpoint that addiction and dependency were criminal activities, as opposed to health issues requiring medical solutions, was further institutionalized with the advent of more punitive laws, heightened law enforcement, incarceration and in some cases institutionalization.The 1950s witnessed a significant increase in the severity of penalties for drug law violations, including the creation of the first mandatory minimum sentences for these violations.[9] For example, a first-time marijuana possession offense carried a minimum sentence of two to ten years.

The 1960s and the Movement toward Treatment

In 1962, the tide began to turn toward a more public health or medical approach with the Supreme Court case *Robinson v. California.* This case affirmed addiction as a medical condition rather than a criminal offense.[10] State sentencing structures began to adopt this stance and for the first time, adopted treatment as an alternative to punitive penalties. Following suit, in the 1960s and early 1970s, policy began to favor rehabilitation, particularly with the proliferation of drug use among counter-cultural movements. Further focus on rehabilitation occurred with a wave of soldiers returning from Vietnam with heroin addictions.

In the early 1970s, the Drug Enforcement Agency was formed and the scheduling of drugs, which remains in place to this day, occurred. During the 1970s, the Law Enforcement Assistance Administration made funding available to local jurisdictions to develop demonstration programs to implement treatment alternatives to incarceration for non-violent, drug involved offenders, known as the Treatment Alternatives to Street Crime or the "TASC" program.[11]

By the 1920s, drug dependency was considered a criminal matter.

The 1980s and the Escalation of the War on Drugs

During the 1980s, federal legislators enacted laws that increased penalties for both the use and sales of drugs. Congress established the Office of National Drug Control Policy (ONDCP) as a cabinet level office, signifying an elevated stance on drug use. Congress also enacted significantly harsher penalties for drug violations, many of which remain in place today, such as the dramatic disparity in federal sentencing for crack and powdered cocaine.[12]

Since the creation of the ONDCP, approximately 70 percent of federal anti-drug money has been spent on supply-reduction strategies such as drug control in source countries, and street-level enforcement, while 30 percent has been spent on prevention and treatment.[13] Today national fiscal allocations for interdiction and law enforcement far exceed allocations for prevention and treatment, even though studies evaluating the efficacy of interdiction and punitive measures have been almost completely neglected.[14] Most state budgets echo these allocations. Many states, including Illinois, began to initiate increasingly harsh penalties for drug possession and distribution. Unlike many other states, Illinois was a forerunner in legislating treatment alternatives to incarceration.

Today only 30 percent of anti-drug money is spent on prevention and treatment.

The Basic Design of Illinois Drug Policy

Crimes in Illinois are classified as either misdemeanors or felonies, with multiple classes in each category to account for differences in the severity of the crime. The primary distinctions between misdemeanors and felonies are type and seriousness of the offense(s) and the amount of prison time to be served. The majority of drug offenses in Illinois fall into one of two categories: a) possession, and b) manufacture, delivery and possession with intent to manufacture or deliver.

Felony Class

Most Severe----------Least Severe

Class X -- Class 1 -- Class 2 -- Class 3 -- Class 4

Like many states, Illinois employs a graduated penalty structure for drug law violations, by which the penalty is dependent on the weight of drugs (or number of pills) involved. As the weight increases, offense classification and the resulting penalties become increasingly severe. The graduated penalty structure utilizes the type of drug and the amount of drugs involved in the offense to determine the sentence. The type and weight may be the difference between treatment and probation, or between probation and prison time.

Evolution of Drug Policy in Illinois

The basic underpinning of Illinois drug policy was constructed in the early 1970s, when schedules for specific drugs were created along with felony classifications and accompanying sentences for drug offenders. By the late 1970s, the Class X felony level was introduced for drug sales offenses and weight reductions occurred within each felony class for both sales and possession offenses. In the early 1980s, the weight of the substance was further reduced within the equivalent felony class.

Enhanced Penalty Zones and Escalation of Penalties

In 1985, the first "special condition" rule was added to the sales offenses, otherwise known as "Drug Free Zones." Beginning in 1985, any individual selling an illicit substance within 1,000 feet of any school effectively faced doubled penalties. The law was passed, despite the fact that the General Assembly had already addressed sales to minors in a legislative amendment in 1978. In 1992, legislature clarified the language of the Drug Free Schools Zones to explicitly prohibit drug sales even when children were not present in school. Nine additional enhanced penalty zones were added from 1988 to 1999 to include public parks, public housing, busses and bus

The amount of drugs required to "trigger" a prison sentence has decreased dramatically over the past two decades.

stops, truck and rest stops, places of worship and nursing homes. These laws effectively place much of Chicago in an enhanced penalty zone.

In the early 1990s, a graduated system of mandatory minimums and extension of maximum sentences for Class X felonies was enacted. These changes to the Illinois Code effectively disqualified some offenders from receiving treatment in the community, and required long prison sentences. Additionally, legislative changes throughout the 1980s and 1990s continually decreased the weight of drugs that triggered a prison sentence for both sales and possession offenses (see timeline in Appendix A for detailed information).

Possession Offenses

In an approximately 25-year time period, the felony classification and criminal charges for drug possession offenses have changed dramatically. Currently, individuals who possess smaller amounts of drugs face greater penalties than in the past (Table 1). Since the reclassification of drug offense weights, an individual convicted of possession of 15 grams of cocaine—about ½ a tablespoon—is now eligible to serve the same sentence as a violent offender convicted of sexual assault or child pornography (Table 3).

Table 1: Example of Felony Class Changes for Possession of an Illicit Drug Offense, 1982 and Current

Year	Drug	Class 1 Felony	Class 4 Felony
1982	Cocaine or Heroin	≥30 grams	<30 grams
Current	Cocaine or Heroin	≥15 grams	<15 grams

Possession of 15 grams of cocaine, about half a tablespoon, carries the same sentence as sexual assault.

Sales Offenses

For sales offenses, the amount of drugs required to "trigger" a prison sentence has decreased dramatically over the past two decades. In 1982, more than 30 grams of cocaine constituted a mandatory prison sentence, but today sales of five grams of cocaine or heroin—about ½ a teaspoon—carries a mandatory prison sentence. Currently, an individual convicted of sales of half a teaspoon, or 5 grams, of cocaine can serve the same sentence as a violent offender convicted of sexual assault. Sales of 15 grams, about ½ a tablespoon, carries the same sentence as armed robbery or aggravated criminal sexual assault, a prison sentence ranging from 4 to 15 years. Sales of very small amounts of drugs, less than one gram of cocaine, about 1/10 of a teaspoon, carries the same sentence as arson or robbery, a sentence range of 3 to 7 years (Tables 2 and 3).

Table 2: Example of Felony Classification Changes for Sales of an Illicit Drug Offense, 1982 and Current

Year	Drug	Felony Class			
		Probationable		Mandatory Prison Time	
		2	1	1	X
1982	Cocaine	<10 g	10 to <30 g	N/A	≥30 g
	Heroin	<10 g	10 to <15 g	N/A	≥15 g
Current	Cocaine	<1 g	1 to <5 g	5 to <15 g	≥15 g
	Heroin	<1 g	1 to <5 g	5 to <15 g	≥15 g

Table 3: Example of Drug Offenses, Equivalent Offense Classification and Sentence Range[15,16]

Example Drug Offense	Felony Class	Example Equivalent Offense	Prison Sentence Range
Possession of <15 grams of heroin or cocaine	**Class 4**	Stalking; Unlawful possession of a firearm	1-3 years
Sale of <1 gram cocaine	**Class 2**	Robbery; Arson	3-7 years
Sale of ≥1 gram cocaine	**Class 1**	Child pornography; Sexual assault	4-15 years
Possession of 15 grams of cocaine			
Sale of 15 grams of heroin or cocaine	**Class X**	Armed robbery; Aggravated criminal sexual assault	6-30 years

Concurrent Creation of Treatment Alternatives in Illinois

In parallel to the development of more punitive drug laws, a treatment alternative infrastructure was also in legislative development. As early as 1968, Illinois State legislators recognized the burden of the substance-using offender entering and re-entering the criminal justice system. In response, legislators passed laws allowing for treatment alternatives to incarceration. At this time, treatment programs were operated directly by the State Department of Mental Health, which was required to answer court orders, attend hearings, refer clients to treatment and report to the courts. With limited staff, a fundamental breakdown in communications occurred and placed the state in contempt of court. The state determined that a liaison agency was needed to coordinate treatment for criminal justice populations. In 1974,Treatment Alternatives for Safe Communities (TASC) was first established in Illinois.[17]

In the mid 1980s, further federal funding allowed for statewide expansion. Additional statutes and licensure regulations codified the role of TASC as the "Designated Program" (see Section III for details), the rules for eligibility, and the process for accessing those alternatives. This marked the first time that any state in the country had legislated treatment alternatives to incarceration on a broad-scale and statewide level.[18]

Section I Synopsis

Over the past 25 years, the Illinois General Assembly has enacted nearly 20 laws that have significantly increased penalties for drug offenses. By the late 1980s, legislative changes mandated that some drug offenses were ineligible for probation. Legislative changes continually decreased the weight of the substance amount within the equivalent felony class for both sales and possession offenses.

Despite the introduction of treatment alternatives, laws became more punitive and increasingly favored incarceration over treatment. A fundamental conflict arose between the laws that provided for treatment alternatives to incarceration and the increasing severe sentences for drug offenders. This clearly represents a contradiction in current Illinois drug policy.

Section II

Implications of Illinois Drug Policy

Large Prison Increases: Drug Offenses Accountable

Since 1970, when the modern era of drug policy began, Illinois' prison population has increased by over 500 percent, with a current average daily population of almost 45,000 individuals. This represents an annual cost to Illinois taxpayers of approximately $1.3 billion.[19] Increasing numbers are mirrored throughout the Illinois criminal justice process, including the number of individuals on probation. Since 1985, the number of individuals on probation has nearly doubled from 75,000 to almost 145,000 individuals.[20]

In 2005, drug offenders accounted for about one-third of the total Illinois prison population. Nearly 25 percent of individuals incarcerated in Illinois Department of Corrections were drug possession offenders. Roughly 10 percent of inmates housed in Illinois prisons were convicted of sales offenses and the majority of incarcerated sales offenders were low-level offenders.[21]

According to analysis of the Department of Justice Prison Admissions data sets from 1984 to the most current year (2002),[22, 23, 24] the number of incarcerated drug offenders in Illinois increased by 1,968 percent. These offenders represented the fastest growing segment of the prison population. In 1984, 628 individuals were incarcerated for a drug offense. In 1992, 5,165 individuals entered prison for a drug offense and by 2002, 12,985 individuals entered Illinois prisons for a drug offense. In 1984, drug offenders comprised 6 percent of total state prison admissions, but by 2002, 38 percent of total prison admissions were drug offenders (Chart 1 and 2).

Chart 1: 1984 State Total Proportion of Drug Offenders as Percentage of Total Prison Entrances (n=9,788)

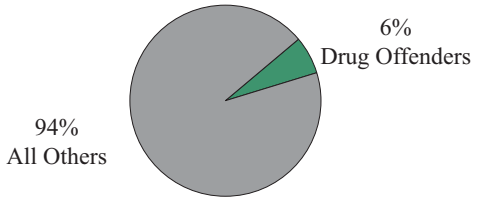
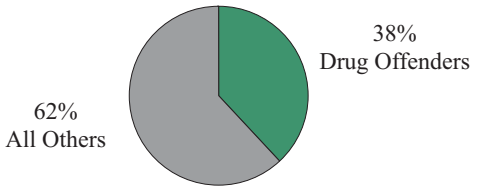


Chart 2: 2002 State Total Proportion of Drug Offenders as Percentage of Total Prison Entrances (n=34,183)



Analysis of the same data sets demonstrate that in 1988, Illinois ranked 10th in the country for the number of individuals entering prison for drug offenses. In 2002, Illinois ranked 2nd in the nation for the number of individuals entering prison for drug offenses (see Appendix B). From 1988 to 2002, the number of offenders entering prison in Illinois increased by 758 percent, a higher percentage increase than any other state in the nation reporting during that period (Appendix C).

Regional Change in Drug Offenders

In 1984, drug offenders comprised 6 percent of all prison admissions from Cook County. In 2002, 46 percent of all offenders entering prison from Cook County were drug offenders (Chart 3 and 4).

