New Orleans Drug Control Strategy 2012

Greater New Orleans Drug Demand Reduction Coalition

While no one would claim that substance abuse is the cause of all of New Orleans' problems, few would disagree that it is a major contributing factor. Unless there is an organized approach to lowering the demand for drugs and abating the tendencies toward excessive drinking, any silo-like attempts to solve the individual problems besetting New Orleans are far less likely to be effective. What has been lacking heretofore is a *unified* effort that would tie together all of the separate entities under one holistic strategy that could more determinately get at the central issue of substance abuse.

Colonel Jim McDonough, Drug Policy Consultant
and former Director of Strategy for the Office of National Drug Control Policy.

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I. Background

Recognizing the serious nature of the drug abuse[1] problem and that the time was right to address the problem in New Orleans, the Greater New Orleans Drug Demand Reduction Coalition (hereinafter the Coalition) was organized in the summer of 2011. Research and experience indicate that the most effective way to reduce drug abuse and its impact on society is through citizen-based coalitions that work together to implement a strategic plan involving prevention, treatment and law enforcement.[2]

This will be achieved through a holistic, sustainable plan with measurable outcomes that will bring about system change to: ensure efficiency and cost effectiveness; direct services and targeted funding; expose gaps and overlaps in services; and enhance communication between the various entities, public and private, involved in addressing the drug abuse problem.

II. Vision

New Orleans will be a safe, crime and drug-free, healthy community with a good quality of life for all of its citizens.

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III. Mission

To develop and implement a comprehensive and sustainable strategic plan using prevention, treatment, and law enforcement to reduce the negative consequences of the use of illicit drugs and other drugs of abuse and abuse of alcohol in the Greater New Orleans area.

The overall goals of the strategic plan are to:

Promote healthy, safe and drug free youth, families and community.

Heal those who are dependent on alcohol and other drugs to fully restore their health, dignity and safety.

Enhance the public safety by reducing the supply of drugs, disrupting the illegal drug market and deterring illegal drug use by adults and youth.

[1] Drug Abuse is defined as use of any illegal substance or non medical use of prescription and other legal drugs.

[2] National Drug Control Strategy. (2011).Office of National Drug Control Policy. Retrieved from http://www.whitehouse.gov/ondcp/2012-national-drug-control-strategy.

IV. Core Values and Beliefs

1. Every citizen has the right to live in a safe, drug free community and workplace.

2. Drug abuse is a significant contributing factor to the crime, violence and other societal problems in New Orleans.

3. A balanced approach of prevention, treatment, and enforcement is the key to reducing the supply of and demand for drugs.

4. "No use of illegal drugs and no abuse of legal drugs" must be the standard in the community and in all programs, policies and practices.

5. Preventing first drug use from occurring is the key, long-term solution to reducing the demand for drugs.

6. Every person deserves the right to recover from addiction and have access to treatment.

7. Enforcement efforts will never be able to stem the supply of drugs until we first decrease the number of users and decrease the demand for drugs.

8. Drug suppliers and consumers are fueling the drug problem, engaging in criminal activity and should be held accountable with appropriate sanctions.

9. Eliminating drug street markets, a strategy proven to reduce crime and violence, incarceration and racial conflict, must be a community priority.

10. Enforcement must have the resources to disrupt the drug market and lower the supply and the availability of illicit drugs.

11. Offenders should be held accountable with appropriate sanctions, required to be drug free, and supported in a drug free environment.

12. Programs, policies and practices must be data and results driven and demonstrate that they reduce the demand for drugs.

13. The creation of a social climate that is intolerant of drug use should be a top community, neighborhood, family and individual priority.

V. Targets

The Drug Control Strategy identifies specific, measurable targets to achieve within five years, as follows:

Reduction of illicit drug use in New Orleans.

Reduction in underage drinking.

Reduction in drunk and drugged driving deaths.

Reduction in drug overdose deaths.

Reduction in the non-medical use of prescription drugs.

Reduction in drug related crime.

Reduction in drug related child abuse and neglect.

A data collection strategy is being developed to measure targets which will require collaboration with lead agencies to establish indicators measurement standards. Accomplishing these targets will depend on leaders and citizens committed to real change; public awareness of the extent of the problem and its connection to crime and other social problems; infrastructure to support prevention, treatment and enforcement; more effective coordination of efforts; sustained partnerships; knowledge and utilization of best practices; and the effective and efficient targeting of resources.

Success depends on the leadership, coordination and the engagement of all citizens. New Orleans must mobilize all resources and engage every segment of the community just as we did in the successful community rebuilding effort since Hurricane Katrina.

VI. Community Needs Assessment

Drug abuse exacts a high price - it affects the lives of too many of our citizens. It causes crime and violence and fosters child abuse and low school performance, decreases productivity in the workplace, increases accidents, hospital admissions, and medical costs, and contributes to neighborhood deterioration.

In order to address these issues and to guide the strategic planning process, the Coalition recognized that a needs assessment was essential to identify the nature, extent and impact of drug abuse in the community. The Metropolitan Human Services District generously provided a needs assessment contract for an independent consultant. The needs assessment provides a baseline of data to better apply resources, to identify gaps and overlaps in services and to look at the

underlying causes of the problem.

VII. Strategic Planning Process

In the fall of 2011, Coalition members, with the assistance of United States Attorney for the Eastern District of Louisiana, James Letten, who served as convener, brought together specialists in the fields of prevention, treatment and enforcement, and representatives from the health, education, business community, civic groups, and youth organizations to be involved in the development of an action plan to address the drug abuse problem. The time and commitment these experts and community leaders have given to this initiative has been extraordinary. These leaders, already so involved with rebuilding and re-organizing this city, are committed to the strategic planning process and have generously given their time and expertise without any recompense except the hope of a safer and healthier New Orleans.

The planning process was guided by the principles of drug demand reduction and is focused on the areas of prevention, treatment, enforcement/criminal justice. The planning groups identified the problems and key issues. They discussed strategies to effectively address and bring down drug abuse. They identified the need for better coordination and communication, better data collection and utilization of data.

The strategy thus provides a framework for citizens, policy-makers and service providers to work together and to bring all resources to bear over the next five years to carry out the strategic plan. The core values of the Coalition, listed on page five of this document, unite the effort and reflect the ideals that are fundamental to reducing the drug abuse problem and creating a healthier and safer community.

VIII. Impact of the Problem

The following newspaper headlines tell the story of how drug abuse plagues our community:

Holy Cross neighborhood of Lower 9th Ward plagued by spate of killing

In a 10-block stretch of Burgundy Street in the Holy Cross neighborhood, homes with manicured lawns sit alongside run-down houses, still vacant since Hurricane Katrina. Over the past year, gunfire has claimed the lives of at least five people along a 10-block stretch of Burgundy Street in the Holy Cross neighborhood. Drugs are a problem. Fifth District Commander says the upper stretch of Burgundy, near Forstall Street, is a hot spot for drug sales, and that's a

big part of what makes it dangerous.[3]

Drug Ring Busted in Treme

The NOPD First District Narcotics unit busted a mid-level drug dealing operation in Treme. Police arrested two suspects and confiscated about $6,000 of crack cocaine and hydrocodone at 2031 St. Phillip Street.[4]

New Orleans police arrest 51 people on drug, prostitution charges during undercover stings.

Speaking at a news conference with mug shots of dozens of those arrested displayed behind him, NOPD Police Superintendent said the people taken into custody bought and sold thousands of dollars worth of crack cocaine, heroin, marijuana, and counterfeit drugs at different times during the operation.[5]

4 men found guilty in gang rape of 15-year-old in St. Tammany

Four men were found guilty Monday of gang raping a 15-year-old at a 2008 house party where there were drugs and drinking. An Assistant Attorney told the court that the state considers her a victim of a drug-facilitated rape.[6]

Two students from a private high school accused of selling marijuana to teacher

Two students from a private high school were booked with drug distribution after one of them sold marijuana to a school chemistry teacher, authorities said Friday. The teacher also was arrested.[7]

Kenner woman booked with child desertion and possession of drugs

A Kenner woman was booked with child desertion after police found her two young children playing in the middle of the street with no adults at home, according to the

[3]Times Picayune newspaper April 4, 2012.
[4]Times Picayune newspaper January 7, 2011.
[5]Times Picayune newspaper June 8, 2011.
[6]Times Picayune newspaper April 2, 2012.
[7]Times Picayune newspaper February 24, 2012.

Kenner Police Department.[8]

7th Ward man found guilty of drug charges

> A 32-year-old man has been spared hefty prison time before, though not for lack of effort. His record of arrests on cocaine and marijuana charges spans his entire adult life -- most happening around the 7th Ward home where police say he grew into something of a drug lord. And eventually, they say, a murderer. He pleaded guilty to drug crimes five times. In 2007 he was caught with crack cocaine and said it was only a post-Katrina stopgap; he'd "been dealing drugs for three months to repair his residence." A jury cut him loose. But over the past week, an Orleans Parish jury got a fuller measure of his criminal credentials, they allowed prosecutors to air his drug conviction history. The result: A jury on Tuesday convicted this man of two lesser charges: attempted possession with intent to distribute cocaine and attempted possession of marijuana. While jurors heard about his prior drug convictions, they did not know that he also faces an indictment in two murders.[9]

These headlines and excerpts provide only a glimpse of the story. They do not begin to tell the whole story of the human suffering and economic costs to the community generated by those driving the drug trade, by those who buy and consume illicit substances, by those who abuse alcohol and other substances, and by those trapped in addiction. Drug abuse wreaks havoc on children, families and neighborhoods resulting in child abuse, mental illness, poor school and workplace performance, property crime, homelessness and lost hopes and dreams. These stories compel us to move forward and to take action against this serious problem.

The chart below, consisting of data obtained from the Community Needs Assessment (CNA), presents a sampling of the critical nature of drug abuse in our nation, state and city[10]:

[8] Times Picayune newspaper May 16, 2011.

[9] Times Picayune newspaper April 10, 2012.

[10] Gallati, B. (2012). *New Orleans Community Needs Assessment: Quantifying the Problem.*

Problem Identification	Extent and Consequences
Availability of alcohol	30% of New Orleans 10th graders drink and 12% have engaged in binge drinking in the past 2 weeks. 75% of these students received alcohol from acquaintances or family members over age 21.
Availability of illicit drugs	Heroin, cocaine and prescription drugs are the predominate illicit drug threats to New Orleans
Escalating marijuana usage	14 % of New Orleans college students smoke marijuana at least 3 times per week
Drugs and Crime	77 % of convicted jail inmates (U.S.) could be characterized as alcohol or drug-involved offenders
Homicide	49% of both perpetrators and victims in recent New Orleans homicides had prior arrests for drugs.
Property crime	80% of state inmates (U.S.) arrested for property crimes committed their offense to get money for drugs
Violence	60 % of physical violence in New Orleans colleges involved alcohol or illicit drugs
Arrestees and the prison population	2/3rds of persons detained in the Orleans Parish jail had recently used an illicit drug
Deaths attributable to substance use	17 of the 27 New Orleans traffic accident deaths (2010) are alcohol-related. The rate of drug overdose deaths in Louisiana is 20% higher than the national rate.
Child abuse and neglect	18% to 24% of child abuse or neglect cases involve parental drug abuse. For those children placed in foster care 50% to 79% of cases (U.S.) involved parental drug abuse.
Fetal exposure to alcohol	8.4 % of Louisiana infants were exposed to alcohol in the 3rd trimester of their mother's pregnancy
Children with prenatal cocaine	Children prenatally exposed to cocaine are 1.5 times more likely to need special education services (U.S.
Hospital ER/trauma center visits	40 to 60 % of all patients admitted to hospital trauma centers (U.S.) were injured while under the influence of alcohol or other drugs
Homelessness	38% of homeless people (U.S.) are dependent upon alcohol and 26% abused other drugs
Unemployment	17% of unemployed persons (U.S.) have used an illicit drug in the past month
Underage drinking and drug use	Louisiana is ranked 5th for the number of High School students who used marijuana for the first time before age 13, and 4th for youth who used alcohol prior to age 13.
Drug Use/Abuse18-25 Population	Over 9,000 young adults in Orleans Parish experienced a substance use disorder last year.
Low School Performance	26% of New Orleans college students reported performing poorly on a test or school project due to their alcohol or drug use.
Economic Costs of Drug Abuse	Louisiana spent $1.375 billion (17% of its budget) addressing the consequences of substance abuse (2005)

Lack of Available Data Identified:

A key finding of the CNA has been the serious lack of critical baseline data needed to accurately measure outcomes and target areas for drug abuse reduction. Baseline drug abuse data is deficient, resulting in an inability to determine the factors driving the drug abuse problem and then identify appropriate solutions.

The sample size of one important youth drug abuse trending survey (Communities That Care Youth Survey (CCYS), is so low (10%), that school districts, prevention providers and the community have no accurate data to plan prevention strategies and evaluate their effectiveness. Failure to achieve at least a 60 percent sample size in the CCYS survey alone has handicapped New Orleans in seeking funding, especially for services targeted to children and families.[11]

Low sample sizes and underutilization of surveys funded by state and federal tax dollars have limited the ability to target drug abuse and have resulted in ineffective interventions. Other cities throughout the country and other Louisiana parishes have appropriate CCYS sample sizes and are also utilizing drug abuse related surveys to evaluate the impact of drug abuse on hospital admissions, deaths, and arrests such as the "Drug Abuse Warning Network" (DAWN) and "Arrestee Drug Abuse Monitoring" (ADAM) system in a manner that assists them in accurately targeting drug abuse and the related problems that endanger the community.

The Importance of the Risk and Protective Factors Model:

Research has indicated that the more risk factors evident in a community, the more likely it will be for one to develop drug abuse and other behavioral problems.[12] Risk factors are conditions or variables that increase the likelihood of drug and alcohol use, such as perceptions of approval of drug-using behavior in community environments, availability of substances (illicit drugs/alcohol), exposure to violence, economic deprivation, lenient laws about alcohol and drug use and neighborhood disintegration. Protective factors are conditions or variables that help safeguard youth from exposure to risk and reduce the potential for involvement with substance use, such as: parental monitoring with clear rules of conduct and parental involvement in their children's lives; secure and stable families; strong community norms or standards against violence and substance use; strong bonds with faith organizations or other community groups; healthy leisure activities; and access to support services. Interventions designed to reduce risk factors and increase protective factors have been shown to yield immediate and long-term results.

IX. Problem Statements and Goals

[11] Gallati (2012).

[12] Hawkins, J., Catalano, R., & Miller, J. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin*, 112, 64-105.

This section outlines the key issues and lays out the strategic goals in the areas of prevention, treatment, enforcement and criminal justice. Common concerns identified across the three areas were: lack of coordination; lack of sufficient data to guide and evaluate drug abuse related programs; lack of performance monitoring; limited knowledge and application of the risk and protective factor model; lack of evidence-based programs and innovative program models; limited awareness in the community about the connection between drug abuse and crime, short and long term, health problems and other social problems. Common elements identified as fundamental to an effective, integrated strategy are: committed leadership; collaboration and sustained partnerships; data collection and reporting; training and development; policy identification and advocacy; resource alignment and maximization of limited resources; community mobilization; evaluation and monitoring of programs.