In 2002, the vast majority of drug offenders—nearly 70 percent—sentenced to prison in Illinois were convicted in Cook County. However, the Collar Counties and the rest of the state also have experienced significant increases in the number and proportion of drug offenders sentenced to prison over the last two decades.[25, 26] For example, in the Collar Counties in 1984, drug offenders comprised only 9 percent of those convicted and sentenced to prison within that area (68 individuals). In 2002, 30 percent of those convicted and sentenced to prison within the Collar Counties were drug offenders (1,184 individuals). From 1984 to the 2002, the number of drug offenders sentenced to prison within Will County rose by 2,744 percent, greater than Cook County's increase of 2,246 percent. In 1984, drug offenders comprised just 16

Chart 3: 1984 Cook County Proportion of Drug Offenders as Percentage of Total Prison Entrances (n=9,788)

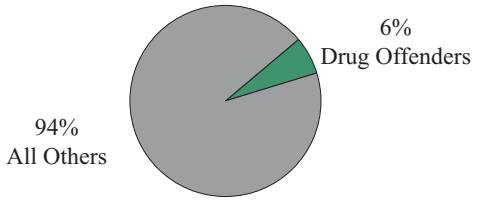
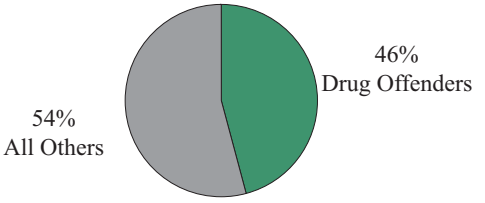


Chart 4: 2002 Cook County Proportion of Drug Offenders as Percentage of Total Prison Entrances (n=34,183)



In 2002, Illinois ranked 2nd in the nation for the number of individuals entering prison for drug offenses.

percent of those convicted and sentenced to prison in Kane County (25 individuals). In 2002, 42 percent of offenders—378 individuals—convicted and sentenced to prison in Kane County were drug offenders (Appendix D).

Counties outside of the Chicago metropolitan area have also been affected by changes in drug policies. In 1984 in Downstate Illinois, drug offenders comprised just 6 percent of those sentenced to prison (179 individuals), but in 2002 drug offenders comprised 22 percent of those sentenced to prison from Downstate courts (2,849 individuals). For example, in 1984 just 2 percent of those sentenced to prison in Champaign County were drug offenders, but by 2002, 31 percent of those sentenced to prison within the county were drug offenders (Appendices E and F).

Increased Racial Disparity

Illinois' shift toward increasing punitive drug policies that favor incarceration over treatment during the last two decades have had a disproportionately negative impact on African American communities. Analysis of Department of Justice data demonstrates a nearly three-fold increase among those entering prison for drug offenses from 1988 to 1990, from 1,511 individuals to 4,458 individuals (Chart 6). This dramatic increase in a two-year timeframe coincides with a number of changes to the Illinois criminal code. In 1988, the enhanced penalty park zones were added, thus doubling the maximum sentencing and fines for individuals convicted of sales of less than one gram of cocaine. In 1990, a graduated system of mandatory minimums was established for Class X felonies. Public housing penalty zones were added in 1990 as well (see timeline). These changes coincided with a dramatic change in the racial composition of those who entered prison for drug offenses.[27, 28] The number of African Americans incarcerated for drug offenses increased 4-fold, from 782 in 1988 to 3,083 in 1990. According to a 2006 Roosevelt University study,[29] despite similar drug use rates among Blacks and Whites, in 2002 Blacks comprised 15 percent of Illinois' population, but constituted more than 80 percent of all drug offenders admitted to prison. In 2002, Illinois ranked first in the nation in the per capita rate of incarcerated African Americans convicted of drug possession offenses.

Racial disparities in Illinois have increased over time, according to analysis of the Department of Justice data from 1984 to 2002, particularly among African Americans. The proportion of Whites and Latinos entering prison for drug violations

Counties outside of the Chicago metropolitan area have also been affected by changes in drug policies.

has decreased (see chart 5). These shifts coincide with drug policy changes, which began in the late 1980s and continue to the present day (see timeline in Appendix A).[30, 31] In 1984, African Americans made up 47 percent of drug offenders entering prison. By 2002, African Americans made up nearly 80 percent of drug offenders admitted to prison. In 1984, 297 African Americans entered prison because of a drug offense. In 2002, more than 10,000 African Americans entered prison for a drug offense. From 1984 to 2002, the number of African Americans incarcerated for drug offenses rose 3,293 percent, while Whites incarcerated for drug offenses rose 799 percent.

The proportion of Whites and Latinos admitted to prison for drug offenses has decreased dramatically. For example, in 1984 White drug offenders comprised 37 percent of drug offenders entering prison. In 2002, however, White drug offenders made up only 16 percent of incarcerated drug offenders. In 1984, Latinos made up 16 percent of drug offenders entering prison, but in 2002, only 6 percent of drug offenders entering prison were Latinos.

Chart 5: 1984-2002 Percent of Drug Offenders in Total Prison Population by Race

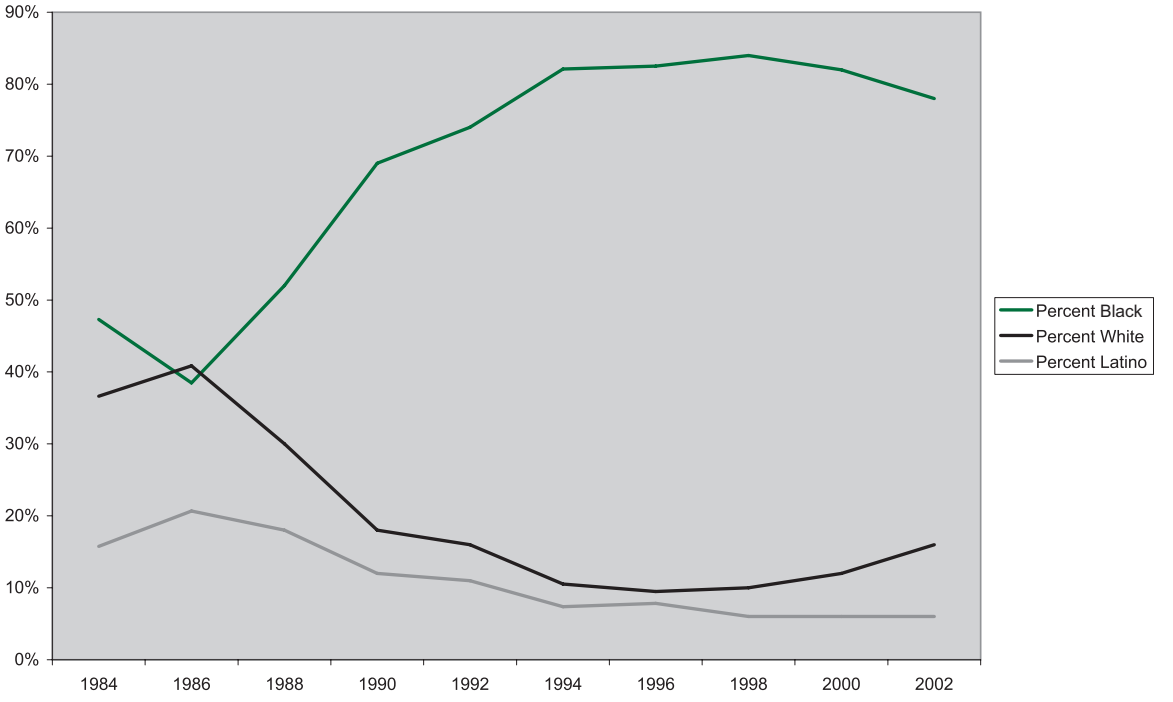
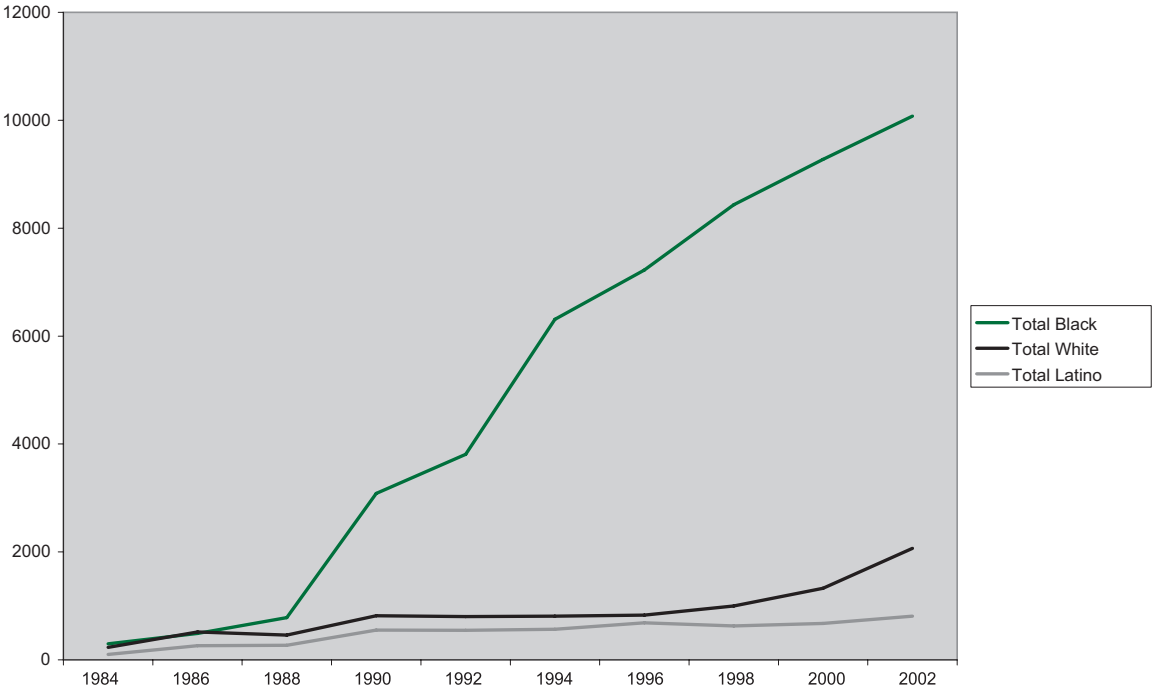


Chart 6: 1984-2002 Total Number of Drug Offenders in Prison Population by Race



Impacts of Illinois Drug Policy

Costs of Incarceration

The cost of imprisoning one individual is estimated to be between $20,637 and $25,900 per year.[32] In 2005, $1.21 billion were allocated for corrections, which represents a 221 percent, or more than a three-fold, increase over 1990 figures.[33]

Impact of a Felony Conviction

A felony conviction can impact an individual's ability to successfully reintegrate into society. Employers, landlords or loan companies often use felony convictions to disqualify individuals from jobs, housing and credit. These restrictions combine to create a massive "roadblock" for an individual seeking to reintegrate and fully function in society. These barriers can make it increasingly difficult to secure employment after

In 2005, it cost Illinois taxpayers $240 million to incarcerate drug offenders.

incarceration, thus fueling a "vicious cycle" of re-entry and re-incarceration.

Recidivism: Prison's Revolving Door

For the formerly incarcerated, the likelihood of returning to prison is extremely high at both the federal and state levels. The number of people entering and leaving state and federal prisons continues to grow. In 2004, more than 697,000 people were admitted to state and federal prisons, and more than 670,000 were released.[35]

Have Illinois' Drug Policies Lowered Drug Availability?

If Illinois' drug policies aim to curb availability, decrease purity, and increase drug prices, these policies appear to be ineffective. According to the National Drug and Intelligence Center,[37] powdered and crack cocaine have become increasingly available with prices declining slightly over a ten-year period. 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 per pound average in the East and Midwest of the United States.[38] 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 New York City.[39]

Drug Availability in Schools

Despite enactment of Drug Free Zones in 1985, which increased penalties and outlawed drugs in schools and within 1,000 feet of schools, drugs appear to be easier to obtain at school in 2005, than in 1993. According to analysis of the 2005 Risk Youth Behavior Survey, children in Chicago and Illinois are much more likely to report having been offered, sold or given an illegal drug on school property than in the past decade.[40, 41]

Costs of Untreated Substance Use Disorders

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.[42] With a lack of treatment capacity, other associated expenses accrue, including medical and social costs.[43] Untreated substance use disorders increase the likelihood of domestic violence and need for mental health services. Left untreated, substance use also lowers worker productivity and increases homelessness, poverty and unemployment, and results in higher incarceration rates.[44]

Fifty-two percent of individuals released from Illinois' prisons in 2002 had returned to state prisons by 2005.

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.[45, 46] The average cost savings from each dollar invested in treatment yields approximately $8 returned to society. Currently, treatment availability in Illinois 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.[47]

Section II Synopsis

The impacts of drug policy changes are reflected in the rise of incarceration of drug offenders. In 1984, drug offenders comprised just 6 percent of Illinois prison admissions; by 2002, nearly 40 percent of the total prison admissions were drug offenders. In 2002, nearly 13,000 individuals entered Illinois state prisons. In 2005, one out of four individuals incarcerated in Illinois' Department of Corrections was a *drug possession* offender.

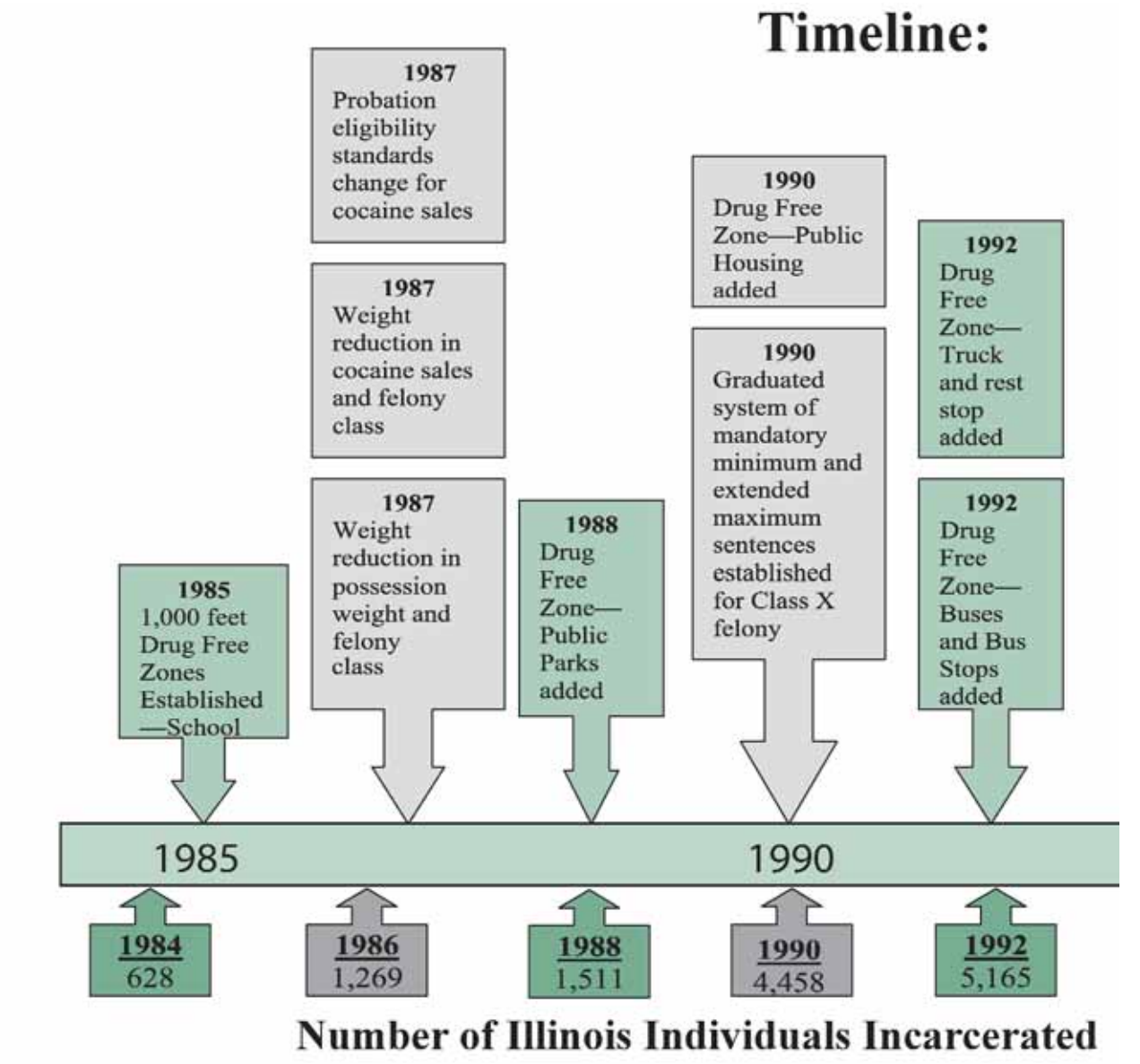
There is a great disparity between the racial and economic composition of Illinois residents and drug offenders housed in Illinois' prisons. Individuals experiencing poverty, homelessness and substance use and mental health disorders are also over-represented in the Illinois criminal justice system.

The extremely large increases in the number of drug offenders entering and exiting the Illinois criminal justice system every year has lead to a system overload. Corrections has become the default system for other overburdened public services and systems, including substance abuse and mental health prevention and treatment, poverty and housing, and basic healthcare.

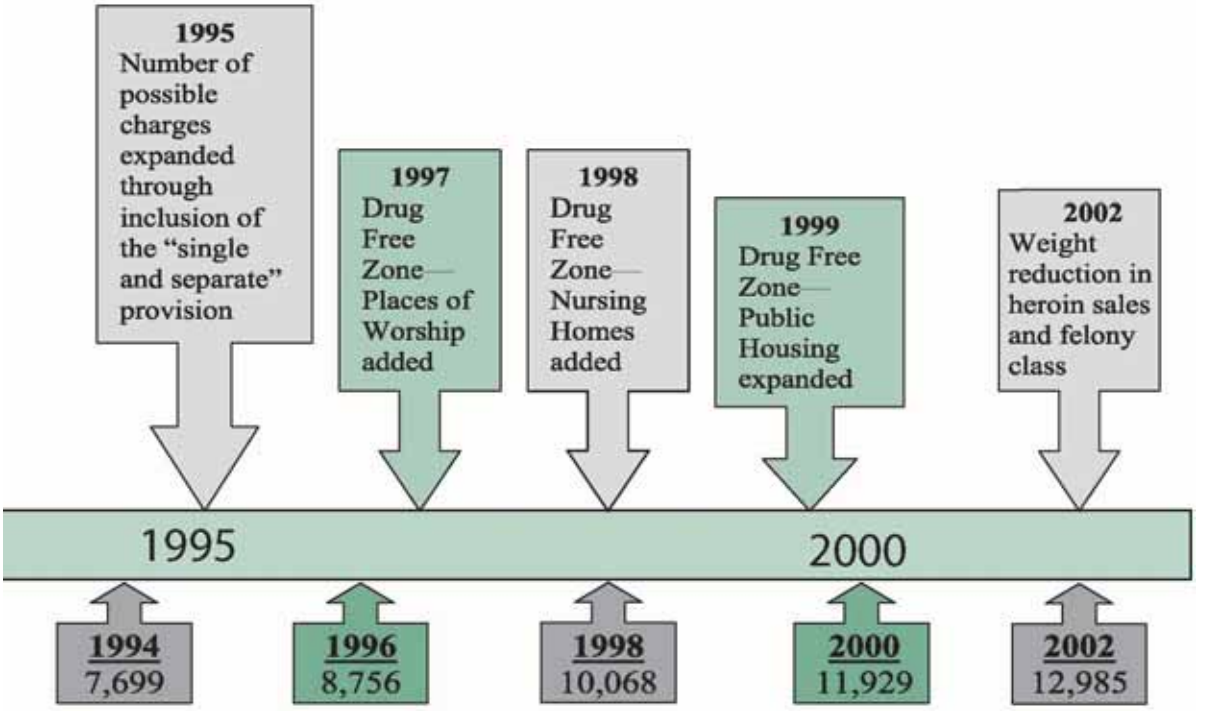
An examination of drug availability demonstrates that Illinois' current policies have not effectively reduced the availability of drugs in either communities or schools. In Illinois, the increasing incarceration of drug offenders appears to have little or no effect in reducing drug supplies or drug use disorders.

Not only are judges, defense attorneys and prosecutors significantly overwhelmed with the large number of defendants on their court dockets, but probation officers, jails and prisons are also struggling to keep pace with the number of individuals entering these systems each year. Unfortunately, the flow of individuals through the criminal justice and corrections system has not been matched by a corresponding increase in rehabilitative resources.

On average, each dollar invested in treatment returns about $8 to taxpayers.


Timeline:
1987
Probation eligibility standards change for cocaine sales
1987
Weight reduction in cocaine sales and felony class
1987
Weight reduction in possession weight and felony class
1988
Drug Free Zone—Public Parks added
1990
Drug Free Zone—Public Housing added
1990
Graduated system of mandatory minimum and extended maximum sentences established for Class X felony
1992
Drug Free Zone—Truck and rest stop added
1992
Drug Free Zone—Buses and Bus Stops added
1985
1,000 feet Drug Free Zones Established —School
1985
1990
1984 628
1986 1,269
1988 1,511
1990 4,458
1992 5,165
Number of Illinois Individuals Incarcerated

Historical Drug Policy Changes and Number of Illinois Individuals Incarcerated for Drug Offenses From 1984 to 2002



for Drug Offenses From 1984 to 2002

Section III

Examination of States' Solutions and Applicability to Illinois

Comparison of States' Alternatives to Incarceration Programs

Many states across the country, through both public and legislative initiatives, have embraced public health approaches and have codified treatment for drug offenders as an alternative to incarceration. According to the recently released Sentencing Project report, "Changing Direction," at least 22 states across the country have enacted sentencing reform for drug offenders between 2004 and 2006. [48] These changes include alternatives to incarceration for drug offenders and expanded probation and parole reforms to ensure that less taxpayer money is spent on incarcerating non-violent drug offenders. Clearly, there is a national movement to promote alternatives to incarceration, including complete diversion from prison to treatment.

In order to present an account of how state systems were both enacted and implemented, we researched 8 states that enacted reforms from 1995 to 2004. Examination of each state's alternative to incarceration program was conducted by reviewing public acts, evaluation research, and interviews with individuals. This section of the paper focuses on the following states: Washington, Arizona, California, Hawaii, Kansas, Indiana, and Maryland. Also examined is the infrastructure for a large-scale diversion from incarceration model in Illinois.

A Quick Glance of State Comparisons: 12 Different Lenses

In order to closely examine sentencing reform for drug offenders or drug-involved offenders, the researchers decided to examine several key components necessary for the implementation of large-scale statewide reform efforts. To this end, we created a 12-part rubric to quickly compare and contrast complex and inherently complicated statewide alternatives to incarceration models. Each state model is unique and required some discretion by the researchers when compressing detailed legislative programs into concise component aspects. For example, in Kansas, treatment is categorized as mandatory, as stated in the law. However, exceptions exist for certain

At least 22 states across the country have enacted sentencing reform for drug offenders between 2004 and 2006.

groups in which case the judge has discretion (e.g., undocumented immigrants). For more information about a particular state program, please see state narrative and citation(s). Pages 24-34 provide an "At a Glance" comparison for each state:

1. Legislation Enactment: Ballot Initiative or Legislation
2. Judicial Discretion for Program Participation
3. Diversion Program Funding
4. Eligible Population
5. Limitations on Diversion Eligibility
6. Infrastructure
7. Assessment and Referral to Treatment and Case Management
8. Mechanisms and Standards for Criminal Justice and Health Agency Communication
9. Treatment Options
10. Length of Treatment Involvement
11. Participant Accountability for Treatment and/or Probation Violations
12. Expungement Available Upon Successful Completion

Legislation Enactment: Ballot Initiative or Legislation?

Arizona	California	Hawaii	Kansas
Ballot Initiative and Legislation[49]	Ballot Initiative[50]	Legislative: Proposed by former Governor Cayetano[51]	Legislative: Proposed by the Kansas Sentencing Commission[52]
Maryland	**Washington**	**Indiana**	**Illinois**
Legislative: Proposed by former Governor Ehrlich[53]	Legislative: Sponsored by Governor Locke[54]	Legislative[55]	Legislative[56]

Is the Program Mandatory or Does the Judge Have Discretion?

Arizona	California	Hawaii	Kansas
Mandatory[57]	Mandatory[58]	Judge has discretion[59]	Mandatory[60]
Maryland	**Washington**	**Indiana**	**Illinois**
Judge has discretion[61]	Judge has discretion[62]	Judge has discretion[63, 64]	Judge has discretion[65]

How is the Program Funded?

Arizona	California	Hawaii	Kansas
Luxury Privilege Tax on Liquor and Tobacco. Distributed by the Administrative Office of the Supreme Court.[66] Able participants are required to pay for some portion of their treatment.[67]	Appropriated $120 million a year for a 5 year period upon implementation which established the Substance Abuse Treatment Trust Fund.[68]	The Emergency and Budget Reserve Fund, approximately $2.2 million a year. Funding is determined on a year-by-year basis, with legislators or the governor. Able participants are required to pay for some portion of their treatment. Requires a fiscal report to the legislature for each fiscal year.[69]	The State General Fund distributes monies to the Kansas Sentencing Commission.[70] The sentencing court determines amount, if any, offenders pay for participation in the program.[71]
Maryland	**Washington**	**Indiana**	**Illinois**
Maryland legislature appropriates money to the Maryland Substance Abuse fund. Able participants pay a $150 administration fee.[72]	Criminal Justice Treatment Account was established on $8,950,000 in 2003 from the general state fund. Receiving $8,250,000 per year, with annual increases decided by price inflation. 70% is distributed directly to counties and 30% is distributed in grants.[73]	The Forensic Diversion Program account is created within the State General Fund. The account consists of money appropriated by the General Assembly, donations and other grants. Monies are solely for providing treatment and related services to participants of the program. The Department of Corrections is responsible for allocating funds to counties based on need and funds available.[74,75]	The State Department of Human Services. Illinois state budget also provides funding to TASC for other treatment services.[76]

Who is Eligible for the Program?