A. Prevention

Problem Statement:

There is a high level of availability and use of alcohol and other illicit drugs by youth. Approximately 2,000 adolescents under age 18 are in need of services for a drug abuse disorder.[13] There is a high level of non-medical use of pain relief medication by adults (26 and older) and young adults (18-25). There is a high rate of "binge drinking" in the young adult and adult population. There is a high level of college students who regularly use marijuana and other illicit drugs. There is a low level of awareness regarding the connection of drug abuse to the many other social problems in the community. There is a lack of understanding of the damage that underage drinking and illicit substances do to the adolescent brain. There is the existence of community norms and parental attitudes favorable to the use of alcohol to youth. There is a low perception of harm related to illicit drug use and alcohol in the under 21 population. There is a lack of consistent 'no use' drug prevention messages aimed at young people (under age 21) and the general population.

Low sample sizes of youth trending surveys make it difficult to plan, implement, and evaluate programs. Currently, programs are not targeted to meet the indicated needs of school populations. There is insufficient evidence-based prevention programming in schools, colleges and the community. There is a critical need for drug abuse prevention education and training for parents, educators, health officials, the faith community and others who work with youth.

Those who are at the highest risk such as those in the criminal justice

[13] Gallati (2012).

population, children of alcoholics and addicts, and trauma victims do not receive adequate prevention education, screening, intervention and referral to treatment resources. The programs that exist are often not informed by supporting data, do not address specific population needs and are often not administered with fidelity to program goals. There is a real need for coordination, information sharing, data collection, monitoring and evaluation of prevention programs and policy advocacy for prevention.

Prevention Goals:

To Foster Healthy, Safe, and Drug-Free Youth, Families and Communities:

1. Prevent and reduce the use and abuse of alcohol and other drugs across the lifespan, particularly in the under 21 population.

    a. Establish a coordinated system of evidence-based drug abuse prevention programs.

    b. Develop and deliver programs that promote family and community protective factors and reduce risk factors.

    c. Promote "evidence-based" prevention education in all educational settings, schools (K-12), universities, colleges, and the community.

    d. Provide drug prevention programs for diverse populations and particularly targeted to high-risk groups, i.e. those in the juvenile justice system; youth drop-outs; disengaged youth (18-25 years of age.)

2. Mobilize the community to support, reinforce, and model effective drug abuse prevention messages and practices.

    a. Provide education and training programs for parents, teachers, civic leaders, faith community, the health community, and the media in the strategies, practices, and policies that work to reduce the demand for drugs in the community.

    b. Develop a media strategy and awareness campaign with clear, consistent messages that foster healthy, drug-free lives, that is ongoing and in multiple settings.

    c. Gain the support and recognition of community leaders and elected officials that drug abuse is a serious issue that must be deliberately addressed in a comprehensive and coordinated way.

d. Build partnerships with community organizations to gain their support in promoting the message and the mission of a safe, healthy and drug free community.

3. Promote and advocate for public policies and practices that contribute to cultural norms that value healthy, safe, and drug-free lives.

    a. Promote the standard of "no use of illegal drugs and no illegal use of legal drugs" in the community and for all programs, policies and practices related to the reduction of drug abuse.

    b. Develop and promote strategies to prevent and reduce the availability of alcohol for those under 21 years of age.

    c. Develop polices and strategies to reduce the availability of other drugs of abuse by youth – especially marijuana, inhalants and prescription opiods and other substances of abuse.

4. Build a collaborative community of prevention practitioners and programs to develop, implement, and evaluate prevention programs, policies, and practices.

    a. Develop a training and development program to build a cadre of prevention professionals.

    b. Research innovative, promising programs and solution-oriented approaches to reduce drug demand.

    c. Develop and implement a community assessment tool and reporting system to identify current financial, technical and human resources targeted for prevention.

B. Treatment

Problem Statement:

Existing barriers to effective treatment include inadequate: treatment access; client need and treatment matching; knowledge of available treatment providers and their capabilities; diversity among the available treatment options; integration among services and treatment providers; standards of care inclusive of evidenced-based practices (EBP); specialized services such as adolescent, and diversion treatment programs; awareness of resources to treat those in the criminal justice system; understanding of the pervasive nature of addiction; training in effective and cutting edge treatment interventions; understanding of and effort

towards coordinated and integrated continuum of care across systems. There are minimal school based clinics and adolescent treatment resources. There is uncertainty about the impact of managed care on treatment services.

Treatment Goals:

To Heal those who are Dependent on Alcohol and Other Drugs to Fully Restore the Individuals' Health, Dignity and Safety.

1. Establish an integrated and coordinated continuum of care that is appropriate and fully accessible to diverse populations that will eliminate barriers and gaps in treatment services.

    a. Identify all substance abuse providers to include each entity's service, delivery, method and capacity.

    b. Identify an entity to serve as a clearinghouse of service providers (public & private).

    c. Identify an ideal/existing entity to handle client tracking.

    d. Facilitate client feedback and involvement in system design.

    e. Develop/implement sustainability plan to support system continuation.

    f. Create infrastructure to support treatment (e.g. transportation, housing, childcare, child development).

2. Establish and provide oversight for implementation of standards of care grounded in evidenced-based best practices (EBP).

    a. Cross train all providers to improve and expand care through knowledge building.

    b. Create infrastructure to support treatment (e.g. transportation, housing, childcare, child development).

    c. Engage faith based services and other related entities.

    d. Advocate to incorporate criminal justice based resources.

    e. Expand services for adolescents and other special populations.

f. Solicit feedback for future planning & development (identify peer-to-peer providers).

3. Develop a comprehensive and integrated "state of the art" data collection system designed with common features allowing for tracking, data sharing and communication across agencies and systems.

    a. Conduct data systems status assessment.

    b. Identify each entity's success indicators or outcome metrics.

    c. Identify appropriate computer technology to meet the need of provider community.

    d. Identify data system elements.

    e. Identify a responsible entity to collect, house and analyze data.

    f. Integrated patient tracking/evaluation system utilized by all providers.

    g. Promote the ongoing use of tracking system.

4. Increase information to healthcare community and community at large.

    a. Establish partnership with healthcare community.

    b. Conduct training and technical assistance for identifying, diagnosing and treating substance abuse.

    c. Disseminate materials inclusive of treatment provider network and access.

    d. Develop community education programs.

C. Law Enforcement/Criminal Justice

Problem Statement:

Heroin, crack cocaine and cocaine hydrochloride are the three illicit drugs that represent the most significant threat in New Orleans. Marijuana availability and abuse remains at high levels in New Orleans. There is a lack of methods and strategies for regularly sharing information on high-

risk individuals involved in drug trafficking and distribution. Illicit drug use in among young adults is at high levels. Alcohol and drugs are involved in the majority of cases of physical violence among college-aged students. Alcohol-related injury crashes are at high levels and the majority of traffic deaths in New Orleans are alcohol-related. There is a high level of illicit prescription drug abuse in the community. There is a lack of unified reporting and standard statistical data regarding drug abuse across criminal justice agencies. There is a reported high level of drug use and dealing in the prison population. Limited data exists regarding the level of arrestees who test positive for drugs and the percentage of offenders in the criminal justice system presenting with addiction and co-occurring disorders. There is a limited assessment and screening services for drug use/abusers prior to first appearance and negligible screening and referral to treatment opportunities within the criminal justice system. There is a need for procedural manuals related to offenders with drug abuse issues. There is a lack of policy, regulation, practice and offender services for successful re-entry (release from Parish Prison). There is a lack of consensus regarding evidence-based program models for offenders. The capacity for prevention, intervention, and treatment services within the Orleans Parish Prison is undetermined.

Law Enforcement Goals:

To Enhance the Public Safety by Reducing the Supply of Drugs, by Disrupting the Illegal Drug Market and by Deterring Illegal Drug Use by Adults and Youth.

1. Disrupt and deter the flow of illegal drugs by synchronizing resources in areas impacted by drug trafficking.

    a. In collaboration with local, state and federal agencies, identify data driven drug patterns and trends of illegal distribution.

    b. Coordinate tactical and operational enforcement efforts at all levels of the illegal criminal activity spectrum.

    c. Identify and utilize innovative strategies and programs to disrupt drug markets and drug distribution.

    d. Enforce existing laws related to drug dealing and trafficking.

2. Reduce drunk and drugged driving.

    a. Better coordinate activities of state police with local law enforcement for “hot spot” traffic enforcement.

3. Reduce youth access to alcohol and other illicit drugs.

    a. Enforce underage drinking laws such as those which prohibit serving youth under 21 and use of false identification to obtain alcohol and enforce use/lose penalties.

    b. Enhance Responsible Vendor Program and partner with alcohol vendors.

4. Disrupt the illegal diversion of prescription drugs.

    a. Increase awareness of prescription drug abuse and collect unwanted prescriptions.

    b. Enhance enforcement operations and laws.

    c. Continue to investigate the illegal diversion of prescription drugs and enhance information sharing processes among local state and federal partners.

    d. Educate stakeholders and the public regarding the state prescription drug registries and increase enforcement for violations (Louisiana Prescription Drug Monitoring).

    e. Increase advocacy for a law requiring a prescription for pseudoephedrine and ephedrine.

5. Utilize strategic operational methods/technology among local, state and federal enforcement agencies to rapidly assess, identify and disrupt criminal activity.

    a. Generate awareness and promote the acquisition of technology to assist with enforcement efforts.

    b. Ensure appropriate reporting systems that record and document criminal activity, including the nexus between substance abuse and criminal conduct.

    c. Establish regional task forces or specifically task existing task forces with analytical and technical support to identify and disrupt drug-related criminal activity on a long-term continuing basis.

    d. Provide awareness and training opportunities for

enforcement and members of judicial system for special interest topics in a joint training environment.

e. Coordinate implementation of effective programs that involve the criminal justice system and the community.

6. Implement innovative enforcement related community practices and programs that mobilize neighborhoods and create a healthy community environment.

a. Enhance neighborhood associations that work in collaboration with the police.

b. Collaborate with neighborhood stakeholders to enforce neighborhood safety policies and programs.

d. Establish community service projects through partnerships with the local police department.

Criminal Justice System Goals:

1. Support a broad array of sanctions and consequences that include mandatory drug education, treatment participation, fines, community service, and regular drug testing of repeat offenders to reduce recidivism rates.

a. Promote drug-screening and evaluation of offenders to ensure effective interventions upon entry.

b. Promote collaboration between defense attorneys, prosecutors, judges, social workers and probation officers during sentencing.

c. Develop Judge's Bench Book with procedures for offenders with drug abuse issues.

d. Support the continued identification and sanction of individuals involved in drug trafficking and distribution.

e. Promote collaboration between courts and treatment or other substance abuse services to better ensure appropriate alternative sentencing.

f. Enhance existing diversion programs with the present statutory system for juvenile and adult systems, i.e. drug courts, pre-trial diversion, and conditional

discharge and develop innovative programs for the 18 to 25 year old population.

g. Research model interventions for minors in possession (MIP) entering judicial system.

2. Research and identify current model substance abuse related alternative criminal justice programming, including but not limited to problem solving courts, diversionary programs and re-entry programs.

a. Promote collaboration between courts and substance abuse service providers to ensure appropriate services for those in pre-entry and re-entry programs.

b. Foster the utilization of diversionary alternatives for offenders with substance abuse disorders in criminal justice programs.

c. Advocate for changes to legislative statutes which prohibit or discourage effective alternative or diversionary practices.

3. Promote the creation of a coordinated continuum of care for those in the criminal justice system that begins at entry and ends with re-entry and continues in release to society.

a. Research the current continuum of care for those entering the criminal justice system.

b. Promote the development of a system with a unique identifier that will follow the individual across all stages of the criminal justice system, from entry to diversion to reentry.

c. Promote prison reentry programs that include community-based services, conflict resolution, life skills, job skills and healthy lifestyle training.

d. Promote, develop, expand and coordinate case management services to link those in the criminal justice system with treatment and community based services (including assistance with employment retention during re-entry).

e. Research and advocate for the implementation of model prevention and treatment programs and other social services, for those in the prison population (i.e., long term felony inmates (including work release participants short term prisoners, those with municipal sentences and probation/ parole technical violators).

f. Research model programs for juvenile inmates and juveniles under court supervision.

4. Develop a model integrated data collection system for the courts, which provides drug abuse and mental health profiles of offenders to ensure better informed sentencing decisions.

    a. Enhance opportunities for collaboration between representatives of the various courts.

    b. Develop a screening and assessment procedure in municipal court in order to detect, document and track persons with drug abuse and mental health problems.

    e. Promote the creation of a mapping procedure to identify and document minors in possession and other juvenile offenses in order to implement the best practices.

5. Promote cross-training in the criminal justice system on issues related to substance abuse and mental health disorders

    a. Develop a cadre of trainers from within the criminal justice system and the community to better share information, data, trends, best practices across agencies

X. Recommendations

For too long, policy and program planning has been implemented without the benefit of valid data to ensure that interventions are appropriate. It is only through assurance of credible data that New Orleans can move forward and have the capacity to more accurately measure targets of reduction such as overall drug use, underage drinking, drug overdoses, prescription drug abuse, drunk and drugged driving, drug related crime and child abuse and neglect. Therefore, a key finding and recommendation from the planning process and the needs assessment is that reliable data should inform all drug abuse related services, including contracting decisions; requests for proposals; and monitoring and evaluation practices. An ongoing assessment of needs and resources is imperative to ensure positive outcomes for all drug abuse related policies, practices and programs.

Other recommendations from the Community Needs Assessment and planning process:

1. All schools should participate in surveys to gather youth trending information for appropriate decision making for programs such as CCYS, Youth Behavioral Risk Factor Surveillance System, CORE (College); Rapid Assessment for Adolescent Preventive Services (School-based Health Services).

2. In order to measure drug abuse in the community and ensure program effectiveness, there should be full participation by relevant entities in surveys such as: CCYS (youth), BRFSS (18 and older), CORE (College), DAWN-ED (hospital emergency visits), DAWN-ME (Coroner), ADAM (Arrestee).

3. Community leaders and professionals in the drug abuse field should work together in "learning communities of practice" to use surveys and other information resources for program planning, implementation and evaluation.

4. The coordinated school health program (CSHP) should be expanded to include New Orleans.

5. All programs, policies and practices related to reducing the drug problem should be designed, developed and implemented to enhance protective factors and reduce/reverse risk factors.

6. The state should coordinate and ensure the participation of treatment and prevention providers in the High Intensity Drug Threat Assessment (HIDTA) provider surveys.

7. Access to quality, patient-centered care for drug abuse problems, and the outcomes of care, should be studied in light of managed care and the Affordable Care Act.

8. Drug courts in New Orleans, a key alternative to incarceration for drug addicted offenders, have been very effective in deterring drug use and steering users toward the help they need and should be supported and expanded.

9. Drug court lab reports should be reviewed and verified regularly to ensure integrity of results.

10. Drug-free workplace programs, which have been proven to reduce accidents, health care costs, and absenteeism and increase

productivity, should be expanded in the community.

11. Drug testing is a reliable tool to detect drug use and to intervene, treat and educate drug users in schools and in the criminal justice system. Louisiana has employment drug testing guidelines.

12. Reported illicit drug use in the prison population should be assessed and be appropriately addressed.

13. Evidence-based program models for offenders and those in the prison population should be reviewed and implemented appropriately.

14. Crime and arrest data should be an integral part of community-level indicators (property crime, violent crime rate etc) used to measure risk and protective factors as well as plan prevention, treatment and enforcement strategies.

15. Research should be conducted on innovative drug market intervention programs designed to eliminate drug markets and drug-related violence, i.e. "The High Point Drug Market Intervention Strategy."

16. A standard set of statistics should be developed regarding the substance abuse and mental health problems of offenders in the various components of the criminal justice system.

17. An agency, such as the New Orleans Health Department, should take the lead for development of local neighborhood-level public health indicators including drug and alcohol-related indicators (drug poisoning, alcohol related vehicle crashes, etc).

18. A treatment and recovery system model should be specified based on appropriate utilization of a continuum of services in order to estimate the need for different types of services and levels of care in the community.

19. An annual survey of treatment providers should be developed in order to document the capacity and utilization of the existing system in terms of persons admitted, length of stay and individuals served at different levels of care.

20. An annual survey of all preventions programs (federal, state, school and/or privately funded) should be developed and implemented to assess unmet need for prevention services in schools and the community.

21. Data analysis and collection capacity should be built within the

coroner's office.

22. Research should be conducted on best practices and models for long-term supportive housing for people in recovery, including populations returning to the communities from jails and prison, or who are placed on probation, including case management for those in need of drug treatment.

23. A cost analysis of the negative consequences of drug abuse on the community of New Orleans and the cost benefit of prevention, treatment, and enforcement is recommended and should be employed by community leaders for decision-making and program planning.

XI. Implementation

The next phase of this initiative is the implementation of the strategic plan. The Coalition accepts the responsibility of directing and overseeing the implementation of the strategy and monitoring and reviewing its progress at annual drug summits over the next five years. Sustainability requires mutual accountability in order to move from vision - to mission - to achievable outcomes that will positively affect the safety and health of our community. The Coalition will continue the relationship with city officials, and hopes to formalize this relationship and to gain their support for the full implementation of the strategic plan. The Coalition plans to engage the citizenry of New Orleans in carrying forward this mission - educators, parents, health officials, criminal justice officials, the media, lawmakers, neighborhood associations, volunteer and civic and business organizations, the faith-community, and youth leadership organizations.

The strategy is a dynamic plan that takes a long-range, holistic view of the city's drug abuse problem. This strategy reflects the will of the citizens of New Orleans and codifies it into a single comprehensive plan. As such, it is the best tool to ensure community efforts and policy are synchronized and focused on one issue – the reduction of drug abuse.

The strategy is a living document and will be adjusted to meet changing conditions and the discovery of new ideas and information. The next steps in developing a model for change are to prioritize the goals and to develop action steps; to build commitment and capacity through training, education, and public awareness; to seek talent and target talent; to leverage resources throughout the communities and agencies; to identify and employ innovative and culturally responsive strategies and to advocate for proven and effective drug demand reduction policies.

XII. Conclusions

We, New Orleanians, have the challenge of maintaining the gracious and festive atmosphere of the city that we love, visited by so many who come to celebrate and enjoy this wonderful city, while at the same time safeguarding our community from the problems associated with the abuse of alcohol and other drugs.

The drug problem is a multi-faceted community problem that requires "a big picture" approach and cannot be compartmentalized. The drug problem is also not hopeless or inevitable. There are proven models and strategies to bring down the problem that have improved lives and communities, in particular, model community coalitions.[14]

The drug abuse problem affects our public image, our health and our personal safety. New Orleans can be a city with a good quality of life for all its citizens - with lower crime rates, safe neighborhoods; fewer hospital admissions; fewer drug addicted babies and mothers; fewer incidents of child abuse; fewer infant mortalities; fewer workplace accidents; fewer school dropouts and higher test scores in schools.

New Orleanians must promote and uphold healthy beliefs and clear standards that protect our community and especially our children from drug abuse and its negative consequences. We must foster among our citizens a culture that supports the responsible use of alcohol by adults and no use by those under 21 years of age and rejects the illicit use of any substances.

The community must come to a consensus that drug abuse is wrong, harmful, and too costly in terms of lost lives and wasted resources and must accept their responsibility in helping to reduce the drug problem in New Orleans. Those driving and perpetuating the drug problem - both suppliers and consumers - should be held responsible by the community and appropriately sanctioned.

Protecting our youth from the dangers of drug abuse is paramount and is a key focus of our strategy. Parents must start early to give their children information and the skills to resist the use of illegal drugs and should model healthy behaviors. We must educate parents about the damage alcohol does to the developing brain and how this damage sets up adulthood addiction. Parents should be aware of the risk factors that contribute to the drug abuse problem and the protective factors that safeguard their children and their children's futures. Educators and schools must see drug prevention as a priority, incorporate evidence-based programs into

[14] Office of National Drug Control Policy. (2011). White house policy office awards to local communities. Retrieved from http://www.newswise.com/articles/white-house-drug-policy-office-awards

school curriculum and fully participate in youth trending surveys.

The community and its leaders must fully embrace an integrated strategy of prevention, treatment and enforcement - this approach is solution-oriented, compassionate and cost effective. Prevention, treatment, enforcement and criminal justice systems must be guided by best practices, proven drug demand reduction models and standards of excellence that are responsive to the unique needs of our community.

Innovative strategies and promising programs adapted to our unique culture and experience need to be developed. Credible data must guide decision-making for all our programs, policies and practices and, as citizens of New Orleans, we must be good stewards of our resources.

A Call to Action:

To achieve these goals and real, measurable, long-term progress, we call upon all New Orleanians to commit their individual and professional power to address the drug problem in New Orleans. All citizens, families, neighborhoods, organizations and agencies are essential in helping to carry out this vital mission. We call upon our leaders to champion this cause and to help move this strategy from words into action.

We recognize the challenges to accomplish this mission, yet we are convinced that with the many dedicated people of integrity and good will in leadership positions today and with the support of the countless citizens and volunteers working to reform and improve our city that we can make a real difference. With the same spirit and determination used to rebuild this city, New Orleans can become a healthier and safer city for all our citizens.

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Supporting Documents Section

XIV. Supporting Documentation

j. Community Needs Assessment

ii. Principles of Drug Demand Reduction

iii. The Three Pillars of Drug Demand Reduction

iv. Biography of Consultants

XIV. i. New Orleans Community Needs Assessment

Report No. 1

Quantifying the Problem

Submitted to the

Greater New Orleans
Drug Demand Reduction Coalition

and the

Metropolitan Human Services District

Submitted by

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April 2012

Definition of Selected Acronyms

ADAM II	Arrestee Drug Abuse Monitoring
BRFSS	Behavior Risk Factor Surveillance System
BJA	Bureau of Justice Assistance
CCYS	Louisiana Caring Communities Youth Survey
Core Survey	Core Institute Alcohol and Drug Survey of students at institutions of higher education
CPDs	controlled prescription drugs
CPS	Child Protective Services
DAWN-ME	Drug Abuse Warning Network – Medical Examiner (Coroners)
DAWN-ED	Drug Abuse Warning Network – Emergency Department (hospitals)
DSM-IV	Diagnostic and Statistical Manual, Fourth Edition of the American Psychiatric Assoc.
FARS	Fatality Analysis Reporting System
FASD	Fetal Alcohol Spectrum Disorders
HIDTA	High Intensity Drug Trafficking Area
LaPRAMS	Louisiana Pregnancy Risk Assessment and Monitoring Surveillance
NCANDS	National Child Abuse and Neglect Data System
NDCS	Nation Drug Control Strategy
NOPD	New Orleans Police Department
NSDUH	National Survey on Drug Use and Health
NVSS	National Vital Statistics System
ONDCP	Office of National Drug Control Policy
OPSO	Orleans Parish Sheriff's Office
SAMHSA	Substance Abuse and Mental Health Services Administration
SUD	Substance use disorder
UCR	Uniform Crime Reports
YRBS	Youth Risk Behavior Survey

New Orleans Community Needs Assessment
Report No. 1: Quantifying the Problem

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Preface

The Greater New Orleans Drug Demand Reduction Coalition has developed a strategic plan that coordinates the efforts of the *enforcement*, *prevention*, and *treatment* communities to reduce drug abuse as well as the negative consequences of substance use and addiction. The needs assessment is intended to support the development, implementation, evaluation and continuing refinement of the strategic plan.

This report describes the threat that drugs present to New Orleans and the Gulf coast region due to the high intensity of drug trafficking. It documents the impact of violence and crime on New Orleans, and the relationship to drug and alcohol use in terms of homicides, violence and property crime, drug and alcohol arrests, and jail and prison populations. Survey data paint a picture of troubling levels of alcohol and drug use, and resulting negative consequences, among our adolescents, adults, young adults and college students. Administrative data reveal unacceptable levels of death and injury due to drug poisoning and alcohol-related vehicle accidents. The effects of substance use on fetal alcohol exposure, child abuse and neglect, emergency room visits and homelessness are described at the state or national level. The report quantifies the substantial social and economic costs of drug and alcohol misuse affecting individuals, families, communities, and our state budget, as well as the benefits of prevention and treatment.

Report No. 1 is limited to readily accessible data from local and national sources, typically available in published reports or on Web sites. A second report will provide strategies and recommendations for improving data collection and the development of indicators to monitor progress. Additional reports will describe current resources and unmet need, identify coordination issues, and initiate specification of model service systems.

The Coalition's approach is consistent with the Nation Drug Control Strategy (NDCS) which stresses the importance of a coordinated approach of prevention, treatment and enforcement. The Coalition is also employing the Strategic Prevention Framework (SPF) developed by the Substance Abuse and Mental Health Services Administration (SAMHSA). This framework includes five phases: assessment, capacity building, planning, implementation and evaluation. The Community Needs Assessment addresses the first phase. However, effective drug demand reduction strategies, the National Drug Control Strategy and the Strategic Prevention Framework call for continuing epidemiological effort to support planning, implementation and evaluation, in order to ensure that the actions are effectively targeted to needs and are achieving their intended purposes, and so that the outcomes of these initiatives can be objectively measured and reported to the community.

The Community Needs Assessment is funded by Metropolitan Human Services District (MHSD) which is the local Human Services Authority responsible for substance abuse, mental health and developmental disability services for the three parishes: Orleans, Plaquemines and St. Bernard.

Introduction

The Greater New Orleans Drug Demand Reduction Coalition (the Coalition) is concerned about the effects of alcohol and drug abuse and substance use disorders on our community, including social, economic and public health problems. They are especially concerned about violence. The Coalition envisions that "New Orleans will be a safe, crime and drug-free, healthy community with a good quality of life for all of its citizens."

The Coalition seeks to "develop and guide the implementation of a strategic plan involving prevention, treatment and enforcement to decrease the use of illicit drugs and abuse of alcohol and other drugs, and the negative consequences of substance abuse/addiction" including crime, poor health, disrupted neighborhoods, domestic violence, child abuse, poor school and work performance, automobile accidents and violence.

The approach the Coalition is taking is consistent with the Nation Drug Control Strategy (NDCS) which stresses prevention, intervention and treatment as well as enforcement-related efforts. The NDCS includes alcohol use among its concerns, especially underage drinking. The Coalition's approach is also consistent with the Strategic Prevention Framework developed by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). This framework includes five phases: assessment, capacity building, planning, implementation and evaluation. Throughout the phases, sustainability of the effort and cultural competence must be addressed. SAMHSA's first phase includes assessment of both the need in the community and the resources available to address the need.

The needs assessment is intended to support the development, implementation and continuing refinement of the strategic plan by (1) developing frameworks and methods for assessing needs as well as the adequacy and integration of resources to meet those needs, and (2) implementing those methods to the greatest extent possible within a limited time frame, including production specific reports and products useful to the planning process.

The Strategic Plan is being built on three pillars: **enforcement**, **prevention** and **treatment**. Within these areas, the needs assessment will address needs, resources, and the coordination and integration of resources. This first report will focus principally on needs within the general population. Subsequent reports will address the need for specific services and the resources available within the community.

Population and Geographical Context

In 2005, Hurricane Katrina destroyed much of the physical infrastructure of New Orleans, but also greatly damaged its social institutions. Many of its residents who evacuated have not returned to the City. While not all problems can be blamed on the hurricane, the damage left the City especially vulnerable. Similarly, alcohol and drug abuse leaves the community vulnerable and threatens its recovery. While more could have been done to prevent the damage caused by Katrina, more can be done now to reduce substance use and its consequences.

The New Orleans Metropolitan Statistical Area (MSA) encompasses 7 parishes and over 1 million residents. (Orleans Parish and the City of New Orleans are coterminous.) The MSA population is concentrated in Orleans and in the urban part of its immediately surrounding parishes: Jefferson, St. Bernard and Plaquemines. Geographically, these four parishes are relatively isolated from the rest of Louisiana by Lake Pontchartrain and marsh and bayou areas with few residents. Commuting from other parishes is principally by routes I-10 and US-90 east and west and by a 24-mile long causeway across Lake Pontchartrain north and south. In this report, Orleans, Jefferson, St. Bernard and Plaquemines parishes will be referred to as the ***Metro Area***. These four parishes constitute health region No. 1.[1]

Population Change by Parish for the New Orleans Metropolitan Statistical Area (MSA), 2000 to 2010

Parish	Population, April 1		Population Change	
	2000	2010	Number	Percent
Orleans Parish	484,674	343,829	-140,845	-29.1
Jefferson Parish	455,466	432,552	-22,914	-5.0
Plaquemines Parish	26,757	23,042	-3,715	-13.9
St. Bernard Parish	67,229	35,897	-31,332	-46.6
Metro Area	1,034,126	835,320	-198,806	-19.2
St. Charles Parish	48,072	52,780	4,708	9.8
St. John Parish	43,044	45,924	2,880	6.7
St. Tammany Parish	191,268	233,740	42,472	22.2
New Orleans MSA	1,316,510	1,167,764	-148,746	-11.3

Source: U.S. Census Bureau, 2010 Census and Census 2000, released September 2011.

One of the principal legacies of Hurricane Katrina is that the New Orleans MSA lost over 10 percent of its population from 2000 to 2010. While the three parishes outside the Metro Area gained population (especially St. Tammany), the Metro Area lost 19 percent of its population, almost 200,000 residents. In particular, Orleans lost almost one-third and St. Bernard almost half of their residents between 2000 and 2010. While population has been increasing, abandoned residential property remains a problem.

Population Estimates for Needs Assessment Age Categories based on 2010 US Census SF-1 Data for Parishes

Age Group	Orleans	Jefferson	St. Bernard	Plaque-mines	Metro Area	Louisiana
Ages 0-11	49,367	65,303	6,231	4,123	125,024	745,731
Ages 12-17	23,848	32,094	2,946	2,206	61,094	372,284
Aged 18-25	49,215	44,705	4,538	2,151	100,609	528,543
Ages 26 & older	221,399	290,450	22,182	14,562	548,593	2,886,814
Total	343,829	432,552	35,897	23,042	835,320	4,533,372
Adults 18 & older	270,614	335,155	26,720	16,713	649,202	3,415,357
Ages 18-20	17,265	15,768	1,645	857	35,535	204,473
Ages 12-20	41,113	47,862	4,591	3,063	96,629	576,757

Source: National Center for Health Statistics from 2010 US Census. www.cdc.gov/nchs/nvss/bridged_race.htm . Population for age 25 is estimated by interpolation.