Arizona	California	Hawaii	Kansas
Non-violent offenders convicted of possession or use violation for the first or second time. Nonviolent drug related offenders currently in prison, who show a need for the service. Others who demonstrate a need for the service after all those mandated to treatment have been serviced. [77]	Non-violent first or second time offenders convicted of possession, use of any controlled substance, paraphernalia, and/or an offense committed under the influence of a controlled substance[78,79]	Non-violent first time offenders convicted of possession, use or paraphernalia violation for the first time. Probation and parole violators (only if violation is drug related).[80]	Non-violent offenders convicted of possession violation for the first or second time.[81]
Maryland	**Washington**	**Indiana**	**Illinois**
Any drug involved offender.[82] Inmates may be released on parole if: The inmate has been sentenced to 6 months or more and has served one-fourth of aggregated sentence If the inmate is amenable to treatment and the appropriate treatment program is available.	Any drug involved offender, dependent on offense, criminal background and standard sentence range.[83]	The Department of Corrections must determine the offender to have an addictive disorder and/or mental illness. For both tracks, the offender must be charged with a non-violent crime and not have been convicted of a violent crime within the previous 10 years. Track 1: The offender has been charged with a Class A, B, or C misdemeanor, or a Class D felony that may be reduced to a Class A misdemeanor. Offenders on the pre-conviction track must enter a plea of guilty. Track 2: Offenders on the post-conviction track may not have been convicted of a drug dealing offense, but include other non-drug felonies.[84]	Non-violent offenders who abuse and/or are dependent on drugs or alcohol who are convicted of a crime that is probationable. Only those who have never participated in the program, or have participated one time in the past two years are eligible. Eligible individuals are sentenced to probation.[85]

What are the Limitations on Program Eligibility?

Arizona	California	Hawaii	Kansas
The crime is considered violent or the defendant has a previous violent crime conviction. The defendant refuses or is not amenable to treatment. The individual is convicted of sale/manufacture offense. The individual cannot have two prior drug possession convictions or a methamphetamine possession offense. Must not pose a "threat to the community safety." [86]	The crime is considered violent or the defendant has any violent felony conviction within the previous 5 years. The defendant refuses or is not amenable to treatment. A conviction in the same proceeding of a misdemeanor, not related to the use of drugs. Received two separate convictions for a non-violent drug offense and 2 failed treatment attempts.[87]	The crime is considered violent or the defendant has any violent felony conviction within the previous 5 years. The defendant refuses or is not amenable to treatment. The individual cannot be convicted of sale/manufacture offense.[88]	The crime is considered violent. The defendant refuses or is not amenable to treatment. The person cannot be convicted of sale/manufacture offense. Two prior drug possession convictions.[89]
Maryland	**Washington**	**Indiana**	**Illinois**
The crime is considered violent or the defendant has any violent felony conviction within the previous 5 years. The defendant refuses or is not amenable to treatment. The individual cannot be a habitual offender. No large quantity manufacturing, distribution, possession or for hiring, soliciting, engaging, or using a minor to manufacture, dispense, distribute, or possess a dangerous substance offenses.	The crime is considered violent or the defendant has any violent felony conviction within the previous 10 years. The defendant refuses or is not amenable to treatment. The offender has been convicted for a sex offense at any time. The offender has received a drug offender sentencing alternative more than once in the prior ten years before the current offense[90]	The crime is considered violent or the defendant has any violent felony conviction within the previous 10 years. The defendant refuses or is not amenable to treatment If the crime or a previous crime is drug trafficking in nature, unless little monetary gain.[91]	The crime is considered violent and/or the defendant has a history of violence. The defendant refuses or is not amenable to treatment or the crime is not probationable. The offender has participated in treatment on two prior occasions within a two-year time period. The offender has pending criminal proceedings "alleging commission of a felony." If applicable, the probation or parole authority does not consent to the offender's participation in the program.[92]

What is the Program Infrastructure?

Arizona	California	Hawaii	Kansas
Statewide County probationary departments oversee allocating funds, screening, assessment, treatment and probationer's progress. The Administrative Office of the Courts must approve fund allocation, screening and assessment process.[93]	Statewide Managed overall by the California Department of Alcohol and Drug Programs.[94] Courts, counties, and probation departments oversee program participants.[95]	Statewide The Alcohol and Drug Abuse division under the Department of Health oversees the assessment and treatment referral which is reported to the probation department. Interagency coordination by Department of Health and Probation/Parole Department.[96, 97]	Statewide The Kansas Sentencing Commission oversees the majority of the program components. Community Corrections officers oversee offenders who receive services under SB 123.[98,] The Kansas Department of Corrections trains and certifies treatment providers to treat SB 123 population.[99]
Maryland	**Washington**	**Indiana**	**Illinois**
Statewide The Department of Health and Mental Hygiene is responsible for maintaining and providing certified treatment programs. The Department of Parole and Probation is responsible for diverting defendants and inmates, treatment compliance, and escalating sanctions for non-compliance.[100]	Statewide Department of Corrections is responsible for establishing program criteria, providing initial assessment to offenders and contracting with counties operating Drug Courts.[101]	10 County Pilot Operated at the county level. The county's Community Corrections Advisory Board or Forensic Diversion Advisory Board is responsible for developing, operating, and monitoring the program.[102,103]	Statewide Interagency coordination between case management agency and State Department of Human Services.[104]

What is the Process for Assessment, Service Referral and Case Management?

Arizona	California	Hawaii	Kansas
Probation gives 2 assessments and makes referral: Instrument #1 determines the offenders' risk of re-offending and the level of need. Instrument #2 determines the levels of individualized treatment planning. All assessment, treatment placement and treatment progress is logged in the Probation Information Management system.[105]	The Probation and Parole Department is responsible for coordinating treatment with a designated provider.[106]	8 treatment providers use integrated case management to provide services. Treatment Agency and clinicians provide comprehensive clinical assessments, individualized treatment planning, referrals to treatment and other social services. Includes clinical case management, monitoring of compliance, and reporting to probation.[107,108]	After conviction, participants are assigned a community corrections officer who finds a treatment provider to do an initial drug abuse assessment. The community corrections officer then contacts the appropriate treatment facility and consults with a counselor to determine the specifics of the offender's treatment program.[109]
Maryland	**Washington**	**Indiana**	**Illinois**
Department of Health and Mental Hygiene assesses participants to determine appropriate treatment. Judges can follow the advice of the assessment or choose to utilize a more supervised treatment option.[110]	Initial offender assessment is completed by the Department of Corrections. Assessment includes: A proposed treatment plan, certified treatment provider, recommended frequency and length of treatment, proposed monitoring plan and a recommended crime-related prohibitions. After assessment the court imposes a sentence consisting of either a prison-based sentence or community based treatment alternative.[111]	The Department of Corrections performs initial offender assessment. Court determines eligibility from assessment. Each county Advisory Board creates partnerships with community treatment facilities to provide services. The Division of Mental Health & Addiction must certify all treatment providers.[112]	Use integrated case management facilitated by independent, designated, and certified agency. TASC, the designated agency, is responsible for assessment, individualized treatment planning, referrals to treatment and other social services. Includes use of clinical case management.[113,114]

How do the Criminal Justice Systems and Treatment Providers Communicate?

Arizona	California	Hawaii	Kansas
Information is placed in the Probation Information Management System for collection and communication purposes.[115]	Regular, standardized communication on client's progress required between the treatment provider and probation.[116]	Department of Public Health maintains statewide records. Clinical assessments completed by treatment agency. Assessment then provided to probation/parole officer. Treatment agencies must provide frequent communication with the offender's probation/ parole case manager.[117]	The corrections department works with the treatment facility to ensure supervision and monitoring. Treatment providers are required to notify probation and the court if offenders fail to meet the terms of probation or treatment plan. At the court's discretion, treatment providers may be required to appear at sentencing and probation hearings.[118]
Maryland	**Washington**	**Indiana**	**Illinois**
Treatment centers must notify Division of Parole and Probation of any noncompliance of treatment participants. Department of Public Safety and Correctional Services notify the court when offender is non-compliant. The court will issue warrant for arrest. The court may incarcerate offender or require more treatment.[119]	A progress hearing informs the judge of the offender's performance in treatment. The court may evaluate the offender's progress in treatment at any time. A treatment termination hearing is set 3 months before the end of the program in which the court may authorize the Department to terminate the offender's community custody status. Monitoring for controlled substances is conducted by the Department of Corrections or a comparable court or agency-referred program.[120]	To monitor individual activity, periodic progress reports are required to the court from the treatment facility.[121]	The designated agency monitors participant compliance in treatment and reports to the court and probation departments. The independent agent works between the offenders, courts and the treatment system.[122]

What are the Options for Treatment?

Arizona	California	Hawaii	Kansas
Pre-treatment motivational enhancement for those not yet ready for treatment. Substance abuse education for low risk offenders. Standard and intensive outpatient treatment for medium/low, medium/ high-risk offenders. Day treatment, short term/ long-term residential treatment for high-risk offenders.[123]	Treatment ranges from inpatient treatment, outpatient treatment, residential half-way houses, methadone maintenance therapy, detoxification to drug education or prevention classes for offenders with the least severe drug abuse issues. Other services such as vocational training, family counseling, and literacy training are provided in addition to drug treatment.[124, 125]	Treatment ranges from residential treatment to intensive outpatient and general outpatient. After treatment completion, aftercare includes: the creation of a relapse plan that addresses other medical, psychological, vocational and/or educational goals. There is continued linkage with other community resources (e.g. housing, transportation).[126]	Treatment ranges from alcohol/drug abuse education, detoxification, halfway houses, inpatient treatment, outpatient treatment and relapse prevention. Kansas provides continuing care and aftercare services, and "family and auxiliary support services."[127, 128]
Maryland	**Washington**	**Indiana**	**Illinois**
Treatment includes inpatient treatment, intensive outpatient, ambulatory detoxification with extended on-site monitoring. Also includes, clinically managed medium-intensity residential treatment and DWI education treatment. Non-treatment services (e.g., childcare).[129 130]	Most common type of treatment is intensive outpatient: 5, 6, 9,or 12-week treatment program, which is available in confinement and community. Long term residential (6-12 months) is available only in confinement. Continuing care consists of weekly sessions for a minimum of 3 months for offenders who have completed one of the initial treatment types.[131] Ancillary services include transportation and childcare services.[132]	Treatment ranges from inpatient to outpatient treatment and aftercare services.[133]	Treatment ranges from inpatient, outpatient, and aftercare.[134]

What is the Duration of Treatment?

Arizona	California	Hawaii	Kansas
Not specified in the legislation.	Probationers are limited to 12 months of treatment with an option for 6 months of additional aftercare services.[135]	Treatment is typically between 6 to 9 months in length.[136]	Offenders are assigned to treatment programs for a time period of up to 18 months.[137]
Maryland	**Washington**	**Indiana**	**Illinois**
Treatment shall last from 72 hours to no more than 1 year. If the Drug and Alcohol Administration show good cause, treatment can be increased in increments of 6 months.[138]	Length is determined by a rubric considering offense, criminal record, etc. Minimum for community based tract is 2 years.[139]	Limited to two years for misdemeanor offenses and three years for felony offenses.[140]	The length of probation and the individualized treatment plan drives length of treatment involvement.[141]

What are the Sanctions for Treatment and/or Probation Violations?

Arizona	California	Hawaii	Kansas
Court may impose incarceration if defendant refuses treatment or probation terms.[142] Violations include re-offending, absconding, or a probation officer's petition to revoke probation.[143] Accountability includes graduated sanctions.	Drug related probation violations follow a three-tier plan. First and second time violations may result in revocation of probation if court determines offender as a danger to others, or not amenable to treatment, or if an alteration was made to the original treatment plan. A third drug related violation results in a court hearing to determine if the offender should be incarcerated. Probation may be revoked after the first offense for non-drug related probation violations. A court hearing is conducted to determine revocation.[144]	The court has discretion to return the offender to prison if the terms of probation have been violated by a new drug offense (only applicable to possession and paraphernalia charges). The court can impose alternate treatment methods, a continuation of current treatment, or incarceration.[145]	Individuals are removed from the treatment program if they commit another crime, except for drug possession and/or show a pattern of deliberate noncompliance in the treatment program.[146]
Maryland	**Washington**	**Indiana**	**Illinois**
The treatment facilities are not required to treat those who refuse treatment or not amenable to treatment. The Department of Public Safety and Correctional Services must notify the court that issued treatment of the violation. A warrant is issued for the defendant's arrest and the court may require more treatment.[147]	Any offender, in either tract, that fails to complete the program or is terminated will be required to serve the unexpired term of their sentence in a state corrections facility.[148]	If the individual fails to participate or successfully complete the program as outlined by the forensic diversion program, the stay will be lifted, a judgment of conviction will be entered (for pre-conviction offenders), and the offender will be sentenced accordingly. Probation may also be revoked for those offenders in post-conviction diversion.[149]	A series of jeopardies address the violation based on its nature and adjusts the treatment and supervision plan accordingly. Probation and the court are contacted with violations to ensure the public safety. Violation of the treatment plan holds the possibility of probation revocation.[150]

Is Expungement Available Upon Successful Completion?

Arizona	California	Hawaii	Kansas
Expungement is not addressed in the legislation. [151]	Offenders who successfully complete treatment under SACPA may petition to have their charges dismissed and possible expungement from their record.[152, 153]	The offense is expugnable after the individual provides written application to judge. Expungement is granted once[154]	The legislation does not specify provisions for expungement[155]
Maryland	**Washington**	**Indiana**	**Illinois**
Convictions do not occur if treatment is successful, but individual must petition the court to receive expungement of arrest or of court proceedings.[156]	There is no expungement for the offense upon successful program completion.[157]	Upon successful completion, the court shall waive entry of the judgment of conviction and dismiss the charges.[158]	Offenders may petition to have their judgment vacated, for a first felony offense. Otherwise, the offender is subject to Illinois' laws related to expungement and sealing of criminal records.[159]

State Process and Implementation Narratives

To contextualize the state examinations, this section provides "lessons learned" from the earliest reforms to the more recently enacted laws. These process narratives examine alternatives to incarceration in finer detail then can be accomplished in a simple legislative review. Close examination and research demonstrates that enactment of legislation does not necessarily equal broad scale change. For example, Texas enacted House Bill 2668 in 2003. However, no funding appropriations occurred, so while the reforms exist on paper, in practice, House Bill 2668 had little effect in diverting non-violent drug offenders from jail to treatment. As a result, Texas' projected tax savings were never realized.

The process narratives complement the "Quick Glance" sections. Some states have enacted significant changes to the original program. These changes suggest that programs have been altered to promote efficacy. Illinois stands to benefit from examination of these states' modifications, challenges, and changes to programs. The narratives help to demonstrate the complexity of these processes.

Understanding the progress and process of these models may help refocus Illinois drug policy, and view it through a different lens—a lens that offers significant cost savings and reframes drug use as a public health issue.

Illinois Drug Offender Alternatives (1987)

Recognizing that drug use plays a role in many offenses that are not specifically drug crimes, Illinois' law related to the treatment of non-violent offenders is driven by demonstrated drug use or addiction, not just the current offense. Treatment alternatives in Illinois are theoretically available to any addict convicted of a crime, not just a drug offense, subject to program eligibility criteria. In Illinois, individuals are sentenced to probation—in lieu of incarceration—as part of their participation in a licensed treatment program under the Treatment Alternatives law.

In 1987, Illinois institutionalized its systemic approach to dealing with drug-involved offenders in the Alcoholism and Other Drug Abuse Dependency Act (AODADA).[160] The AODADA describes eligibility and processes for criminal justice interventions for drug-involved individuals (20 ILCS 301/40). This provision is unique. Most criminal justice provisions are generally written into portions of the Illinois code relating to criminal offenses, sentencing, or corrections. However, treatment alternative provisions for individuals involved in the justice system fall under the purview of the Department of Human Services. Therefore, unlike other justice related provisions, the legislature intended that substance abuse treatment services be provided for and monitored by one independent state agency, and not solely the justice system.

To ensure quality and control over services provided by the designated program, the AODADA required the Department of Human Services to develop licensure criteria for the clinical case management of criminal justice clients. This mandate resulted in the designated program licensure provisions currently put forth in Illinois Administrative Rule. Among the key distinctions of this rule is that the designated program be a single organization providing uniform services statewide, with accountability between and among the designated program, the courts, and the community-based treatment network. Illinois' law has reporting requirements, with communication between the courts, probation and treatment providers. Additionally, the designated agency maintains the statewide, unified information system containing clinical records of all participants.[161]

In 1987, Illinois institutionalized its systemic approach to dealing with drug-involved offenders in the Alcoholism and Other Drug Abuse Dependency Act.

Alternatives for drug offenders in Illinois are facilitated by the independent organization who provides assessment and clinical case management services. The designated program provides a layer of clinical supervision on top of probation supervision and serves as the independent agent between the courts and the treatment system. The agency is also responsible for the development of each individual's treatment plan based on comprehensive assessment and proper referral and engagement of the individual in other social support services including mental health, education, and job training.

Monies for designated program services in Illinois are provided through the State Department of Human Services, which oversees the designated program services for criminal justice clients. The State also provides funding for direct treatment services. The designated agency is audited on an annual basis by the State as a condition of its licensure.

The designated program does not provide treatment directly, which means the courts rely on the designated program to make objective clinical determinations, in the best interests of the individual and within the justice system mandates. This helps to maintain consistency in the courts and treatment, and relieves the court and/or probation department of monitoring individual clients' progress in treatment and other clinical services.[162]

In Illinois, any drug-involved individual charged with or convicted of a probationable crime may elect treatment under the supervision of the "designated program," but the judge may mandate participation based on the agency's recommendation. Eligible offenders are sentenced to probation with supervision by the designated agency as a condition of treatment. The length of probation drives length of treatment involvement.

In Illinois, those charged with manufacture or delivery offenses involving very small amounts *are* eligible. Drug possession offenders are also eligible, but only up to a certain weight or quantity of drugs. Treatment alternatives are available to parolees, although they are not mandated, and are not limited to drug possession violations. Illinois' limitations on eligibility include: whether the crime is considered violent, if the defendant has a history of violence, or if the defendant has unsuccessfully been involved in treatment twice before.

Illinois' program allows for probation revocation for violation of the treatment plan. The designated agency utilizes

sanctions that address the violation based on its nature and adjusts the treatment and supervision plan accordingly. The agency also maintains close contact with probation and the court as violations occur to ensure that public safety considerations are met. The agency is also responsible for monitoring of clinical compliance, and making recommendations to the court for escalations or reductions in the intensity of treatment or supervision.

The individualized treatment plan will make recommendations for aftercare services and when possible the offender is connected to those services. Offenders who successfully complete treatment in Illinois may likewise petition to have their judgment vacated, provided it is their first felony offense. Otherwise, the offender is subject to Illinois' laws related to expungement and sealing of criminal records.

In fiscal year 2006, Illinois criminal courts sentenced over 6,500 felony offenders across the State to probation and substance abuse treatment in lieu of incarceration at a cost of $5,925 per year, per offender.[i] Based upon the seriousness of their crimes and their prior criminal history, these individuals could have otherwise been sentenced to state prison for an average of one year at an estimated cost of $21,622 per year, followed by at least one year on parole, at an average cost of $1,000 per year.[ii] Treatment and supervision of these 6,500 individuals in the community, instead of prison, followed by parole, saved taxpayers about $109 million that year.

[i]Average cost of probation based upon estimate from the Administrative Office of the Courts FY 2006 Budget. Estimates for treatment and TASC based upon Illinois Department of Alcohol and Drug Abuse Budget for FY 2006.
[ii]Estimates based upon Illinois Department of Corrections Budget for FY 2006.

Treatment of 6,500 individuals in 2006 under existing treatment alternatives saved Illinois taxpayers $109 million.

Washington's Drug Offender Sentencing Alternative (1995), (1999), Diversion from Prison (2005), and Sentencing Reform (2002)

The 1995 Drug Offender Sentencing Alternative (DOSA) attempted to better utilize state resources and save money by treating drug offenders in prison with follow up in the community. Initially, only drug offenders were eligible for the alternative, which was a combination of a reduced prison sentence with prison-based treatment and follow up treatment within the community.[163] In 1999, eligibility was expanded to include any offense other than a non-violent or sex offense. Substance use disorders, rather than type of offense, determined eligibility. Previous program participation within the last ten years makes an individual ineligible for the program.[164] In 2005, legislation expanded the program to allow complete diversion—with no prison time—for eligible individuals into community-based treatment.[165]

Determination of Eligibility: Two Tracks

Prior to the individual's sentencing, the Department of Corrections conducts an initial screening to determine the individual's treatment needs. The Department then develops an appropriate treatment plan certified by the Alcohol and Substance Abuse division of the Department of Social and Health Services. The information, including need, current crime, and the offender's criminal record determines the offender's eligibility for treatment. The court can then impose a sentence consisting of a prison-based alternative treatment or community-based treatment. In the prison-based alternative, individuals are sentenced to treatment in prison for half of the imposed sentence and the latter half of the sentence in a community-based alternative, which is equivalent to probation. Participants who violate any term of the program and/or probation terms, are returned to prison for the length of the original sentence.

Drug Sentencing Structure

In Washington, sentencing is determined by a number of factors including the severity of the current crime and the individual's criminal justice record. Offenders with previous violent convictions and/or significant criminal histories are given higher offender scores, which increases the offender's sentence length.

Diversion from Prison

The judge decides on the individual's treatment track based on a sentencing grid, which includes the offender score. Individuals who commit criminal offenses in which the mid-point of the standard sentence range is two years or less are eligible for the community-based treatment alternative.[166] In the community-based

treatment alternative, individuals are completely diverted from prison but are required to serve half of the offense's standard sentence range or two years (whichever is greater) on probation. Individuals who violate any of the program terms may be required to return to prison for the remainder to the sentence. Offenses are not expunged from the individual's records upon completion of the program.[167]

Drug Offender Sentencing Alternative Evaluation

The Washington State Institute for Public Policy's 2005 evaluation report found the program effective *only among drug offenders*. Drug offenders sentenced to the Drug Offender Sentencing Alternative resulted in greater benefits with estimate savings between $7.25 and $9.94 per dollar of cost.[168] The felony recidivism rate among drug offenders receiving the alternative was shown to be 30 percent, while the rate without the alternative was 40.5 percent, a statistically significant difference.[169, 170] Recidivism rates and cost benefits for drug-involved property offenders who received the alternative were not statistically significant.[171, 172]

Drug Sentencing Reform

House Bill 2338 (2002) modified sentencing classifications for drug offenses. Legislators and the Sentencing Guideline Commission placed drug offenses into the lowest tier of felony class. Originally, drug offenses were composed of 16 levels of felony class, with Class I as the least severe and Class XVI as the most severe. Today, only three felony levels exist for drug offenses as a result of the sentencing reform. Prior to 2002, the manufacture, delivery or possession with intent to deliver heroin or cocaine was a felony offense classified with Arson I and Manslaughter II. After sentencing reform, sales offenses were decreased to a Level II class, equal to counterfeiting or theft over $1,500 (Tables 4 and 5).

Table 4: Washington State Drug Sentencing Classification Changes for Possession Offenses

First Time Offender Cocaine Possession Offense	Felony Classification	Example Equivalent Crime
Before Sentencing Reform	Class II	Theft over $1,500
After Sentencing Reform	Class I	Theft under $1,500

Table 5: Washington State Drug Sentencing Classification Changes for Sales Offenses

First Time Offender Cocaine Sales Offense	Felony Classification	Example Equivalent Crime
Before Sentencing Reform	Class VIII	Manslaughter II
After Sentencing Reform	Class II	Theft over $1,500

Arizona's "Drug Medicalization, Prevention and Control Act" (1996), (2002), (2006)

Initial Enactment

Arizona's Proposition 200, also called the Drug Medicalization, Prevention and Control Act, was enacted by voter initiative on December 7, 1996. Proposition 200 allows all non-violent drug possession offenders to be paroled or placed on probation and receive drug treatment and educational services. Proposition 200 changed treatment possibilities statewide for non-violent convicted individuals with substance abuse problems, and made it possible for individuals who are terminally or seriously ill to have access to medically useful Schedule I drugs.