The dynamic state of the Metro Area population complicates the needs assessment. For instance, in examining trends in rates, it is especially difficult to estimate population denominators. Further, population components (gender, age, race, ethnicity, housing and socio-economic status) may be changing. Fortunately, the 2010 US Census provides a useful anchor point. In many cases, the most recent data available from survey and administrative sources are for 2010.

[1] For purposes of substance abuse, mental health and developmental disability services, the Metropolitan Human Services District serves Orleans, St. Bernard and Plaquemines parishes while Jefferson Parish is served by the Jefferson Parish Human Services Authority. Jefferson parish is sometimes referred to as Region 10.

Drug Threat Assessment for the Gulf Coast Region

The Gulf Coast High Intensity Drug Trafficking Area (HIDTA) program includes state and local law enforcement officials from 26 counties/parishes in four states: Louisiana, Mississippi, Alabama and Arkansas. In addition to sharing intelligence, the HIDTA produces an annual Drug Threat Assessment for the region. The Gulf Coast is a corridor for transporting illicit drugs from the Mexican border areas to the northeast and from Florida to the west and mid-west. Drugs may also enter the region through the Port of New Orleans and other ports along the Gulf Coast as well as by commercial airlines and other carriers. The most current information available is the 2011 Drug Market Analysis:[2]

Cocaine is the greatest drug threat to the Gulf Coast HIDTA region because of its widespread availability, with strong and stable supplies of cocaine to most drug markets in the region. Cocaine seizures increased in the Gulf Coast HIDTA region in 2010, totaling 1,339 kilograms—a 58 percent increase from 2009. Law enforcement officials report that cocaine is available in sufficient quantities to meet demand and that cocaine prices have remained relatively stable over the past 12 months in most Gulf Coast HIDTA drug markets.

Availability of methamphetamine is consistently high throughout most of the Gulf Coast HIDTA region. Most of the methamphetamine available in the Gulf Coast HIDTA region is produced locally. The number of methamphetamine laboratories seized in all Gulf Coast HIDTA counties increased nearly 220 percent from 2006 through 2010. While lab seizures in Louisiana increased dramatically in 2009 and 2010, of the 71 seizures, none occurred in Orleans Parish and only 2 occurred in Jefferson Parish. However, local producers are now using a "one pot" method so that small amounts of methamphetamine can actually be produced in a large plastic soda bottle, "shake and bake." Local producers employ users to purchase small quantities of pseudo-ephedrine at multiple pharmacies; this is called "smurfing." Small scale production may make urban areas more vulnerable as potential production sites and consumption areas.

The availability and abuse of prescription opioids have increased in the Gulf Coast HIDTA region over the past 18 months. Law enforcement officers report that increased diversion of controlled prescription drugs (CPDs) from rogue pain management clinics (commonly referred to as pill mills) in Florida and Texas has led to increased availability and abuse of these drugs in the Gulf Coast HIDTA region. Officers report that local residents often travel to Florida or Texas to acquire prescription drugs at pill mills and either transport them back by car or, in an attempt to thwart highway interdiction operations, mail the drugs to their home addresses. In addition, some law enforcement officials report that distributors and abusers are diverting CPDs through local doctor-shopping, prescription fraud, and pharmacy robberies. CPD seizures increased in the Gulf Coast HIDTA region in 2010, further supporting the notion of increased availability. In 2010, HIDTA initiatives reported a greater than 15 percent increase in CPD seizures from 2009 (86,279 dosage units) through 2010 (99,612 dosage units).

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[2] National Drug Intelligence Center. *Gulf Coast High Intensity Drug Trafficking Area, Drug Market Analysis 2011*. Office of National Drug Control Policy, Dept. of Justice, September 2011. http://www.justice.gov/ndic/dmas/Gulf_Coast_DMA-2011%28U%29.pdf

Heroin availability and abuse in the Gulf Coast HIDTA region are most prevalent in the New Orleans metropolitan area. *Law enforcement officials in New Orleans indicate that heroin poses the greatest drug threat* and is available at high levels in their jurisdictions. They report that *heroin distribution and abuse are significant contributors to crime in New Orleans*, where levels of violent and property crime remain high. Heroin also poses a significant threat to Birmingham, Huntsville, and Memphis. Throughout most of the region, however, heroin is available at low levels.

Marijuana poses a lower threat to the Gulf Coast HIDTA region than cocaine, methamphetamine, and CPDs. Marijuana availability and abuse remain stable at high levels throughout the region. Much of the marijuana available in the region is commercial-grade Mexican marijuana; however, over the past 12 months, the availability of high-potency marijuana supplied from sources in California, Colorado, and Oregon has increased in some markets in the region. Locally grown marijuana is also available in the region; however, the extent of cannabis grow operations in Gulf Coast HIDTA counties cannot be fully evaluated because county-level cannabis eradication data are not available.

Law enforcement officials report some abuse of synthetic cannabinoids, such as Spice and K2, especially among teens and young adults. In 2010, every state in the Gulf Coast HIDTA region passed laws or authorized emergency bans prohibiting the sale of products containing the chemicals commonly found in these synthetic cannabinoids. However, law enforcement officers report that manufacturers of these products have responded to the bans by altering the chemical compounds so that the products are no longer prohibited. Consequently, new legal forms of synthetic cannabinoids, similar to Spice and K2, are being sold in some areas in the region.

Alcohol, although a legal, regulated substance, presents great challenges to law enforcement and the community in general, especially in the Greater New Orleans area. The legal drinking age in Louisiana is 21 years; however, there is a loophole in the State's law allowing 18 year olds to enter bars and lounges where social availability of alcohol is common. In addition there are drive-thru daiquiri shops where only the driver is asked for identification for age verification."[3]

[3] Office of Behavioral Health. Louisiana FY 2012 Combined Behavioral Health Assessment and Plan. (Public Draft of SAMHSA Block Grant Application) Department of Health and Hospitals, September 1, 2011.

Impact on the Crime and Justice

Drug and Alcohol Arrests

Over two years, drug offense arrests in New Orleans declined by half, from 6,723 in 2009 to 3,378 in 2011. Arrests for public intoxication also declined by half, from 5,608 in 2009 to 2,314 in 2011. At the same time arrests for driving while intoxicated increased almost 50 percent, from 1,206 in 2009 to 1,743 in 2011. These arrest trends were the results of changes in policies and procedures intended to improve the efficiency and effectiveness of policing while reducing unnecessary detention and incarceration. The New Orleans Police Department has begun issuing summons for minor drug offenses, accounting for some of the decrease in drug arrests. In addition they have begun using a crisis team approach for handling mental health and severe intoxication problems. Arrests of juveniles, which represent a very small portion of all arrests, show a similar trend. However, a disturbing finding from the 2010 Caring Communities Youth Survey (discussed below) is that about 6 percent of New Orleans high school students self-reported that they themselves had sold illegal drugs in the past year.

Drug and Alcohol Arrests* Tallied by the New Orleans Police Department

	2009	2010	2011
All Arrests			
Drug Abuse Viol.	6,723	4,931	3,378
DWI	1,206	1,367	1,743
Public Drunkenness	5,608	3,443	2,314
Total	13,537	9,741	7,435
Juvenile Arrests			
Drug Abuse Viol.	290	239	154
DWI	62	83	74
Public Drunkenness	254	128	108
Total	606	450	336

*These counts represent "physical arrests" in which the offender is taken into custody rather than just issued a summons.

Comparative data for Louisiana and nationwide are available for 2010 (at the mid-point of 2009 and 2011). In 2010 the drug offense arrest rate for New Orleans is 1,434 per 100,000, twice the rate for Louisiana and almost three times the national rate. The 2010 public intoxication arrest rate for New Orleans is 1,001 per 100,000, ten times greater than for Louisiana. While the New Orleans rate is about five times greater than the nationwide rate, this is not actually comparable since in many states public intoxication is not an offense, so the true difference would be somewhat less dramatic. The 2010 New Orleans arrest rate for driving while intoxicated is 398 per 100,000, more than one-quarter higher than the rate for Louisiana. Although lower than the nationwide rate for 2010, the New Orleans drinking driver arrest may have exceeded the national rate in 2011.

Drug and Alcohol Arrests Rates per 100,000 Population, Calendar Year 2010

Adult and Juvenile Arrests	New Orleans	Louisiana*	National*
Drug Abuse Viol.	1,434	738	531
DWI	398	311	453
Liquor Law Viol.	n.a.	83	167
Public Drunkenness	1,001	92	184

* Louisiana rates are based on 106 reporting agencies and the population covered by those jurisdictions. National rates are similarly based on reporting jurisdictions and their populations. Source: Crime in the United States, FBI, online.

The apparent increase in drinking driver enforcement would seem to be appropriate. In 2010, a total of 27 persons died in traffic accidents on the streets and highways of New Orleans. Alcohol was involved in 17 of these deaths (63%). In addition, 493 persons were injured in alcohol-related crashes. Orleans Parish ranked 7th in alcohol-related injury crashes per licensed driver,

exceeded by only 6 rural parishes. The total cost of alcohol-related accidents in Orleans Parish amounted to $48.3 million in 2010.[4]

Violent Offenses and Property Offenses

Drug and alcohol abuse can erode family and community value systems, contributing to an ethic of lawlessness. Crime to support a drug lifestyle can become an accepted norm. The use of alcohol and drugs can change behavior, resulting in criminal activity when people do things they would not do if they were rationale, free of the drug's influence. Some offenders suffer emotional and/or brain damage due to drug use, contributing to mental illness and anti-social behavior.

Based on Uniform Crime Reports, the number of both violent and property crimes in New Orleans decreased between 2007 and 2010. While 2007 may have been a high point in many crime categories, this decline occurred at the same time that the population in New Orleans increased.

The number of property crimes as a whole decreased 19 percent, from 15,583 in 2007 to 12,645 in 2010. Violent crime numbers as a whole decreased 25 percent, from 3,451 in 2007 to 2,593 in 2010. Only forcible rape appears to have increased. Murder and non-negligent manslaughter declined 16 percent from 209 in 2007 to 175 in 2010.

Uniform Crime Report for New Orleans By Calendar Year

	2007	2008	2009	2010
Violent Crime				
Murder/Manslaughter	209	179	174	175
Forcible rape	115	65	98	144
Robbery	1,154	1,085	932	953
Aggravated assault	1,973	1,540	1,410	1,321
Total	3,451	2,869	2,614	2,593
Property Crime				
Burglary	5,039	4,591	3,821	3,695
Larceny-theft	7,354	7,081	6,507	6,540
Motor vehicle theft	3,190	3,208	2,612	2,410
Total	15,583	14,880	12,940	12,645

Source: Uniform Crime Reporting Statistics – Data Online, FBI

Nevertheless crime rates for 2010 indicate that crime continues to plague the City. In particular, the violent crime rate at 754 per 100,000 population is over a third higher than for Louisiana and nearly double the national average of 404. Of particular concern is the number of homicides which has not declined since 2008. At 51 per 100,000, the New Orleans homicide rate is 5 times greater than the Louisiana rate and 10 times greater than the national average.

The 2010 New Orleans property crime rate of 3,678 per 100,000 is about equal with the Louisiana rate but about one-quarter greater than the national average. While the larceny rate is about the same as the national average, the burglary rate for both New Orleans and Louisiana is about 50 percent higher than the national average. Of

Uniform Crime Rates per 100,000 Population, Calendar 2010

	New Orleans	Louisiana	National
Violent Crime			
Murder/Manslaughter	51	11	5
Forcible rape	42	27	28
Robbery	277	115	119
Aggravated assault	384	396	252
Total	754	549	404
Property Crime			
Burglary	1,075	1,002	700
Larceny-theft	1,902	2,427	2,004
Motor vehicle theft	701	218	239
Total	3,678	3,648	2,942

Source: Uniform Crime Reporting Statistics – Data Online, FBI

[4] Schnieder, H. *Louisiana Traffic Records Data Report 2010*. Highway Safety Group, Louisiana State University, 2011. (Tables D-2, D-5, J-11-13, O-38) http://datareports.lsu.edu/Reports/SpecialReports/2010_FactBook.pdf

particular note, the New Orleans auto theft rate at 701 per 100,000 is three times the rate for Louisiana and the nation.

Homicide Rates

The National Vital Statistics System (NVSS) indicates that in 2008 there were 541 homicides in Louisiana, yielding a rate of 12.2 per 100,000. This rate is more than double the national of 5.9 for that year. Louisiana ranked first among states in homicide, followed by Mississippi (11.3) and Alabama (10.0).[5] New Orleans represents a little over 7 percent of the Louisiana population but accounts for over one-quarter of homicides. Without Orleans Parish, the state homicide rate would have been about 10 per 100,000.

A study of homicide in New Orleans sponsored by the Federal Bureau of Justice Assistance (BJA) was recently completed.[6] Although New Orleans' violent crime rate and property crime rate are higher than the national rates, what stands out is the homicide rate which in 2009 was 52 per 100,000 residents—5 times higher than the average for cities of similar size and 10 times higher than the national rate. The number of homicides reached a peak of 209 in 2007, followed by 179, 174 and 175 in 2008 through 2010. While the recent number of homicides is unacceptable and preventable, the number has been high historically since at least 1985, having reached over 400 in 1994.

The BJA study reviewed records for 200 homicides in 2009 and 2010. This analysis found the following: About 40 percent of homicides occur between the hours of 8:00 PM and midnight; 75 percent occur outside; 59 percent occur in residential areas; 90 percent involved firearms. The official classification of motive was: 29 percent drug-related; 24 percent revenge; 19 percent argument or conflict. Only 10 percent involved robbery, 6 percent were classified as domestic, and one case was classified as rape. (The official classification of motive was validated by the study's record review.) Thus, in addition to the 29 percent that were manifestly drug-related, 42 percent involved interpersonal conflicts that are often fueled by alcohol and drug use.

Findings regarding the homicide victims include: 92 percent of victims were Black; only 1 percent were involved in a gang; 49 percent of victims had been previously arrested for a drug offense; 42 percent had been arrested for a violent offense; 40 percent had been arrested for a property offense; and 29 percent had been arrested on a firearms charge. Only 27 percent had no arrest record.

Of the 200 homicides in the study, 102 had been cleared by the end of data collection, meaning that the offender is known. Finding regarding offenders include: 78 percent knew their victim, but only 4 percent were rival drug dealers; only 3 percent were gang members; 17 percent were juveniles under age 18 while 38 percent were young adults aged 18-24; 50 percent had a prior

[5] Miniño, Arialdi M et al. Deaths: Final Data for 2008, *National Vital Statistics Reports* Volume 59, Number 10 December 7, 2011, p. 138.

[6] Wellford, Charles; Bond, Brenda; and Goodison, Sean. *Crime in New Orleans: Analyzing Crime Trends and New Orleans' Responses to Crime*. Sponsored by the Bureau of Justice Assistance, Department of Justice, March 2011.

arrest for a violent offense; 49 percent had a prior arrest for a drug offense; 47 percent has a prior arrest for a property offense; and 35 percent had been arrested on a firearms charge.