Funding

The Act created the Drug Treatment and Education Fund, which uses 35 percent of the taxes collected from Arizona's Tobacco and Liquor luxury tax. The monies are split equally between Arizona's diversion program and Arizona's Parents Commission on Drug Education and Prevention, which aims to increase parental involvement in drug prevention.[173] Funding is not equally distributed among treatment facilities as fiscal allocations are based on community need. The areas with the most severe needs receive greater allocations. However, the type of treatment provided in the area depends on the resources of that facility and how the facility chooses to utilize their funding. Therefore not all treatment is available in all areas or at all treatment centers.[174]

Current Program Eligibility and Assessment

Currently, the diversion portion of the Act allows non-violent individuals convicted for the first or second time of personal possession, drug use, or drug paraphernalia to be immediately released on probation. Probation personnel immediately assess the individual's level of need, substance abuse, and treatment level. The treatment type received by individuals is based on need as shown in assessment scores. The Act also allows other non-violent individuals in prison who show a need for the service to be released on probation and treated, although priority is given to the individuals in which substance abuse treatment is mandatory.[175]

Legal Issues

After Proposition 200 was enacted there were legal issues due to ambiguous wording in the Proposition. For example, there were occasions where law enforcement and prosecutors charged offenders with possession of paraphernalia because the issue was not directly addressed in the legislation. In *State v. Holm* (1998), the Court of Appeals ruled that possession of drug paraphernalia was not included under Proposition 200.[176] However, in *Calik v. Kongable* (1999), *State v. Estrada* (2001), and *State v. Gallagher* (2003) the Court of

Appeals ruled, "that first-time drug offenders convicted of both possession of drugs and of associated paraphernalia for personal use, from the same occasion, should be sentenced under Proposition 200 as though they have only one conviction."[177] Otherwise, a second conviction may require some jail time. Additionally, problems arose with individuals who continually resisted participation in the treatment program because, according to the law, these individuals were mandated to treatment rather than prison. The initiative lacked accountability measures because the initiative language did not allow drug possession offenders to be incarcerated.[178]

Voter and Legislative Responses

In response, there were several attempts in early 1997 by the Arizona legislature to change the intent of the original legislation. House Bill 2475 changed the Board of Clemency standard for judging a potential parolee, and excluded those serving time for other crimes and individuals with a previous felony from being paroled under Proposition 200. Senate Bill 1373 would have changed the law to require the incarceration for a first time probation offense. It also attempted to bar defendants from treatment if they had been convicted of a violent or sexual crime, previously participated in, refused to participate in, or failed a diversion treatment program before, but voters defeated that bill.[179]

Since 2000, both the legislature and voters have attempted to amend Proposition 200. In 2002, Proposition 201 attempted to increase money for the program through the confiscation of drug-related assets, create tougher punishments for serious drug felons, update medical marijuana provisions, and clarify any ambiguities from the 1996 Proposition 200. This proposition failed to win enough voter support.[180]

In 2002, Prop 302 passed, which allowed the court to incarcerate individuals who refuse probation or participation in treatment.[181] In 2006, Senate concurrent resolution 1033 (Prop 301) passed. Proposition 301 makes offenders ineligible for mandatory probation if they are convicted of personal use or possession of methamphetamine.[182]

Cost Savings

The latest cost savings evaluation performed by the Arizona Office of the Courts demonstrates that the substance abuse treatment program continues to save the state of Arizona a substantial amount of money. In fiscal year 2005, the state spent a total of $3,113,494 on treatment for 8,575 individuals, which saved the state $11,703,554. Almost 60 percent of these individuals completed the treatment successfully and just over 40 percent of the individuals were terminated from the treatment program.[183]

In 2005, Prop 200 saved Arizona taxpayers $11.7 million.

California Substance Abuse and Crime Prevention Act (2001)

Enactment

In July 2001, Proposition 36, also known as the Substance Abuse and Crime Prevention Act (SACPA), was implemented in California. Voters enacted SACPA to create a systemic treatment intervention for low-level, non-violent drug offenders. SACPA is built on the premise that treatment is, in the long run, a more effective and cost-efficient approach for the restoration of individuals with drug offenses to a place of health, self-sufficiency and a crime-free lifestyle.[184]

Legislation was sparked by the high costs of incarceration and the steadily increasing number of individuals incarcerated for non-violent offenses. By June 2000, California held a record 20,116 people in state prisons whose most serious crime was drug possession.[185] By diverting drug offenders from incarceration, the initiative sought to save the state millions of dollars by opening jail and prison space for more serious and violent offenders.

Eligibility

Any person convicted of first or second time possession and/or use of any controlled substance or an offense committed under the influence of a controlled substance is sentenced to a term of probation that requires substance abuse treatment through a program licensed or certified by the state. Upon enactment, previous possession offenses did not impact program eligibility criteria. For example, an individual with 5 previous possession convictions prior to 2001 is still eligible for treatment under SACPA. Individuals were effectively given a "clean slate" to participate in the program.

Reasons for inelgibility include a history of violence or using a firearm while possessing or under the influence of a controlled substance.[186] Eligibility requirements pertain to both individuals on probation and parole.

Assessment and Oversight

Individuals from the Probation Department or the Parole Authority are responsible for coordinating treatment with a designated provider. The designated provider then develops a treatment plan based on their assessment of the offender. Progress reports from the treatment provider to the applicable entity (i.e., probation officer) are required on a quarterly basis. Revocation of probation or parole does not occur unless the individual has unsuccessfully completed three prior attempts at treatment.[187]

Treatment

Treatment is limited to 12 months with an option for 6 months of aftercare. Treatment services under the legislation range from inpatient to outpatient treatment services, as

In 5 years, over 150,000 people benefited from treatment services and Prop 36 has saved California taxpayers approximately $1.3 billion.

well as drug detoxification. Other services such as vocational training, family counseling, and literacy training are provided in addition to drug treatment.[188] Some treatment modalities lack sufficient funding under SACPA, including methadone maintenance treatment and residential inpatient treatment. Individuals who were dependent on opiates, therefore, were not offered the most effective treatment option. The lack of these two treatment modalities might have impacted the completion rates of some individuals sentenced under SACPA, especially those with long histories of substance use disorders.

Funding

In addition to California's existing drug treatment funding, Proposition 36 originally appropriated $120 million per year to the Substance Abuse Treatment Trust Fund, ending in the 2005-2006 fiscal year. The Department of Alcohol and Drug Programs distributes funds to each county for treatment programming based on the per capita arrests for controlled substance possession violations, treatment bed availability, and individual offender needs.[189] Funding for the Proposition 36 program was reauthorized in the fiscal year 2006-07 Budget Act and was increased by a new $25 million. The offender treatment program component was added, which allowed counties to request additional funds to improve treatment outcomes. Counties must be able to contribute a 10 percent match under this new program.[190]

Evaluation and Cost Effectiveness

Proposition 36 requires the State Department of Alcohol and Drug Programs to conduct an annual evaluation of the program, as well as an independent evaluation by a public university. University of California Los Angeles's cost-analysis report for the first and second years of the initiative showed that SACPA participants who *completed* treatment achieved a cost savings of $4 to $1. Approximately 35,000 individuals each year receive treatment under Proposition 36 services. In 5 years, over 150,000 people benefited from treatment services and SAPCA has saved taxpayers approximately $1.3 billion.[191] But, individuals with five or more convictions in the 30-month period prior to the diversion enactment, approximately 1 percent of the eligible population generated costs *ten times higher* than the typical offender. Evaluation of the program demonstrates that diversion efforts may be better allocated by limiting potential participants based on previous convictions.[192] Despite limited sanctions and low completion rates, overall savings under Proposition 36 was $2.50 per every $1 invested.[193]

Despite limited sanctions and low completion rates, overall savings under Prop 36 was $2.50 per every $1 invested.

Hawaii Act 161 (2001), (2004)

Enactment and Eligibility

In 2001, Hawaii Governor Cayetano proposed SB 1188, Sentencing for Drugs and Intoxicating Compounds Offenses (passed as Act 161), in response to Hawaii's emerging "ice" or methamphetamine using population. The Act legislated mandatory substance abuse treatment for all first time non-violent offenders and for drug related probation or parole violations such as use or possession of drugs. An individual charged with manufacture or distribution, or with a recent violent felony (within 5 years), is ineligible.[195] Act 161 was amended in 2004 to alter eligibility and assessment conditions. The 2004 amendments removed the mandate of treatment and placed the treatment alternative under judicial discretion.

Treatment

A certified substance abuse counselor initially assesses each person and individual eligibility is based on criminal history. An individual's ability to contribute or locate funding for treatment is also measured.[196] Treatment programs are based on the individual's needs as determined by the initial assessment. Available treatment services range from residential long-term care to day treatment programs and are accredited by the Department of Health.

Act 161 requires interagency coordination and places the Department of Public Health (the Alcohol and Drug Abuse Division) in the role of facilitator between all organizations. The Department of Health is responsible for submitting an annual report to the legislature before the convening of each regular session. The report includes the status and progress of the interagency cooperative agreement, the effectiveness of the delivery of services, and expenditures made under this Act.[197] Upon successful treatment completion and compliance with the terms of probation, the individual can apply for a one-time expungement for the particular offense.[199] The Department of Health, Alcohol and Drug Abuse Division, demonstrate a dramatic recidivism decrease among the serviced population.[198]

Funding

Just over $2.1 million was appropriated in the initial legislation for adult criminal justice substance abuse treatment and integrated case management services. Since 2002, an additional $2.2 million has been allocated for funding of Act 161.

Hawaii's Department of Health Alcohol and Drug Abuse Division demonstrate a dramatic recidivism decrease among those individuals who received treatment.

Kansas Senate Bill 123 (2003)

Enactment and Eligibility

Kansas enacted Senate Bill 123 on November 1, 2003 because the Kansas Sentencing Commission recognized need to develop new ways to curb the rising prison population. Data demonstrated that Kansas's prisons would reach their maximum capacity within the following three-year time period. Between 1997 and 1999, the number of people sentenced for first time, low-level drug possession increased by 65 percent. With prisons at 98 percent capacity in 2000, and a projected 7 percent increase by 2003, the Sentencing Commission looked to the prison population deemed least threatening to the general population: individuals convicted of possessing very small amounts of drugs**.** Most offenders sent to prison for first and second, low-level offenses originally received probation sentences, but many were remanded to prison for probation violations, often due to use of illicit substances. These rising incarceration rates illustrated the increased need for treatment, as opposed to sanctions such as incarceration.[200]

Scale

Kansas's officials estimate that more than 1,400 individuals each year became eligible for sentencing under the new legislation, approximately 500 of who would have faced incarceration without this legislation.[201] From the date of implementation until November 30, 2006, nearly 4,000 individuals have been treated under SB 123.[202] According to Kansas Governor Sebelius, incarceration costs the state $19,615 per individual per year while treatment under SB 123 costs only $4,700 per individual, per year.[203]

Treatment Options and Funding

Treatment options range from drug education to inpatient services, relapse prevention and aftercare. Treatment providers directly bill the Kansas Sentencing Commission after treatment is completed[204] and these costs are paid by the State General Operating Fund.[205] Legislation requires the Kansas Department of Corrections to train and certify treatment providers in order to treat individuals under SB 123.[206] Each program participant is allocated approximately $4,700 for all treatment needs.[207] Evaluation of Kansas' program indicated a lack of treatment providers in the western portion of the state, a large barrier to treatment completion.

Kansas officials estimate that over $7.1 million dollars per year has been saved under SB 123.

Texas House Bill 2668 (2003)

Enactment

Representative Allen, author of House Bill 2668, stated "The time has come for smart on crime policies that protect public safety, while saving our state money. First time drug offenders need a chance to recover from their addiction so that they can become productive members of our community." [208] Texas HB 2668 became effective September 1, 2003, however a Texas budget crisis stymied the implementation of this much needed policy.[209] The enacted legislation called for judicial discretion and allowed offenders to alternatively be jailed for periods of 90 to 180 days, as part of probation or if treatment was unavailable. The bill never defined treatment or developed a standardized tool for assessment.

Prison Overcrowding

When the legislation was enacted, Texas prisons faced overcrowding. One out of every 21 adults in Texas was under the supervision of the Texas Department of Criminal Justice in 2003.[210] In fiscal year 2002, over 9,000 offenders entered Texas state jails for possessing one gram or less of a controlled substance. Of those 9,000 admissions, about 4,000 had no other charges and no prior sentences with the Texas Department of Criminal Justice.[211]

Lack of Funding

In addition to prison overcrowding, Texas also underwent a budget crisis during 2003. Due to the budget crisis—a $10 billion shortfall—the Texas legislature never appropriated funding to implement treatment programs under HB 2668. Existing treatment programs' budgets were also cut, straining an already under-funded treatment system. The bill sponsors and fiscal analysts indicated that the Act, if funded, would have saved Texas taxpayers $115 million over a period of five years.[212]

Some offenders have been placed on probation under HB 2668, but due to lack of treatment funding, very few individuals have received treatment services. The state jail drug offender population has declined since the enactment of the bill, but it appears that some individuals have been remanded to county jails instead, leading to overcrowding in specific jail systems.[213]

Funding for HB 2668 was never appropriated.

Indiana's Forensic Diversion Program (2004)

In response to Indiana's budget crisis, particularly for the state's Department of Corrections, which faced a two-year budget freeze, the Indiana General Assembly passed Senate Bill 476, a Forensic Diversion Program, in 2004. The bill offers individuals with a diagnosable mental illness and/or an addiction disorder, charged or convicted of a non-violent crime, the opportunity to receive treatment and other services like mental health treatment, as an alternative to incarceration.[214]

Determination of Eligibility: Two Tracks

Program eligibility requirements differ somewhat in terms of the offense and determines the treatment track. There are two separate tracks for the program, pre-conviction and post-conviction. In pre-conviction cases, offenders must be diagnosed with a mental health or addiction disorder, and charged with a non-violent crime. An individual with an offense equivalent to a Class D felony (typically not eligible) can have the charge reduced to a Class A misdemeanor if the crime did not involve child pornography, domestic battery or if the individual had a prior unrelated felony convicted as a Class A misdemeanor. [215]

In the post-conviction track, individuals have to be diagnosed with a mental health or addiction disorder, and convicted of a non-violent, non-drug dealing offense, regardless of felony level. In the pre- and post- conviction tracks, a violent conviction or a prior violent conviction within the last ten years, deems the offender ineligible for the program. If the Court determines that the individual is eligible, the defendant is placed on probation, given a suspended sentence and assigned to treatment.

Treatment

Treatment may include any variation of inpatient, outpatient, and aftercare services but the Division of Mental Health and Addiction must certify all treatment, including mental health components. Treatment is limited to two years for individuals charged with misdemeanors and three years for felony charges. If the offender successfully completes treatment, the court dismisses the charges. However, if the offender fails to complete treatment, the court enters a judgment of conviction and sentences the person accordingly, or may require the individual to serve the balance of the suspended sentence.[216]

Funding and Participation

Indiana's Forensic Diversion Program is a pilot program. To date, 10 counties participate in the program. The Indiana Department of Corrections is currently funding pilot programs in seven out of the ten participating counties. Funding also comes from the State General Fund and monies are distributed to the counties where the program has been implemented. These funds are used solely for providing treatment services to offenders participating in the diversion program. The Forensic Diversion Study Committee evaluates the effectiveness of the program and funding adequacy.[217]

Non-violent individuals with either a substance use or mental health disorder may receive time in treatment instead of prison.

Maryland's Treatment Not Incarceration Bill (2004)

Enactment and Eligibility

Maryland's former Governor Ehrlich's[218] House Bill 295, also called "The Treatment Not Incarceration" bill, was enacted October 1, 2004. HB 295 helps defendants avoid incarceration and a criminal record. Eligible individuals include all drug-involved offenders, with exceptions for large distribution offenses, and violent crimes. The diversion portion of the bill allows the State's Attorney to dismiss charges upon successful completion of a drug or alcohol treatment program or to indefinitely postpone adjudication during treatment. If the defendant does not complete the program successfully, prosecution of the original charge goes forward. After successful completion of the program, the individual may have their records expunged.[219] The Act requires the Parole Commission to consider any inmate that may be suitable for parole if they have a drug or alcohol problem, have completed one fourth of his or her sentence, and is amenable to treatment.

Discretion, Assessment and Treatment

The Department of Parole and Probation and The Department of Health and Mental Hygiene assess participants and create the treatment plan, but the judge has discretion to alter the treatment plan. Treatment ranges from inpatient, outpatient and detoxification to medium intensity residential treatment. Treatment services last 72 hours to 1 year, although the law allows for extensions in 6-month increments, if needed. The treatment programs notify the probation department about violations of the treatment plan. If the individual violates the treatment plan, an arrest warrant may be issued. The judge has the discretion to incarcerate the offender or modify the treatment plan.

Funding

In fiscal year 2005, Maryland's legislature budgeted $3 million solely for the treatment alternative program under the Alcohol and Drug Abuse Administration. The Act also requires financially able individuals who participate in the program to pay an administration fee of $150, which is deposited into the Maryland Substance Abuse Fund and is used for evaluation and treatment.

Cost Savings

Assuming that one hundred diversion participants, who would have been incarcerated, would need an extensive and structured therapeutic community at a cost of $11,833 per participant for a year, the total cost of treatment for one hundred participants would be $1,183,300. According to the Bureau of Justice Statistics, it cost Maryland $26,398 to imprison one person; therefore for one hundred offenders it would cost Maryland $2,639,800.[220] Even with the high cost of inpatient treatment, the potential cost savings could be estimated at $1.3 million for 100 offenders, per year under this program.

POLICY RECOMMENDATIONS

Nearly all of the state models have demonstrated that cost-savings can be achieved through codified wide-scale alternatives to incarceration. Arizona estimates its cost savings for the most recent fiscal year to be more than $11.7 million.[221] Washington State's Drug Offender Sentencing Alternative (DOSA) saved taxpayers between $7.25 and $9.94 for every $1 invested in treatment for drug offenders.[222] California's Substance Abuse and Crime Prevention Act, for every $1 invested, $2.50 in savings was incurred, despite limited sanctions, a participation rate of about 70 percent, and a completion rate of only 34 percent of participants.[223]

Using evaluation research from Washington and California cost-benefit analyses, if $20 million of Illinois state dollars were invested in the model alternative to incarceration program, we can safely estimate that Illinois taxpayers have the potential to save between $50 and $150 million per year. If Illinois implemented a large-scale diversion program based on the following policy recommendations, including sanctions for non-participation and expansion of treatment programs, Illinois can certainly exceed the cost benefits demonstrated by California's program, thus realizing savings closer to $150 million.

Recommended Diversion Program Codification

1. Create a statewide alternative to incarceration plan to treat non-violent drug offenders. Statewide alternatives to incarceration have been enacted in California, Washington, Arizona, Hawaii, Kansas, and Maryland**.** Ensure that policies and processes for providing treatment alternatives to incarceration are enacted in Illinois' laws and are reflected in any subsequent legislation.

- Build upon existing codified infrastructure to construct a larger capacity for a statewide diversion from incarceration program.
    - Continue to utilize the designated liaison agency for offender assessment, case management and communication between treatment providers and the criminal justice system.
    - Expand use of the drug school model (i.e., Cook County drug school) for maximum cost savings to serve individuals with the least severe substance use issues as applied in Maryland, Arizona and California.

- Mandate clinical assessment, that is, all individuals entering the criminal justice system for non-violent drug offenses should be individually and professionally assessed for substance use and mental health disorders by an independent entity, prior to time of plea or trial, in order to impact the sentence decision.

    - In Indiana's diversion program, screening for co-occurring mental health and substance use disorders is priority.

    - As in Arizona and Washington, the assessment should include two components: 1) the risk of re-offending and 2) the level of need for substance use treatment and other social services. Together these assessments should be used to create an individualized treatment plan.

        - Transportation and childcare needs should be evaluated as these are shown to be barriers towards successful program completion. Washington, Maryland and Hawaii address these issues and provide funding for these services for individuals in the diversion program.

- Mandate written notification of the alternative to incarceration for all non-violent drug-offending individuals who qualify for the program. Each individual should be informed of the program requirements, expungement benefits, and services available.

    - The individual's choice should be documented within the individual's case folder. If the individual declines the treatment diversion option, reason should be captured.

    - As in all other statewide diversion programs, those who are not amenable to treatment should receive time in prison, instead of time in treatment.

2. Illinois community needs must be assessed to develop the most effective and appropriate large-scale implementation. All systems, including criminal justice and treatment, need to be evaluated to understand the current capacity and level of needed expansion. This evaluation will guide the development of the diversion program and will help all systems to be brought to scale in Illinois, as learned from the Indiana, Washington and Kansas implementation process.

3. Create new revenues to establish the statewide alternatives to incarceration, a lesson learned from Arizona and Washington. The alternative to incarceration program in Illinois could be funded through taxes on served coffee beverages, fast food items, alcoholic beverages, energy drinks, tobacco and/or gambling establishments to ensure adequate funding to bring the diversion program to scale. This fund could supplement general revenue funding for treatment and community supervision. The allocated monies should be kept in a separate fund as in Arizona, Washington, California, and Maryland. For maximum fiscal impact, funding allocations should include the following areas:

- Increase resources for the criminal justice system, such as probation and parole officers. Expanded resources would allow for increased training, smaller caseloads, individualized interventions and sanctions, and more contact with drug offense probationers.

- Increase fiscal resources for expansion of treatment centers reflecting the needs demonstrated by the community assessment. Some areas of Illinois may need more capacity building than others. This problem has occurred in states where the highest density populations resided in one part of the state (e.g. urban areas). Kansas, for example, had difficulty delivering services to rural populations in the western part of the state.

- Funding appropriations should be allocated based on a calculated community need, as in Arizona.

- All participating individuals should be given a monetary assessment. Individuals who have money to pay for the treatment should do so, and this money should be deposited into the diversion fund, as done in Hawaii, Arizona and Washington State.

- Monies that are not spent directly on treatment services should be allocated to prevention and drug education, as learned from Arizona.

4. Illinois must follow research-based interventions for the drug offending population. Illinois needs to offer clinical interventions at each stage of the criminal justice continuum to ensure individuals in the diversion program are successful in treatment.

- Continue to use an independent entity that is responsible for the following:

individual assessment, creation of individual treatment plans and any alterations during diversion process, court recommendation, and case management. Case management includes service linkage and appropriate aftercare, and main communicator between the individual, probation, treatment and the courts.

- The treatment plan should be based on the assessment outcomes. The plan should address the individual's needs, including type of services to be received and the length of program involvement.

    - The majority of the states utilize a continuum of treatment alternatives dependent on the severity of the individual's substance use disorder, ranging from drug education programs to medically enhanced therapies (such as methadone maintenance), to intensive outpatient and inpatient treatment modalities and aftercare.

5. The alterative to incarceration program must have sanctions for program violations and accountability measures, as in Maryland, Arizona, Hawaii, Kansas, Indiana and Washington. Illinois must create a penalty scale according to probation or parole violation severity that includes a range of options for the probation officer. Identify and train all related personnel on appropriate sanctions for failing to comply with treatment plan to ensure accountability. For example:

- As in Arizona, the court intervenes when an individual has no contact with the treatment center within 30 days of the first appointment date.

- As in Hawaii, Kansas and California, individuals who actively participate in a diversion program *should not* be sent to prison or jail for a one-time drug possession *violation* that occurs *while undergoing treatment.*

- As in California and Kansas, individuals who actively participate in a diversion program *should not* be sent to prison or jail for a positive urine analysis, rather clinical intervention and treatment plan alteration should occur.

6. After successful completion of the treatment plan, and all other court and/or probation requirements, individuals should receive automatic expungement of the case, as in Maryland and Indiana.

7. As in California and Washington, Illinois should evaluate the effectiveness of the diversion program. The diversion program should be evaluated by an independent agency, such as a public university, to track program implementation, cost savings, and the number of people served under the new legislation. Evaluation should examine treatment completion rates and recidivism rates, by offender type and treatment option. The effectiveness of case management, assessment and referral to services constitute integral components of the program and also must be evaluated. Evaluation reports should be bi-annual, publicly presented to the Illinois Legislature, allow for monitoring and improvement, and for maximum cost effectiveness.

8. Re-examine Illinois drug sentencing guidelines. Over time, Illinois has followed other states and has significantly increased the penalties associated with non-violent drug offenses, resulting in large prison increases. Illinois faces budget crisis, prison overcrowding, and is in a position to evaluate and revise how the state currently handles the large and growing population of non-violent drug offending individuals. Like in Washington, Illinois sentencing guidelines need to be evaluated and reformed so that more individuals can be eligible for probation or sentenced to community-based treatment in lieu of incarceration.

Illinois experienced a three-fold increase among those entering prison for drug offenses from 1988 to 1990. This dramatic increase in a two-year timeframe coincides with a number of changes to the Illinois criminal code. These increases also coincide with a dramatic change in the racial composition of those who entered prison for drug offenses.

- Review the impact of particular sentencing enhancements like Drug Free Zones, as these laws effectively include the majority of the city of Chicago. Consider lowering the number of feet to reflect urban populations, or limiting these provisions to areas directly adjacent to the affected area (schools and public walkways across from schools).
    - Penalty enhancements already exist for sales to minors, therefore Illinois legislators should carefully consider the intent and unintended consequences of drug free zones.
- Review the impact of lowered drug weight and equivalent felony penalty

class for both possession and sales offenses. Currently, the sentence imposed for sale of 1 gram of cocaine is equal to child pornography. Possession of 15 grams—about one half of a tablespoon—is equivalent to sexual assault.

- Broaden probation eligibility for drug offenses.