Thus, half the offenders and victims of homicide had involvement with drugs to the point of being arrested. Many others are likely to have had alcohol or drug problems and many of the homicides are likely to have been fueled by intoxication.

Arrest and Recent Drug Use

The 2010 Annual Report for the Arrestee Drug Abuse Monitoring (ADAM II) system finds that, across 10 major cities, between 50 and 85 percent of arrestees test positive for recent use of illicit drugs based on urinalysis screens.[7] New Orleans is not currently part of the ADAM program, but did participate in the late 1990's and early 2000's. The ADAM report for 2000 indicates that 69 percent of male arrestees in New Orleans tested positive for recent illicit drug use.[8] Drugs involved included cocaine (32%), opiates (15%) and marijuana (47%); 20 percent were positive for multiple drugs. Among arrestees, 20 percent were heavy drinkers, binging at least 5 times in the past month, while 34 percent were heavy drug users, using drugs 13 or more days in the past month, and 9 percent had injected drugs in the past month. Only 4 percent had received any treatment in the past year.

Jail Populations

The 2002 national Survey of Inmates in Local Jails found that 50 percent of jail inmates had used alcohol or drugs at the time of their offense—33 percent had used alcohol and 29 percent had used drugs. Among violent offenders, 47 percent had used alcohol or drugs—38 percent using alcohol and 22 percent using drugs. Based on type of offense and/or substance use, 77 percent of inmates could be characterized as alcohol or drug-involved offenders.[9]

The Orleans Parish Sheriff's Office (OPSO) operates jail facilities with a capacity of 3,500. Utilization has been between 2,900 and 3,200 over the past year. The jail population includes: detainees awaiting arraignment, bail, or trail; inmates sentenced for misdemeanor offenses; and inmates transferred from state prison for "re-entry" to the community. Approximately 35,000 persons went through the jail intake process in 2011, which includes screening by a nurse in the Medical Unit. About 80 percent receive follow-up appointments based on the screening findings. The intake includes screening for mental health and substance use issues. As part of the intake, individuals are asked if they would like to see the jail's substance abuse counselor.

During intake only between 10 and 15 percent self-report using drugs. However, based on 2010 ADAM findings in other major cities and 2000 ADAM findings for New Orleans, we would expect between 50 and 80 percent to have recently used drugs. This suggests that a more

[7] Office of National Drug Control Policy. *ADAM II, 2010 Annual Report,* Arrestee Drug Abuse Monitoring Progam, May 2011.
[8] National Institute of Justice. *ADAM Preliminary 2000 Findings on Drug Use and Drug Markets, Adult Male Arrestee*s. December 2001.
[9] Bureau of Justice Statistics. *Profile of Jail Inmates, 2002, Special Report*. US Department of Justice, July 2004 (revised 10/12/04).

structured screening, brief intervention and treatment referral process would be warranted for this population. There is the question, what type of services should be provided to which populations within the jail setting. Medical and program staff never know when an inmate may be transferred or released, which makes providing a regime of services or planning referrals very difficult. Further, as New Orleans continues to reform its arrest and bail policies and procedures, fewer and fewer persons will be detained or incarcerated. Thus access to screening, intervention and referral services might more efficiently and effectively be provided in the court setting.

State Prison Populations and Re-entry

The 2004 national Survey of Inmates in State and Federal Correctional Facilities found that almost one-third (32%) of all offenders in state prisons, including 28 percent of violent offenders, committed their crime under the influence of drugs, that is, having used drugs at the time of the offense. One-in-six (17%) committed the crime to obtain money for drugs and, among those whose most serious offense was a property crime, one-third (30%) committed the crime to get money for drugs. Over half (53%) of state prisoners met the diagnostic criteria for drug dependence or abuse.[10]

As of December 31, 2011, there were a total of 39,476 state prisoners in Louisiana. About half of these prisoners are housed in local sheriffs' facilities, especially those who are expected to be released soon to their communities. Based on the highest charge of conviction, these prisoners can be classified as violent (37%), drug (35%), property (17%) and other (11%). Each year over 1,500 prisoners are released from state incarceration. In 2010 a total of 17,246 prisoners were released. Because of differences in length of sentence, the classification of prisoners released is different from those incarcerated: violent (15%), *drug (39%),* property (35%) and other (11%). On December 31, 2011, there were 811 state inmates housed in the Orleans Parish Jail. Many of these would be receiving re-entry services; 72 were enrolled in the Work Transition Program. [11]

According to materials describing the re-entry program, 80 percent of offenders in the state correctional system have substance abuse problems that contribute to their criminality. The re-entry program for state prisoners includes basic education, job skills training, substance abuse treatment, values development (faith-based), and community involvement. The Transition Work Program is a work release program. Probation/parole officers provide supervision and oversight of work release facilities.[12]

Survey of Justice Agencies in New Orleans

A survey of criminal justice agencies in New Orleans has been initiated. Agencies to be surveyed include: New Orleans Police, Sheriff's Office, Coroner's Office, District Attorney, City Attorney, Public Defender, District Court, Municipal Court, and Parole. The focus is on the offender populations the agencies deal with, the number and characteristics of offenders with

[10] Bureau of Justice Statistics. *Drug Use and Dependence, State and Federal Prisoners, 2004, Special Report*. US Department of Justice, October 2006 (revised 1/19/07).
[11] Louisiana Department of Public Safety and Corrections. Briefing Book, January 2012 Update.
[12] Louisiana Department of Public Safety and Corrections. Reentry Initiatives Overview, http://doc.la.gov/pages/reentry-initiatives/overview/ (accessed 4/26/2012).

drug or alcohol problems, how these problems are identified and what the agency attempts to do in regard to drug and alcohol problems. The survey also asks about issues and problems in accessing community services and coordination among justice agencies as well as recommendations for system improvement. The survey should provide a broad view of what resources currently exist to deal with substance use problems in justice populations, how they are deployed, and the current and potential demand for various prevention, intervention and treatment services. The results of the survey will be described in future reports.

Community-level Population Surveys

Adolescents

Biennially, in the fall of even numbered years, Louisiana conducts the Caring Communities Youth Survey (CCYS) of students in Grades 6, 8, 10 and 12. The CCYS provides the most comprehensive data about substance use among Louisiana adolescents and is available for 2006, 2008 and 2010. For Orleans Parish there are serious problems with the CCYS sample due to exceptionally poor school participation. Nevertheless, there are sufficient data to provide *reasonable but conservative estimates* for purposes of strategic planning; however, these estimates are not accurate enough to be used for monitoring trends or evaluating programming at the community or parish levels.[13]

Alcohol and other drugs are widely available to our children. By the 10th grade (approximately age 15): 60 percent of students in Orleans Parish had had a full drink of alcohol; about 24 percent had smoked cigarettes; about 16 percent had tried marijuana; about 9 percent had used inhalants; about 5 percent had used prescription sedatives (without a doctor's direction); and about 3 percent had used prescription narcotics (again without a doctor's direction).

Estimates of Substance Use Among 10th Graders in Orleans Parish

Substance Used	Lifetime Use	Past 30 days
Alcohol	60%	30%
Binge Drinking	n.a.	12%**
Cigarettes	24%	6%
Marijuana	16%	7%
Inhalants	9%	n.a.
Sedatives Meds	5%	3%
Opiate Meds	3%	2%

Source: 2010 Caring Communities Youth Survey. **in the past 2 weeks.

Current use of a substance is usually defined as use in the past 30 days.[14] Among 10th graders in Orleans parish approximately 30 percent used alcohol in the past 30 days while 12 percent engaged in binge drinking *in the past 2 weeks*—having 5 or more drinks on one occasion. Approximately 6 percent smoked cigarettes in the past 30 days; 7 percent used marijuana; 3 percent used prescription sedatives (without doctors direction); and 2 percent used prescription narcotics (with a doctor's direction) in the past 30 days.

Students in Orleans Parish, surveyed in grades 8, 10 and 12, self-reported a number of serious consequences of substance use. About 9 percent had been drunk or high at school in the past year. In the past 30 days, over one-quarter of students had been in a car being driven by someone who had been drinking. About 5 percent had themselves, in the past 30 days, driven a car after drinking. (This figure may be as high as 15 percent for 12th graders.) *About 6 percent of students self-reported that they themselves had sold illegal drugs in the past year.*

[13] Except where otherwise indicated, the data source for adolescent need assessment is the Caring Communities Youth Survey conducted biennially in Louisiana in grades 6, 8, 10 and 12. (This report focuses only on grades 8, 10 and 12 which approximates the population ages 12-17.) Because of small sample sizes for New Orleans, estimates are made by reviewing data from the 2006, 2008 and 2010 surveys. Data from adjacent parishes (Jefferson and Plaquemines) and statewide figures are also considered to assure that estimates are reasonable and conservative. Tenth grade findings may be given more weight in representing ages 12-17 because this grade is at the mid point of the grade distribution and 10-grade responses are less likely to be affected by potential reading and comprehension problems at younger grades and high drop-out rates among older adolescents.

[14] A person who is a regular user of a substance would be a current user (past 30 days); but "current use" does not imply regular use. For instance, some current users may only have begun to use a substance in the past month, and some may not use it in the future.

In addition to selling of illicit drugs, the CCYS survey asks about other violent and or criminal behaviors. These behaviors are often influenced by substance use, but the CCYS survey does not explicitly ask whether substance use was involved. Prevention of violent and criminal behaviors can be addressed within the risk and protective factor framework. Reductions in these behaviors would be an expected outcome of well-implemented, evidence-based substance abuse prevention services. Violent and criminal behaviors self-reported by our students include the following:

- About 3 percent of students reported having stolen or having tried to steal a vehicle in the past year.
- About 20 percent reported having attacked someone and trying to seriously hurt them in the past year.
- About 6 percent had carried a hand gun in the past year—one-in-a-hundred brought it to school.
- Over 20 percent of students had been suspended from school in the past year.
- Finally, about 8 percent had been arrested in the past year.

The CCYS survey includes 34 scales measuring risk and protective factors in 4 domains: Community, Family, School and Peer-Individual. These are designed to enable prevention planners and providers to select appropriate evidence-based program models and design effective prevention services in both the school and the community. The 2010 CCYS also includes questions about perceived risk, parental disapproval and peer disapproval regarding alcohol, cigarette and marijuana use. Unfortunately, due to the poor level of participation in the survey by New Orleans schools, no findings can be reported here.[15]

Approximately 8 percent of students, in addition to using alcohol and or drugs, self-reported experiencing 3 or more symptoms of substance dependence (6 percent for alcohol and 2 percent for other drugs). Thus, they meet the criteria in the American Psychiatric Association's Diagnostic and Statistical Manual for alcohol or drug dependence. These students qualify for admission to addictions treatment. Applying the 8 percent rate to the Orleans Parish adolescent population (about 24,000 aged 12-17) means that about 2,000 adolescents under age 18 are in need of services for a substance use disorder.

[15] Two issues present themselves. (1) In 2010, about 10 percent of students enrolled were surveyed. But, since the survey is administered to all students within the surveyed grades, this means that only about 10 percent of schools participated, resulting in a non-random, self-selected, non-representative sample. Samples in 2006 and 2008 were only slightly better. (2) New Orleans is a large city. For purposes of prevention services, the City cannot be considered one community. Different communities or neighborhoods of the City will have different needs, differences that the CCYS is intended to measure. Unlike simply trying to provide a reasonable and conservative estimate of substance use, interpretation of the risk and protective factor scales explicitly requires comparison to state and national norms. There is no reason to believe that students in a neighboring parish would experience the same risk and protective factors. If we ignore these fundamental problems, the data would suggest there is high risk due to low neighborhood attachment and early initiation of anti-social behavior. New Orleans appears to score low risk on family attitudes favorable to antisocial behavior and drug use, friends' drug use and rewards for antisocial behavior. New Orleans appears to score high on protective factors concerning the opportunity and reward for pro-social involvement across the family, school and peer domains. However, these apparent findings could be completely wrong, simply an artifact of the poor sample.

Adults and Young Adults

The National Survey on Drug Use and Health (NSDUH) provides sub-state estimates for a limited number of indicators measuring substance use, substance use disorders and risk factors. For Louisiana sub-state areas include the Metropolitan District (Orleans, Plaquemines and St. Bernard parishes) combined with the South Central parishes. In this report, these parishes will be referred to as the "New Orleans area." (NSDUH provides separate estimates for Jefferson Parish.) Thus NSDUH does not provide Orleans-specific or metropolitan-specific statistics, and therefore may not be sensitive to the unique substance use aspects of New Orleans. While NSDUH interviews about 70,000 persons annually, the number of respondents in each sub-state area is limited. Therefore, estimates are made by pooling 3 years of data. The most current estimates available are based on data from 2006, 2007 and 2008; on average the data are four years old. This is an important limitation given the dynamic population changes resulting from Hurricane Katrina. Nevertheless, *NSDUH provides the most comprehensive information available based on a national standard and permits comparisons across sub-state areas, states and regions as well as monitoring of trends over time*.[16] For the New Orleans area, we find:

Illicit drugs were used by 7.2 percent of adults in the New Orleans area in the past month. This is consistent with the state as a whole and southern states in general, but slightly less than the national rate (8.0%).

Marijuana was used by 5.1 percent of adults in the New Orleans area in the past month. Again this figure is consistent with the state as a whole and southern states in general, but slightly less than the national rate (5.9%).

Drug and Alcohol Use Indicators from the National Survey on Drug Use and Health (NSDUH) Pooled Survey Data from 2006, 2007 and 2008.

Adults Ages 18 and Older (percentages)	Regions				
	Metro-politan & South Central	Jeffer-son	Louisi-ana	Southern States	Total United States
Illicit Drug Use in Past Month	7.2	7.6	7.1	7.2	8.0
Illicit Drug Use Other Than Marijuana in Past Month	4.1	4.1	4.0	3.6	3.6
Marijuana Use in Past Month	5.1	5.3	5.0	5.1	5.9
First Use of Marijuana *(in past year)*	0.9	0.9	0.9	0.9	1.0
Marijuana Use *in Past Year*	10.2	8.4	9.0	8.9	10.0
Cocaine Use *in Past Year*	3.1	2.7	2.6	2.3	2.4
Nonmedical Use of Pain Relievers *in Past Year*	5.5	5.1	5.7	4.8	4.8
Alcohol Use in Past Month	56.4	**n/a**	53.6	51.0	55.2
Binge Alcohol Use in Past Month	28.5	26.9	26.2	23.4	24.8

n/a – indicator could not be estimates due to small sample size.

Four percent of adults in the New Orleans area used an illicit drug other than marijuana in the past month. This figure is consistent with the state as a whole. New Orleans and Louisiana rates may be slightly higher than those for southern states in general and the nation as a whole (but this difference is not statistically significant).

[16] The National Survey on Drug Use and Health (NSDUH) is conducted annually by the Substance Abuse and Mental Health Services Administration (SAMSHSA). http://www.samhsa.gov/data/NSDUH.aspx Recommendations will include redefining sub-state areas to provide estimates for the Metropolitan District which has regained sufficient population to permit separate estimates.

Nonmedical use of pain relief medication *in the past year* was reported by 5.5 percent of adults in the New Orleans area. This figure is consistent with Louisiana as a whole, but slightly greater than the southern states and national rates (4.8%).