Appendix A

Historical Overview of Illinois Drug Policy (1972-2002)

1972 *Manufacture, Delivery or Possession with Intent to Deliver a Controlled Substance and Possession of a Controlled Substance* (PA 77-757)
Controlled Substance Act established the scheduling and according sentences of illicit substances, excluding cannabis

Manufacture, Delivery or Possession with Intent to Deliver a Controlled Substance and Possession of a Controlled Substance (PA 77-757)
Controlled Substance Act established that any adult selling a controlled substance to a minor, at least two years his junior, is punishable by twice the maximum charge

1973 M*anufacture, Delivery or Possession with Intent to Deliver a Controlled Substance and Possession of a Controlled Substance (PA 77-2097 and PA 77-2722)*
Unified Code of Corrections established the felony classification of illicit substances

- Class 1 is the most severe consecutive to Class 4 as the least severe

Manufacture, Delivery or Possession with Intent to Deliver a Controlled Substance and Possession of a Controlled Substance (PA 77-2097 and PA 77-2722)

- Class 1 felony, drug conspiracy and delivery to a minor are no longer eligible for probation

1977 M*anufacture, Delivery or Possession with Intent to Deliver a Controlled Substance and Possession of a Controlled Substance (PA 80-707)*
Weight reduction for heroin and cocaine

- Sales
  - Class 1 Felony
    - ≥ 15 grams of heroin
    - ≥ 30 grams of cocaine
- Possession
  - Class 1 Felony
    - ≥ 30 grams of heroin
    - ≥ 30 grams of cocaine

1978 Manufacture, *Delivery or Possession with Intent to Deliver a Controlled Substance and Possession of a Controlled Substance (PA 80-1099)*
Class X felony established for sales offenses. Possession, delivery to a minor or class X offense are no longer eligible for probation

1979 M*anufacture, Delivery or Possession with Intent to Deliver a Controlled Substance (PA 81-583)*
Class X Felony implemented for sales offenses; shifts in classification

- ≥ 15 grams of heroin is now a Class X felony, the most severe offense classification

1982 M*anufacture, Delivery or Possession with Intent to Deliver a Controlled Substance (PA 82-528)*
Additional illicit substances added to classification system and weight reduction for specific substances

- Sales
  - Class X Felony
    - ≥ 15 grams of heroin
    - ≥ 30 grams of cocaine
  - Class 1 Felony
    - 10 to 14 grams of heroin
    - 10 to 29 grams of cocaine

1985 *Manufacturing, Delivery, and Possession with Intent to Distribute with Special Conditions (PA 84-1075)*
Enhanced Penalties: Drug Free Zones, Schools

- Within 1,000 feet of a school. Automatic one felony class more severe

1987 *Possession of a Controlled Substance* (PA 84-1475)
Weight reduction in distinctions between felony classifications for cocaine and heroin

- Possession
  - Class 1 Felony
    - ≥15 grams of cocaine or heroin
  - Class 4 Felony
    - <15 grams of cocaine or heroin

Manufacture, Delivery or Possession with Intent to Deliver a Controlled Substance (PA 84-1475)
Cocaine Weight Reduction in Distinctions between Felony Classifications

- Sales
  - Class X Felony
    - ≥15 grams cocaine
  - Class 1 Felony
    - <15 grams cocaine

Manufacture, Delivery or Possession with Intent to Deliver a Controlled Substance (PA 84-1475)
Probation Eligibility Standards Change
>5 grams cocaine NOT eligible for probation, meaning mandatory incarceration

1988 *Manufacturing, Delivery, and Possession with Intent to Distribute with Special Conditions* (PA 85-616)
Enhanced Penalties: Drug Free Zones, Public Park

- Within 1,000 feet of a public park. Doubles the maximum sentence and fines.
  Up to 1 gram cocaine

1990 *Manufacture, Delivery or Possession with Intent to Deliver a Controlled Substance (PA 86-266)*
Graduated System of Mandatory Minimum and Extended Maximum Sentences established for Class X Felony

Manufacturing, Delivery, and Possession with Intent to Distribute with Special Conditions (PA 86-946)
Enhanced Penalties: Drug Free Zones, Public Housing

- Within 1,000 feet of public housing property. Automatic elevation of felony class.

1992 *Manufacturing, Delivery, and Possession with Intent to Distribute with Special Conditions* (PA 87-524)
Enhanced Penalties: Drug Free Zones, Buses and Bus Stops

- Within 1,000 feet of a school bus stop or mode transporting children to school. Automatic one felony class higher.

Manufacturing, Delivery, and Possession with Intent to Distribute with Special Conditions (PA 87-1225)
Enhanced Penalties: Drug Free Zones, Truck and Rest Stops

- Within 1,000 feet of a truck stop or safety rest area. Double penalties and double fines.

Manufacturing, Delivery, and Possession with Intent to Distribute with Special Conditions (87-524)
Enhanced Penalties: Drug Free Zones, Time of Offense

- Time of day, time of year and whether classes were currently in session at the time of the offense is irrelevant

1995 *Possession of a Controlled Substance & Manufacturing, Delivery, and Possession with Intent to Distribute* (PA 89-404)
Number of possible charges expanded through inclusion of the "single and separate" provision

1997 *Manufacturing, Delivery, and Possession with Intent to Distribute with Special Conditions (*PA 89-0451)
Enhanced Penalties: Drug Free Zones, Places of Worship

- Within 1,000 feet of any church, synagogue or building used primarily for worship. Automatic felony class elevation

1998 *Manufacturing, Delivery, and Possession with Intent to Distribute with Special Conditions* (PA 90-0164)
Enhanced Penalties: Drug Free Zones, Nursing Homes

- Within 1,000 feet of nursing homes, assisted living centers, and other complexes for the care of the elderly. Automatic felony class elevation

1999 *Manufacturing, Delivery, and Possession with Intent to Distribute with Special Conditions* (PA 91-0673)
Enhanced Penalties: Drug Free Zones, Public Housing

- The provision related to public housing was expanded to include any residential property owned or leased in part by a public housing agency, including mixed income developments

2002 *Manufacture, Delivery or Possession with Intent to Deliver a Controlled Substance (PA 92-0698)*
Heroin weight reduction in felony classification

- Sales
  - Class 1 Felony
    - 1 to 14 grams heroin
  - Class 2 Felony
    - Up to 1 gram heroin

Manufacture, Delivery or Possession with Intent to Deliver a Controlled Substance (PA 92-0698)
Probation eligibility standards change
>5 grams heroin NOT eligible for probation, meaning mandatory incarceration

Appendix B

Total Number of Drug Offenders Admitted to Prison, by State Rank
1988 and 2002

1988 Drug Offenders by State Rank			2002 Drug Offenders by State Rank		
Rank	State	Total	Rank	State	Total
1	California	20,803	1	California	39,878
2	Florida	10,368	**2**	**Illinois**	**12,985**
3	New York	7,341	3	New York	11,610
4	Texas	7,020	4	Texas	11,425
5	Georgia	5,017	5	Ohio	9,077
6	New Jersey	2,613	6	Florida	7,942
7	Ohio	2,124	7	New Jersey	6,836
8	North Carolina	2,037	8	Louisiana	6,130
9	Michigan	1,788	9	Georgia	5,995
10	**Illinois**	**1,511**	10	Missouri	5,955
11	South Carolina	1,462	11	Maryland	5,126
12	Virginia	1,367	12	North Carolina	4,852
13	Maryland	1,087	13	Pennsylvania	4,410
14	Massachusetts	1,013	14	Mississippi	3,365
15	Tennessee	985	15	Oklahoma	3,354
16	Oklahoma	961	16	South Carolina	3,244
17	Alabama	893	17	Virginia	3,204
18	Missouri	816	18	Kentucky	3,127
19	Washington	785	19	Arkansas	3,017
20	Pennsylvania	743	20	Tennessee	2,853
21	Oregon	705	21	Michigan	2,750
22	Mississippi	536	22	Washington	2,656
23	Kentucky	514	23	Alabama	2,338
24	Nevada	460	24	Colorado	2,225
25	Colorado	281	25	Wisconsin	1,953

Data obtained from:
U.S. Department of Justice Statistics. National corrections reporting program, 1988. United States computer file. Conducted by U.S. Dept. of Commerce, Bureau of the Census. ICPSR ed. Ann Arbor, MI: Inter-university Consortium for Political and Social Research, 1997.
U.S. Department of Justice Statistics. National corrections reporting program, 2002. United States computer file. Conducted by U.S. Dept. of Commerce, Bureau of the Census. ICPSR ed. Ann Arbor, MI: Inter-university Consortium for Political and Social Research, 2006.

Appendix C

Top 20 States in 2002 for Total Number of Drug Offenders Admitted to Prison, Percent Increase, from 1988 to 2002

State	1988	2002	Percent Increase
Illinois	1,511	12,985	759%
Colorado	281	2,225	692%
Wisconsin	252	1,953	675%
Missouri	816	5,955	630%
Mississippi	536	3,365	528%
Kentucky	514	3,127	508%
Pennsylvania	743	4,410	494%
Maryland	1,087	5,126	372%
Ohio	2,124	9,077	327%
Oklahoma	961	3,354	249%
Washington	785	2,656	238%
Tennessee	985	2,853	190%
Alabama	893	2,338	162%
New Jersey	2,613	6,836	162%
North Carolina	2,037	4,852	138%
Virginia	1,367	3,204	134%
South Carolina	1,462	3,244	122%
California	20,803	39,878	92%
Texas	7,020	11,425	63%
New York	7,341	11,610	58%

Data obtained from:
U.S. Department of Justice Statistics. National corrections reporting program, 1988. United States computer file. Conducted by U.S. Dept. of Commerce, Bureau of the Census. ICPSR ed. Ann Arbor, MI: Inter-university Consortium for Political and Social Research, 1997.
U.S. Department of Justice Statistics. National corrections reporting program, 2002. United States computer file. Conducted by U.S. Dept. of Commerce, Bureau of the Census. ICPSR ed. Ann Arbor, MI: Inter-university Consortium for Political and Social Research, 2006.

Appendix D

Drug Offenders Admitted to Prison in the Chicago Metro Area, by County and Percent Increase 1984 to 2002

County	1984	2002	Percent Change
Cook	381	8,940	2,246%
Kane	25	378	1,412%
Will	9	256	2,744%
Lake	16	310	1,838%
DuPage	17	202	1,088%
McHenry	1	38	3,700%
Collar Counties Total	68	1,184	1,641%

Drug Offenders Admitted to Prison in the Chicago Metro Area, by County and Percentage of Total Offenders, 1984 and 2002

County	1984	2002
Cook	6%	46%
Kane	16%	42%
Will	6%	37%
Lake	9%	26%
DuPage	8%	20%
McHenry	2%	18%
Collar Counties Total	9%	30%

U.S. Department of Justice Statistics. National corrections reporting program, 1988. United States computer file. Conducted by U.S. Dept. of Commerce, Bureau of the Census. ICPSR ed. Ann Arbor, MI: Inter-university Consortium for Political and Social Research, 1997. U.S. Department of Justice Statistics. National corrections reporting program, 2002. United States computer file. Conducted by U.S. Dept. of Commerce, Bureau of the Census. ICPSR ed. Ann Arbor, MI: Inter-university Consortium for Political and Social Research, 2006.

Appendix E

Total Number of Illinois Drug Offenders Admitted to Prison by County Rank, 1984 and 2002

1984 Drug Offenders by County Rank			2002 Drug Offenders by County Rank		
Rank	County	Number	Rank	County	Number
1	Cook	381	1	Cook	8,940
2	Kane	25	2	Kane	378
3	Peoria	24	3	Lake	310
4	DuPage	17	4	Winnebago	264
5	Lake	16	5	Will	256
6	Macon	12	6	Champaign	243
7	Rock Island	11	7	DuPage	202
8	Madison	11	8	McLean	164
9	Will	9	9	Macon	157
10	Winnebago	7	10	Peoria	155
11	St. Clair	7	11	Sangamon	104
12	Fulton	6	12	Madison	93
13	Jefferson	6	13	Kankaee	88
14	McLean	6	14	Adams	80
15	Whiteside	5	15	Coles	78
16	Vermilion	5	16	Marion	71
17	Greene	4	17	Vermilion	68
18	Randolph	4	18	St. Clair	63
19	Jackson	4	19	Rock Island	59
20	Marion	4	20	La Salle	58
21	McDonough	3	21	Edgar	41
22	Stephenson	3	22	Tazewell	40
23	Williamson	3	23	McHenry	38
24	Coles	3	23	Henry	37
25	Sangamon	3	25	Stephenson	37

U.S. Department of Justice Statistics. National corrections reporting program, 1988. United States computer file. Conducted by U.S. Dept. of Commerce, Bureau of the Census. ICPSR ed. Ann Arbor, MI: Inter-university Consortium for Political and Social Research, 1997.
U.S. Department of Justice Statistics. National corrections reporting program, 2002. United States computer file. Conducted by U.S. Dept. of Commerce, Bureau of the Census. ICPSR ed. Ann Arbor, MI: Inter-university Consortium for Political and Social Research, 2006.

Appendix F

Top 20 Downstate Counties with the Highest Proportion of Incarcerated Drug Offenders in 2002: 1984 and 2002

County	1984	2002
Wayne	25%	69%
Edgar	6%	41%
Coles	7%	36%
Livingston	8%	36%
Henry	9%	36%
Marion	10%	35%
Adams	4%	34%
Macoupin	8%	33%
Champaign	2%	31%
McLean	6%	31%
Kankakee	0%	31%
Winnebago	4%	31%
Knox	0%	29%
Sangamon	2%	28%
Vermilion	8%	27%
Peoria	11%	27%
DeKalb	0%	25%
Stephenson	9%	25%
La Salle	1%	22%
Macon	6%	21%

U.S. Department of Justice Statistics. National corrections reporting program, 1988. United States computer file. Conducted by U.S. Dept. of Commerce, Bureau of the Census. ICPSR ed. Ann Arbor, MI: Inter-university Consortium for Political and Social Research, 1997. U.S. Department of Justice Statistics. National corrections reporting program, 2002. United States computer file. Conducted by U.S. Dept. of Commerce, Bureau of the Census. ICPSR ed. Ann Arbor, MI: Inter-university Consortium for Political and Social Research, 2006.

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