Over half (56%) of adults in the New Orleans area drank alcohol in the past month while over one-quarter (28.5%) engaged in binge alcohol use in the past month—having 5 or more drinks on one occasion. The binge drinking rate for the New Orleans area and Louisiana are higher than for southern states in general (23.4%) while the binge drinking rate for southern states is slightly lower than the national rate.[17] The rate of past-month binge alcohol use among adults is over 3 times greater than the past-month use of illicit drugs.

Young Adults

The National Survey on Drug Use and Health provides estimates for young adults (ages 18-25) and older adults (26 and older) as well as for adults as a whole. NSDUH also provides the same statistics for adolescents (ages 12-17), but these under estimate the adolescent substance abuse when compared to school-based surveys.

Illicit drugs were used by 16.8 percent of young adults in the New Orleans area in the past month. This is more than twice the rate for all adults (7.2%) but slightly less than the national average for young adults (19.7%).

Marijuana was used by 13.0 percent of young adults in the New Orleans area in the past month. This is more than twice the rate for all adults (5.1%) but slightly less than the national average for young adults (16.4%).

Illicit drugs other than marijuana were used by 8.4 percent of young adults in the New Orleans area in the past month. This is twice the rate for all adults (4.1%) but about the same as the national average for young adults (8.3%).

Drug and Alcohol Use Indicators from the National Survey on Drug Use and Health (NSDUH) Pooled Survey Data from 2006, 2007 and 2008.

Young Adults Ages 18 to 25 (percentages)	Regions				
	Metro-politan & South Central	Jeffer-son	Louisi-ana	Southern States	Total United States
Illicit Drug Use in Past Month	16.8	**n/a**	17.4	18.0	19.7
Illicit Drug Use Other Than Marijuana in Past Month	8.4	8.9	8.6	8.3	8.3
Marijuana Use in Past Month	13.0	**n/a**	13.7	14.4	16.4
First Use of Marijuana (*in past year*)	5.5	6.8	5.4	5.7	6.4
Marijuana Use *in Past Year*	25.1	**n/a**	23.3	24.4	27.6
Cocaine Use *in Past Year*	5.2	5.7	5.5	5.8	6.3
Nonmedical Use of Pain Relievers *in Past Year*	12.9	13.0	13.3	12.2	12.2
Alcohol Use in Past Month	**n/a**	**n/a**	60.0	57.4	61.4
Binge Alcohol Use in Past Month	**n/a**	**n/a**	38.6	38.0	41.7

n/a – indicator could not be estimates due to small sample size.

[17] The 2009 Louisiana Behavior Risk Factor Surveillance System (BRFSS) for the New Orleans Metro Area provides similar results regarding adult alcohol use in the past month (54%) but differs in estimates of binge drinking (17%). Louisiana Department of Health and Hospitals. *The 2009 Louisiana Behavior Risk Factor Surveillance System Report*. March 2011.
http://www.dhh.state.la.us/assets/oph/pcrh/brfss/BRFSS_2009_Final_Version.pdf

Nonmedical use of pain relief medication *in the past year* was reported by 12.9 percent of young adults in the New Orleans area. This is more than twice the rate for all adults (5.5%). The rate of past-year nonmedical use of pain relievers by young adults in Louisiana (13.3%) is slightly greater than the national rate (12.2).

While the alcohol use indicators could not be precisely estimated, we can state that approximately 40 percent of young adults in the New Orleans area engaged in binge drinking in the past month.[18] This is more than one-third greater than the rate for all adults (28.5%). The rate of past-month binge alcohol use among young adults is over 2 times greater than the past-month use of illicit drugs.

Risk and Protective Factors among Adults

The National Survey on Drug Use and Health (NSDUH) includes a number of questions addressing risk and protective factors; however, only the three items on perception of risk are estimated for sub-state areas. Almost half (47%) of all adults in the New Orleans area indicated that smoking marijuana once a month posed a great risk. This figure is consistent with the state as a whole. Louisiana state figures are slightly higher than those for southern states and substantially higher than national figures. Among young adults (ages 18-25), less than one-third (30%) indicated that smoking marijuana once a month posed a great risk. Across the regions, young adult figures are about one-third lower than those for all adults.

Perception of Risk from Substance Use, National Survey on Drug Use and Health (NSDUH) Pooled Survey Data from 2006, 2007 and 2008.

Perception of Great Risk (percentages)	Regions				
	Metro-politan & South Central	Jeffer-son	Louisi-ana	Southern States	Total United States
Smoking Marijuana Once a Month					
All Adults (ages 18 and older)	47.3	43.8	46.3	42.9	38.8
Young Adults (ages 18-25)	30.4	**n/a**	30.3	27.1	24.2
Five or More Drinks of an Alcoholic Beverage Once or Twice a Week					
All Adults (ages 18 and older)	44.4	45.5	45.2	44.7	42.2
Young Adults (ages 18-25)	41.7	38.6	40.2	35.8	33.0
Smoking One or More Packs of Cigarettes Per Day					
All Adults (ages 18 and older)	73.9	74.4	73.5	73.3	74.2
Young Adults (ages 18-25)	69.4	70.7	70.3	69.0	69.8

n/a – indicator could not be estimated due to small sample size.

Almost half (44%) of all adults in the New Orleans area indicated that consuming five or more drinks of an alcoholic beverage once or twice a week posed a great risk. This rate is consistent across regions, with a national rate of 42 percent of adults indicating great risk. Among young adults the figure is slightly lower for the New Orleans area and Louisiana, 42% and 40 percent, respectively. For southern states and nationally the young adult rates are substantially lower than adult rates.

Three-quarters (74%) of all adults and 69 percent of young adults in the New Orleans area indicated that smoking one or more packs of cigarettes per day posed a great risk. These figures are consistent with state, regional and national rates.

[18] SAMHSA was unable to estimate this figure (binge drinking) for the New Orleans area, but the Louisiana rate and national rate are 38.6% and 41.7%, respectively. Thus the figure would be about 40% based on New Orleans' relative position on related indicators.

Prevalence of Substance Use Disorders

Substance use disorder (SUD) is defined in the *Diagnostic and Statistical Manual* (DSM-IV) of the American Psychiatric Association as "a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by … [the following criteria], occurring at any time in the same 12-month period."[19] Separate criteria are provided for dependence and abuse. A dependence condition can be considered more clinically serious or a progression from an abuse condition, but consequences and costs can be substantial in any case. An assessment of dependence or abuse based on DSM-IV criteria is generally accepted as a requirement for admission to treatment services (but does not itself determine the level of care needed). NSDUH provides separate SUD estimates for alcohol and other drugs, but does not provide estimates for specific other drugs at the state and sub-state levels.

Prevalence of Substance Use Disorders, National Survey on Drug Use and Health (NSDUH) Pooled Survey Data from 2006, 2007 and 2008.

Substance Use Disorders and Receiving Treatment Services (percentages)	Regions				
	Metro-politan & South Central	Jeffer-son	Louisi-ana	South-ern States	Total United States
All Adults Ages 18 and Older					
Alcohol Dependence in Past Year	3.85	3.58	3.73	3.45	3.64
Illicit Drug Dependence in Past Year	2.30	1.95	2.06	1.88	1.89
Alcohol Dependence or Abuse in Past Year	7.90	7.58	7.57	7.23	7.80
Illicit Drug Dependence or Abuse in Past Year	3.23	3.25	2.82	2.68	2.63
Dependence on or Abuse of Illicit Drugs or Alcohol in Past Year	9.68	9.49	9.24	8.73	9.22
Needing But Not Receiving Treat-ment for Alcohol Use in Past Year	7.68	7.39	7.39	6.94	7.41
Needing But Not Receiving Treat-ment for Illicit Drug Use in Past Yr.	2.62	3.09	2.48	2.38	2.34
Young Adults Ages 18 to 25					
Alcohol Dependence in Past Year	5.95	5.97	6.23	6.75	7.37
Illicit Drug Dependence in Past Year	5.31	5.13	5.22	5.38	5.51
Alcohol Dependence or Abuse in Past Year	15.27	14.70	14.38	15.44	17.19
Illicit Drug Dependence or Abuse in Past Year	7.82	8.79	7.17	7.75	7.88
Dependence on or Abuse of Illicit Drugs or Alcohol in Past Year	18.10	18.23	17.90	19.26	20.91
Needing But Not Receiving Treat-ment for Alcohol Use in Past Year	14.56	13.60	14.04	14.95	16.58
Needing But Not Receiving Treat-ment for Illicit Drug Use in Past Yr.	6.69	8.37	6.63	7.16	7.32

Among all adults, 9.7 percent experienced a substance use disorder (dependence or abuse) in the past year. Applying this rate to 2010 US Census population estimates, this means there are over 26,000 adults with substance use disorders in Orleans Parish.

Among just young adults, 18.1 percent experienced a substance use disorder in the past year. Again, applying this to 2010 population estimates, means that about 9,000 young adults in Orleans Parish have substance use disorders—over a third of the adult total.

[19] American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV). Washington DC, 1994, pp. 181-2. Physiological dependence symptoms (withdrawal and/or tolerance) are neither necessary nor sufficient conditions for a dependence diagnosis. Substance use disorders (SUDs) are defined for different classes of substances using the same criteria. Dependence and abuse conditions have separate sets of criteria, although a diagnosis of dependence supersedes a diagnosis abuse.

NSDUH asks the respondents whether they received any substance use treatment in the past year and whether that treatment was received in a specialty treatment facility (such as would be licensed by the state).[20] SAMHSA calculates *treatment need* by counting those who received specialty treatment or experienced a substance use disorder in the past year.[21] Unmet treatment need is calculated by subtracting the estimated number of persons receiving specialty treatment in the past year from the treatment need. NSDUH provides state and sub-state estimates of unmet treatment need, but not for treatment need itself or specialty treatment utilization.

NSDUH estimates that 7.7 percent of all adults needed treatment for an alcohol use problem but did not receive it in the past year while 2.6 percent needed treatment for a drug use problem but did not receive it. Among young adults, NSDUH estimates that 14.6 percent needed treatment for an alcohol use problem but did not receive it while 6.7 percent of these young adults needed treatment for a drug use problem but did not receive it. Although NSDUH provides state and sub-state estimates of unmet treatment need separately for alcohol and other drugs, it does not publish state or sub-state estimates of the unmet need for substance use treatment (combining alcohol and drugs). Simply adding the alcohol and drug figures would over estimate unmet need by double counting individuals with both unmet needs. However, for planning purposes, this figure can be extrapolated from tabulations of the 2009 and 2010 NSDUH which provide national estimates of unmet need for alcohol and drugs treatment combined and separately. Based on NSDUH's definition of treatment need, and by extrapolation, 9.2 percent of all adults and 17.8 percent of young adults needed but did not receive treatment services.

NSDUH may provide reasonable, probably conservative, estimates of the prevalence of substance use disorders. But SAMHSA's method for estimating treatment need and unmet need is not practical. A system capable of providing treatment services to 10 percent of the population would be grossly underutilized, and costly. Alternative methods for estimating treatment service need will be discussed in a future report.

In Summary

Seven percent of adults in the New Orleans area used an illicit drug in the past month while 29 percent of adults engaged in binge drinking in the past month (consuming 5 or more drinks on one or more occasions). One-in-ten adults (9.7%) experienced a substance use disorder in the past year. Based on SAMHSA's definitions, 9 percent of adults needed but did not receive treatment services in the past year.

Seventeen percent of young adults in the New Orleans area used an illicit drug in the past month, a rate more than twice that for all adults. About 40 percent of young adults engaged in binge drinking in the past month (consuming 5 or more drinks on one or more occasions), a rate over one-third higher than for adults as a whole. Eighteen percent of young adults experienced a

[20] NSDUH considers the following responses to be specialty treatment facilities: hospital inpatient, inpatient or outpatient rehabilitation, and mental health centers. The following responses are not considered specialty treatment: self-help groups, prison/jail, emergency room and private doctor's office.

[21] There are a number of rationales for this calculation. (1) We could assume that persons receiving specialty care had a substance use disorder but were not included in the estimate of substance use disorder due to social desirability bias or other downward bias in the survey. (2) Persons in treatment or completing treatment may not have experienced the symptoms (criteria) during the past year although clinically they would have carried the diagnosis.

substance use disorder in the past year, almost twice the rate for all adults. Based on SAMHSA's definition, almost 18 percent of young adults needed but did not receive treatment in the past year.

College Students

The Core Institute survey has been conducted biennially in Louisiana. The most recent data available is from the Spring 2011.[22] The Core Survey provides individual institutions of higher education (IHEs) with information to assess their student population and campus environment. This information can be used to develop preventive policy and programming, and to monitor change. This is consistent with the risk and protective framework used in other settings. Metro Area institutions of higher education (IHEs) participating in the survey included: Xavier University of Louisiana; Tulane University; Southern University of New Orleans; Our Lady of Holy Cross; Loyola University of New Orleans; Dillard University; Delgado Community College; and University of New Orleans.

Three-quarters (75%) of college students in the Metro Area used alcohol in the past 30 days and almost one-third (30%) used alcohol 3 or more times per week. Figures for the Metro Area are

Substance Use: Percentage of College Students Using Alcohol or Other Drugs Among Students Attending Institutions of Higher Learning Who Responded to the 2011 Core Survey by Type of Substance and Level of Use for the Metro Area (including Jefferson Parish), Louisiana Statewide and a National Comparison Sample.

Substance Type	Lifetime Use			Used in the Past Year			Used in Past 30 Days			3+ Times per Week/past yr		
	Metro Area	Louisiana	National	Metro Area	Louisiana	National	Metro Area	Louisiana	National	Metro Area	Louisiana	National
sample size=	1,646	9,763	74,481	1,646	9,763	74,481	1,646	9,763	74,481	1,646	9,763	74,481
Tobacco	45.2	46.6	48.5	38.2	33.6	37.4	27.3	25.1	24.8	12.8	16.8	13.4
Alcohol	88.2	84.8	86.9	84.7	78.3	84.3	74.9	62.6	71.7	29.9	17.0	21.8
Underage Drinking	–	–	–	–	–	–	74.5	60.2	62.4#	–	–	–
Binge Drinking*	–	–	–	–	–	–	50.1*	36.0*	43.1*#	–	–	–
Marijuana	56.2	43.2	45.1	46.4	27.0	31.1	31.4	16.3	17.3	13.6	8.2	6.7
Illicit Drugs ex marijuana**	–	–	–	24.2	14.3	12.0	14.7	8.0	5.9#	–	–	–
Cocaine	14.9	8.4	9.2	11.6	4.0	5.0	5.5	1.7	1.8	0.3	0.3	0.2
Amphetamines	17.2	17.4	11.1	11.7	8.7	5.0	7.2	4.9	2.4	2.6	2.8	1.2
Sedatives	13.0	11.0	7.4	8.0	4.9	3.9	3.9	2.4	1.7	0.7	0.6	0.4
Hallucinogens	14.9	7.9	8.6	10.2	3.6	4.3	3.5	1.3	1.2	0.2	0.2	0.1
Opiates	4.9	3.1	3.0	2.8	1.5	1.4	1.3	0.8	0.7	0.6	0.4	0.2
Inhalants	5.6	3.5	3.4	3.0	1.1	1.0	1.4	0.7	0.4	0.2	0.2	0.1
Designer drugs	17	11.1	6.5	13.0	5.0	2.8	5.0	1.8	0.8	0.2	0.2	0.1
Steroids	0.7	2.2	0.9	0.4	1.0	0.5	0.6	0.6	0.4	0.2	0.3	0.2
Other drugs	6.3	4.6	4.4	3.9	2.1	2.0	1.4	0.9	0.7	0.1	0.3	0.2

In past 2 weeks engaged in binge drinking, i.e., 5 or more drinks in one sitting. **Illicit drugs *other than* marijuana.
#These figures are from the 2009 national sample; figures for 2011 have not been published online. "–" indicates not available.

substantially higher than for Louisiana as a whole (63% and 17%) and slightly greater than for

[22] Core Institute. *Louisiana 2011 Core Survey Statewide Results* and Louisiana *2011 Core Survey – Region 1: Metropolitan Results*. Core Institute, Southern Illinois University Carbondale, 2011. http://uiswcmsweb.prod.lsu.edu/edco/lacasu/ ; 2009 national sample figures are from http://core.siu.edu/index.html .

the national comparison sample (72% and 22%). In addition, 50 percent of students in the Metro Area engaged in binge drinking at least once in the past 2 weeks compared to 36 percent for the state and 42 percent for the national sample.

One-third (31%) of college students in the Metro Area used marijuana in the past 30 days and 14 percent used marijuana 3 or more times per week. Figures for the Metro Area are substantially higher than those for the state as a whole (16% and 8%) and for the national comparison sample (17% and 7%).

One-in-seven (15%) of college students in the Metro Area used illicit drugs other than marijuana in the past 30 days. This figure is substantially higher than for the state as a whole (8%) and the national comparison sample (6%). The two drugs that students were most likely to report using in the past 30 days (other than marijuana) were amphetamines (7%) and cocaine (6%).

Violence and Substance Use among College Students

The use of alcohol and drugs makes Metro Area college students more vulnerable to violence. One-in-ten students (11%) reported being subject to threats of violence around campus in the last year. Of these, half (50%) had consumed alcohol or drugs shortly before the incident. Statewide relatively fewer students experienced threats of violence compared to Metro Area students and, when they did, they were less likely to have been using alcohol or drugs.

Victimization: Percent of College Students Experiencing Harassment or Violence and, Among These, the Percent Who Used Alcohol or Drugs Shortly Before to the Incident, 2011 Core Survey

Type of Harassment or Violence around campus in past year	Metro Area (including Jefferson Parish)		Louisiana Statewide	
	Experienced Harassment or Violence	Used Alcohol or Drugs Prior to Incident	Experienced Harassment or Violence	Used Alcohol or Drugs Prior to Incident
Ethnic or racial harassment	8.6	9.0	7.0	10.7
Threats of physical violence	10.6	49.7	7.4	39.5
Actual physical violence	5.9	60.2	4.2	47.0
Theft involving force or threat of force	2.0	34.8	1.7	41.4
Forced sexual touching or fondling	5.6	68.8	3.2	58.7
Unwanted sexual intercourse	4.5	71.9	2.7	67.1

Six percent of Metro Area college students experienced actual physical violence around campus in the last year. Of these, 60 percent had consumed alcohol or drugs shortly before the incident. Again statewide relatively fewer students experienced actual violence compared to Metro Area students and, when they did, they were less likely to have been using alcohol or drugs.

Six percent of Metro Area college students were subjected to forced sexual touching or fondling while 5 percent were subjected to unwanted sexual intercourse around campus. In 69 percent and 72 percent of these cases the victim had consumed alcohol or drugs shortly before the incident. Metro Area students were more likely to experience forced touching or unwanted intercourse than students statewide, but the involvement of alcohol and drugs was similar.

Negative Consequences of Substance Use

The Core Survey asks students about experiences they have had "due to your drinking or drug use during the past year." One-third (33%) of Metro Area college students indicated that they had gotten into an argument or fight in the past year due to their drinking or drug use. Metro

Area students were more likely to get into an argument of fight than students statewide (26%) but were equally likely as the national comparison sample (31%) to do so.

Although relatively fewer college students in the New Orleans area would have cars, 26 percent of Metro Area students reported driving under the influence of alcohol or drugs in the past year compared to 27 percent statewide and 22 percent for the national comparison sample. Nevertheless, only about one-in-a-hundred college students reported being arrested for DWI/DUI.

Thirteen percent of Metro Area college students reported having been in trouble with the police, residence hall or other college authorities in the past year due to their alcohol or drug use. This figure is substantially higher than for the state as a whole (8%) but about the same as for the national comparison sample (13%).

Many Metro Area students reported missing a class due to alcohol or drug use in the past year (39%) and one-quarter (26%) reported doing poorly on a test or important project due to alcohol or drug use. These figures are substantially higher than for the state as a whole (27% and 20%) and the national comparison sample (28% and 21%).

Negative Consequences: Percent of College Students Attributing Negative Experiences to Their Own Alcohol or Drug Use in the Past Year, 2011 Core Survey

Negative Experience Attributed to Alcohol or Drug Use	Metro Area	Louisi-ana	Nation-al
Damaged property, pulled fire alarms, etc. [criminal mischief]	5.6	3.9	5.6
Got into an argument or fight	33.0	25.5	31.2
Driven a car while under the influence	25.5	27.2	22.3
Been arrested for DWI/DUI	1.1	1.7	1.2
Been in trouble with police, residence hall, or other college authorities	12.7	8.0	13.3
Missed a class	38.9	27.0	28.1
Performed poorly on a test or important project	25.9	19.9	20.8
Been hurt or injured	19.6	11.5	16.3
Seriously thought about suicide	5.0	4.0	4.2
Tried to commit suicide	1.3	1.4	1.1
Done something I later regretted	40.6	28.4	36.0
Been taken advantage sexually	10.3	7.2	9.5
Taken advantage of another sexually	2.3	2.6	2.5
Had a hangover	67.7	55.7	62.0
Got nauseated or vomited	57.2	45.9	54.0
Had a memory loss [blackout]	44.0	27.2	34.7
Been criticized by someone I know	33.8	24.1	29.7
Thought I might have a drinking or other drug problem	15.2	9.1	10.8
Tried unsuccessfully to stop using	6.1	5.1	4.9

One-in-five (20%) Metro Area college students reported being hurt or injured in the past year due to their alcohol or drug use. This figure is substantially higher than the rate for the state as a whole (12%) and slightly higher than the rate for the national comparison sample (16%).

Due to alcohol or drug use, 5 percent of Metro Area college students seriously thought about suicide in the past year. The rate of suicidal ideation appears to be similar for the state as a whole and for the national comparison sample, but the local sample size is too small to be sure.

Ten percent of Metro Area college students reported having been taken advantage of sexually due to their drinking or drug use in the past year. This figure is higher than for the state as a whole (7%) but about the same as for the national comparison sample (10%).

While the Core Survey does not provide an estimate of the prevalence of substance use disorders (SUDs), some items are close to diagnostic criteria. Of Metro Area college students, 15 percent indicated that, in the past year, they thought they might have a drinking or other drug problem. This figure is substantially higher than for the state as a whole (9%) and slightly larger than for the national comparison sample (11%). Of the Metro Area students, 6 percent indicated that they had tried unsuccessfully to stop using alcohol or drugs in the past year.

Risk Factors

Over one-third (37%) of Metro Area college students indicated that the social environment on their campus promoted drug use while 63 percent indicated that the social environment promoted alcohol use. These figures are substantially higher than those for the state as a whole (17% and 34%) and the national comparison group (20% and 48%). Over one-third (38%) of Metro Area college students indicated they had experienced peer pressure to drink or use drugs.

Most Metro Area college students believed that alcohol enhances social activities (80%) and facilitates a connection with peers (65%). These figures are substantially higher than for the state as a whole (67% and 50%) and slightly higher than for the national comparison group (74% and 60%). Three-quarters (73%) of Metro Area students indicated that alcohol gave people something to do. Almost half (46%) believed that alcohol made it easier to deal with stress.

Risk Factors: Percent of College Students Agreeing with Statements about Campus Environment, Alcohol Beliefs and School Policy*

Percent in Agreement	Metro Area	Louisi-ana	Nation-al#
Campus Environment			
Social environment on campus promotes *drug use*	36.7	17.1	19.5
Social environment on campus promotes *alcohol use*	62.7	33.5	47.7
Drinking is a central part of social life for *male* students	84.9	73.7	80.0
Drinking is a central part of social life for *female* students	80.6	63.9	71.9
[You] experienced peer pressure to *drink or use drugs*	37.7	26.2	35.9
[You] held a drink to have people stop bothering you about why you weren't drinking	15.6	10.0	13.2
Beliefs About Alcohol			
Enhances *social* activities	79.6	67.2	74.0
Facilitates *connection* with peers	65.2	50.3	60.0
Gives people *something to do*	73.1	61.8	71.6
Makes it easier to deal with *stress*	45.5	42.5	42.6
School Policy and Prevention			
Campus has *alcohol and drug policies*	89.4	81.5	88.4
Campus is *concerned* about prevention of drug and alcohol use	62.9	63.8	74.9
Campus has a drug and alcohol *prevention program*	39.8	29.4	46.8

*for Students Who Responded to the 2011 Core Survey
#These figures are from the 2009 national sample; figures for 2011 have not been published online.

Nine-of-ten Metro Area college students (89%) indicated that their campus has alcohol and drug policies. This implies that 10 percent of students were unaware of school policies. Two-thirds (63%) of students thought there was concern about alcohol and drug use, but only 40 percent were aware of a prevention program on campus. This implies that 60 percent were unaware of an existing prevention program or that there was no prevention program.

Protective Factors

Substance use can be deterred or moderated by a student's perception of risk associated with substance use or the belief that close friends would disapprove. Only one-quarter (27%) of Metro Area college students perceived great risk from regular use of marijuana, and only 62 percent thought their close friends would disapprove if they were to use marijuana regularly. Perception of risk and friends' disapproval were substantially greater for the state as a whole and the national comparison sample.

Greater risk and disapproval was attributed to cocaine use. Three-quarters (75%) of Metro Area college students perceived great risk from regular use of cocaine. But this means 25 percent did not believe that the risk was that great. Almost all Metro Area students (95%) thought their close

friends would disapprove of regular use of cocaine. For Cocaine, there was no substantial difference among the Metro Area, the state as a whole and the national comparison sample in perceptions of risk and disapproval.

The perception of risk from regular amphetamine use was only slightly lower than for cocaine. Over two-thirds (69%) of Metro Area college students perceived great risk from regular use of amphetamines. Similar to cocaine, there was no substantial difference among the Metro Area, the state as a whole and the national comparison sample in perceptions of risk and disapproval.

Less than two-thirds (61%) of Metro Area college students perceived great risk from taking 4 or 5 drinks every day, meaning that 39 percent did not believe that the risk was that great. However, 88 percent thought their close friends would disapprove if they were to drink this much. These rates are almost identical for the state as a whole and the national comparison sample.

Protective Factors: Percent of College Students Perceiving Great Risk and Friends' Disapproval from Substance Use Behaviors

Substance Use Behavior	People are in great risk of harm if they…			My close friends would disapprove if I…		
	Metro Area	Louisi-ana	Nation-al	Metro Area	Louisi-ana	Nation-al
Try marijuana once or twice	7.6	14.8	11.3	30.3	52.8	46.6
Smoke marijuana occasionally	10.2	20.9	17.7	38.9	62.6	59.6
Smoke marijuana regularly	26.5	39.6	41.6	62.3	77.1	79.2
Try cocaine once or twice	37.1	49.0	46.6	75.1	88.2	88.8
Take cocaine regularly	74.6	74.6	79.2	95.3	95.7	96.8
Try LSD once or twice	39.6	52.9	52.8	71.9	86.7	87.8
Take LSD regularly	71.9	72.7	77.4	94.5	95.1	96.4
Try amphetamines once or twice	39.3	47.3	48.6	na	na	na
Take amphetamines regularly	69.2	66.4	73.4	na	na	na
Take 1 or 2 drinks every day	20.2	26.7	22.0	53.1	60.8	61.0
Take 4 or 5 drinks every day	60.7	59.5	61.6	87.6	87.5	88.5
Have five or more drinks at one sitting	42.4	55.0	49.6	49.8	66.2	57.7
Take steroids for athletic performance	53.2	57.1	56.2	na	na	na

*for Students Who Responded to the 2011 Core Survey

In Summary

Overall, our college students in the Metro Area, engaged in more alcohol and drug use, and experienced greater negative consequences, than students in the rest of the state, the southern states and even the nation as a whole. Our students were at higher risk and lower on protective factors.

- One-third (30%) of our college students drank alcohol 3 times a week or more over the last year and rates of drinking among underage students appear to be the same as for students as a whole.
- One-in-seven (14%) students smoked marijuana 3 times a week or more over the last year.
- Alcohol or drugs were involved in 60 percent of the cases of physical violence and over two-thirds of cases of forced sexual touching and unwanted intercourse.
- One-in-four college students (26%) reported driving under the influence of alcohol or drugs in the past year.
- One-quarter (26%) of students reported performing poorly on a test or school project due to their alcohol or drug use.

Administrative and Other Data

Deaths Attributable to Drug and Alcohol Use

Nationally *drug poisoning deaths* doubled between 1999 and 2008, rising from 6.0 to 12.0 per 100,000 population.[23] Drug poisoning will soon surpass motor vehicle traffic accidents as the leading cause of injury deaths in the United States. In Louisiana in 2008, there were 695 deaths due to drug poisoning—a rate of 16.1 per 100,000, 20 percent higher than the national rate.[24] In 2008, Louisiana ranked 17th among states in the rate of drug poisoning deaths. The number of deaths due to drug poisoning in 2007 was 862; thus drug poisoning deaths in Louisiana may be declining. Drug poisoning accounts for almost all "drug-induced causes" of death reported each year. Drug-induced causes include a large number of drug-induced medical disorders. Excluded are accidents, homicides, and other causes only *indirectly* related to drug use, as well as newborn deaths associated with the mother's drug use. [25]

Alcohol-induced deaths totaled 210 in 2008, and the rate (4.5 per 100,000) is lower than the national rate (7.4). Alcohol-induced causes include a large number of alcohol-induced medical disorders as well as intentional and accidental poisoning. Excluded are accidents, homicides, and other causes only *indirectly* related to alcohol use, and newborn deaths associated with the mother's alcohol use. [26] Metropolitan area data for drug-induced and alcohol-induced mortality are not routinely published.

The Drug Abuse Warning Network (DAWN-ME), operated by the Substance Abuse and Mental Health Services Administration, collects data on drug-related deaths from participating medical examiner and coroner offices in major metropolitan areas in order to identify emerging trends, including the specific drugs involved.[27] The New Orleans metropolitan statistical area (MSA) consists of 7 parishes. Although Orleans Parish has not been participating in DAWN, Jefferson

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[23] Warner, M. et al. *Drug Poisoning Deaths in the United States, 1980–2008*. National Center Health Statistics, Data Brief, No. 81, December 2011. http://www.cdc.gov/nchs/data/databriefs/db81.htm .

[24] This is the age-adjusted rate compared to the national age-adjusted rate of 13.4.

[25] National Center for Health Statistics. Deaths: Final Data for 2008, National Vital Statistics Reports, Vol. 59, No. 10., 2011. http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_10.pdf . Drug-induced death is a broader concept that includes drug poisoning. However, the drug-induced figures are a few cases lower, probably due to a six month difference in the analysis and report publication.

[26] National Center for Health Statistics. Deaths: Final Data for 2008, National Vital Statistics Reports, Vol. 59, No. 10., 2011. http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_10.pdf . Drug-induced death is a broader concept that includes drug poisoning. However, the drug-induced figures are a few cases lower, probably due to a six month difference in the analysis and report publication.

[27] *Drug-related* death means a death related to *recent* drug use, intentional or accidental. (Although deaths resulting from legitimate therapeutic use are recorded, such deaths are not included under this term.) "Drug-related" includes deaths (a) directly caused by drug use as well as deaths (b) in which drug use *contributed* to death but did not cause it, (c) in which a drug was simply *implicated* (presumed to be related to death), or (d) in which a drug's involvement was not well defined. The presence of current medications unrelated to the death are not included. DAWN includes the following types of cases: suicide, homicide by drug, accidental ingestion, overmedication, other accidental, and not determined. The preceding is cited from Substance Abuse and Mental Health Services Administration. Drug Abuse Warning Network, 2003: Area Profiles of Drug-related Mortality, 2005, Page 9. http://www.samhsa.gov/data/DAWN/files/ME2003/ME03FullReport.pdf

Parish has consistently participated. Because they are adjacent and include many of the same populations, Jefferson may serve as a surrogate for Orleans Parish. The most recent published DAWN-ME data is for 2009.

From 2006 to 2009, drug-related deaths reported to the DAWN system by the Jefferson Parish Coroner's Office decreased by more than one-third, from 130 to 78. The 2009 figure is approximately 18 deaths per 100,000 residents. While not strictly comparable, this appears to be substantially greater than the 2008 statewide rate for drug poisoning (12.0).

Drug-related Deaths in Jefferson Parish, LA		
Year	Drug-related*	Suicide Drug-related
2006	130	2
2007	120	5
2008	90	6
2009	78	2
*excludes suicide		

Almost all deaths involved a combination of substance. Opiates were most prevalent, present in 87 percent of cases. Perhaps more important, opiates other than heroin or methadone were present in 74 percent of these deaths. This *suggests that prescription pain medications are the principal substances involved in drug-related deaths in the New Orleans area*. Benzodiazepines were present in 45 percent of deaths while cocaine was present in 29 percent. Marijuana and alcohol were equally likely to be present. (Alcohol alone is not reportable unless the individual was under age 21 at time of death.) Many of the other non-opioid drugs related to death are prescription or over-the-counter medications.

Drug-related Deaths* in 2009, Jefferson Parish, LA		
Drugs Implicated	Number	Percent
Total Deaths	78	100%
Opiates/Opioids	68	87%
Heroin	17	22%
Methadone	16	21%
All other opioids	58	74%
Benzodiazepines	35	45%
Cocaine	23	29%
Alcohol in combination	19	24%
Marijuana	19	24%
Muscle relaxants	16	21%
Misc. Analgesics	13	17%
Antidepressants	12	15%
Stimulants	9	12%
*excludes suicide		

Alcohol and Drug-impaired Driving

Alcohol-impaired driving contributed to 225 deaths in Louisiana in 2010, a rate of 4.95 per 100,000—50 percent higher than the national rate of 3.31. Alcohol-impaired driving fatalities represent 32 percent of all driving fatalities in Louisiana.[28]

In 2010, a total of 27 persons died in traffic accidents on the streets and highways of New Orleans. Alcohol was involved in 17 of these deaths (63%). In addition, 493 persons were injured in alcohol-related crashes. Orleans Parish ranked 7th in alcohol-related injury crashes per licensed driver, exceeded by only 6 rural parishes. The total cost of alcohol-related accidents in Orleans Parish amounted to $48.3 million in 2010.[29]

At the national level 62 percent of all drivers fatally injured in 2009 were tested for the presence of drugs. Over half of these, or 37 percent of all fatally injured drivers, were found to have some type of licit or illicit drug in their system. These data are recorded in the federal Fatality Analysis Reporting System (FARS). In Louisiana a similar portion of fatally injured drivers were tested for drugs; however in almost half the cases the results of testing were unknown or not reported to FARS. As a result, only 10 percent of fatally injured drivers are known to have had a drug in

[28] Based on National Highway Traffic Safety Administration. *Traffic Safety Facts, Louisiana 2006-2010*. n.d. (accessed 3/14/2012) http://www-nrd.nhtsa.dot.gov/departments/nrd-30/ncsa/STSI/22_LA/2010/22_LA_2010.PDF

[29] Schnieder, H. Louisiana Traffic Records Data Report 2010. Highway Safety Group, Louisiana State University, 2011. (Tables D-2, D-5, J-11-13, O-38) http://datareports.lsu.edu/Reports/SpecialReports/2010_FactBook.pdf

their system. FARS records the following categories of drugs: narcotics, depressants, stimulants, hallucinogens, cannabinoids, phencyclidines, anabolic steroids, and inhalants. The presence of a drug does not imply that the drug contributed to accident and the drug may have been taken according to prescription. FARS does not record the amount of drug present.[30] Since there is no generally accepted standard for the amount of a drug that corresponds to a level of impairment, and since many of these substances are illegal, the Office of National Drug Control Policy (ONDCP) advocates that states enact "per se" laws making it illegal to drive with any detectable amount of drugs.[31]

Child Abuse and Neglect

A review of the research on child maltreatment indicates that among substantiated child abuse and neglect cases, 18 to 24 percent involve substance abuse on the part of parents or care givers. Among children placed in foster care, parental substance abuse was a factor in 50 to 79 percent of the cases.[32] The relationship between substance abuse and child maltreatment is complex and may include co-occurring problems such as domestic violence or depression, lack of attention to the child due to preoccupation with substances, and/or a lack of money for both substances and necessities.[33]

Laws, policies and practices regarding child maltreatment vary from state to state. However, the federal Administration for Children and Families (ACF) has established the National Child Abuse and Neglect Data System (NCANDS) which is a source for relatively standardized statistics. Child Protective Services (CPS) agencies, such as the Louisiana Department of Children and Family Services, receive referrals through a state child abuse reporting system. Most referrals come from mandated reporters—health, education and human services professionals and institutions. Referrals are screened to determine whether there is a basis for investigation. The possible outcomes of an investigation include: substantiated, alternative response, unsubstantiated, closed with no finding and other. In substantiated cases the child is considered a victim. Use of these categories varies by state. A child can be considered a victim and the family still receive an "alternative response," but in Louisiana, as in most states that provide alternative response, the child is not considered a victim.

In 2010, NCANDS data for Louisiana indicate that there were 35,443 referrals "screened-in" for investigation. Most of these (21,631) were unsubstantiated, closed or other. Substantiated cases totaled 8,848, which represented 8,344 unique children. Of these children, 82 percent experienced neglect; 27 percent experienced physical violence; 8 percent experienced sexual abuse; and 1 percent experienced psychological maltreatment. Alternative response cases numbered 4,964; in these cases the child is not considered a victim. In 2,326 of the substantiated cases, the child was removed from the home and placed in foster care. In addition, there were 838 non-substantiated cases in which the child was removed from the home and placed in foster

[30] National Highway Traffic Safety Administration. *Drug Involvement of Fatally Injured Drivers*, Traffic Safety Facts, Crash Stats, November 2010 http://www-nrd.nhtsa.dot.gov/Pubs/811415.pdf
[31] Office of National Drug Control Policy. National Drug Control Strategy, 2011. www.whitehousedrugpolicy.gov
[32] Testa, Mark F and Smith, Brenda. Prevention and Drug Treatment in *The Future of Children*, Vol. 19, No. 2, Preventing Child Maltreatment (Fall 2009), p. 151.
[33] Wulczyn, Fred. Epidemiological Perspectives on Maltreatment Prevention in *The Future of Children*, Vol. 19, No. 2, Preventing Child Maltreatment (Fall 2009), p. 56.

care. [34]

NCANDS provides for the recording of risk factors including domestic violence, alcohol abuse and drug abuse of parents/caregivers; however, risk factors were not reported for Louisiana. Therefore there is no data available from NCANDS indicating the involvement of drugs or alcohol in the cases for Louisiana.

Other Health and Social Impacts

The Drug Abuse Warning Network (DAWN-ED) provides national estimates of drug-related visits to hospital emergency departments. Of 120 million visits to hospital emergency rooms in 2009, 4.5 million were drug-related, an increase of 80 percent since 2004. This increase primarily reflects growth in the number of adverse reactions and accidental drug ingestions. Visits involving *drug misuse or abuse* numbered 2.1 million in 2009 and this figure remained relatively stable from 2004. Of these 2.1 million visits, 52 percent involved pharmaceuticals, 35 percent involved pharmaceuticals alone. Illicit drugs were involved in 47 percent of these visits. Alcohol use was involved in 32 percent of the visits. DAWN-ED does not collect information about visits that involve alcohol misuse alone, except for underage drinking. Seven percent of visits involved alcohol alone in patients aged 20 or younger. The most frequently involved substances were: cocaine (43%), marijuana (39%), alcohol (30%), heroin (22%) and stimulants (10%).[35] Hospitals in the New Orleans area are not currently participating in the DAWN-ED system.

Fetal alcohol spectrum disorders (FASD) affect children for the rest of their lives, but are 100 percent preventable. The Louisiana Pregnancy Risk Assessment and Monitoring Surveillance (LaPRAMS) system indicates for 2008 that 8.4 percent of infants were exposed to alcohol in the 3rd trimester of their mother's pregnancy. The rate was slightly higher among black (9.2%) than white (8.1%) mothers.[36] This indicator is published at the state level but is not included with the other Maternal and Child Health data indicators published at the parish level.

Substance use problems are especially prevalent among the homeless, typically contributing to the situation they find themselves in. According to the 2010 Annual Homelessness Assessment Report (AHAR) to Congress, one-third (35%) of sheltered homeless individuals have chronic substance use issues. Studies in New York and Philadelphia indicate that almost one-third of the transitionally homeless and about half of the episodically homeless individuals experience substance abuse problems. According to the 2010 AHAR, 41 percent of mothers of homeless families experience substance use disorders.[37]

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[34] Administration for Children and Families. *Child Maltreatment 2010*. U.S. Department of Health and Human Services, 2011. Available from http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#can .

[35] Substance Abuse and Mental Health Services Administration. *Drug Abuse Warning Network, 2009: National Estimates of Drug-related Emergency Department Visits*. HHS Publication No. (SMA) 11-4659, DAWN Service D-35. Rockville, MD: 2011. http://store.samhsa.gov .

[36] Louisiana Department of Health and Hospitals. *Maternal and Child Health Data Indicators 2007-2009* http://new.dhh.louisiana.gov/index.cfm/page/398 (Accessed March 31, 2012)

[37] Homeless Resource Center. Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States. Substance Abuse and Mental Health Services Administration. Last Updated July 2011. http://homeless.samhsa.gov/ResourceFiles/hrc_factsheet.pdf

Cost of Drug and Alcohol Use and Benefit of Prevention and Treatment

Economic and Social Costs

The economic and social costs of substance abuse have been estimated in terms of losses in productivity, health-related costs, crime-related costs and other costs. At the national level, estimates for 2007 are as follows: $235 billion for alcohol use,[38] $193 billion for drug use[39] and $194 billion for tobacco use.[40] (Please note that, whereas drug costs were directly estimated for 2007 by the National Drug Intelligence Center, the alcohol costs presented here are projected from 1998 estimates using an inflation factor.[41])

Economic and Socail Costs of Drug and Alcohol Use, Nationwide, 2007

Cost Components	Drug Use ($ billions)	Alcohol Use ($ billions)
Total Cost	**193**	**235**
Lost Productivity Cost	120	170
Illness Alcohol and Drug-related	49	110
Incarceration et cetera	52	13
Other	19	47
Crime-related Cost	61	28
Health-related Cost	11	34
Medical Consequences	6	24
Prevention, Treatment, Research	**5**	**10**

For both alcohol and drugs, the largest component of cost is lost productivity, which totals $120 billion for drugs and $170 billion for alcohol. This is measured principally in terms of the inability to participate in the workforce due to premature death, alcohol or drug-related illness, or incarceration. It includes costs to both drinkers/users and victims. The largest component of lost productivity is measured as lost earnings due to alcohol and drug-related illness: $49 billion for drugs and $110 billion for alcohol. The second major component of lost productivity is lost earnings due to crime, principally due to incarceration: $52 billion for drugs and $13 billion for alcohol.

[38] Rehm, J., Mathers, C., Popova, S., Thavorncharoensap, M., Teerawattananon Y., Patra, J. Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. *Lancet*, 373(9682):2223–2233, 2009. Harwood, H. Updating Estimates of the Economic Costs of Alcohol Abuse in the United States: Estimates, Update Methods, and Data. Report prepared by The Lewin Group for the National Institute on Alcohol Abuse and Alcoholism, 2000. http://pubs.niaaa.nih.gov/publications/economic-2000/alcoholcost.PDF . (Accessed 3/10/2012). For purposes of this analysis, 2007 estimates are based on figures provided by Harwood et alia for 1998 inflated by a factor of 1.272, i.e., the ratio of the Consumer Price Index for 1998 and 2007. This makes the estimates comparable with the published estimates for drug use.

[39] National Drug Intelligence Center. *Economic Impact of Illicit Drug Use on American Society*. Washington DC: U.S. Department of Justice, 2011. http://www.justice.gov/ndic/pubs44/44731/44731p.pdf

[40] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, U.S. Department of Health and Human Services. *Best Practices for Comprehensive Tobacco Control Programs*—2007. Available at: http://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2007/bestpractices_complete.pdf. This report provides estimated average daily costs which are multiplied by 365 to obtain annual estimates.

[41] Simple projection does not take into account changes in substance use behaviors, changes in resource allocations, changes in treatment availability and utilization, differences in price inflation across sectors, and other factors.

Crime-related costs (including police, courts and prisons) total $61 billion for drugs and $28 billion for alcohol. The figure for alcohol includes about $20 billion in property damage costs due to motor vehicle accidents.

Health-related costs mostly involve treating the medical consequences of alcohol and drug use: $6 billion for drugs and $24 billion for alcohol. The amount spent on substance use treatment, prevention and research totals about $15 billion. Thus, nationally, services designed to prevent and treat substance use problems represent about one-third of health-related costs of alcohol and drug use and only 4 percent of the total cost ($428 billion) of alcohol and drug use.[42]

Costs of tobacco use have been estimated in terms of health and lost productivity. Nationally about $95 billion is spent annually on direct medical costs related to smoking. In addition, premature deaths from tobacco-related diseases account for approximately $99 billion in lost productivity annually.

State Expenditures

State Expenditures on Consequences of Alcohol, Tobacco and Other Drug (ATOD) Use, and Expenditures on Prevention and Treatment of ATOD Problems, 2005

Budget Category	Nationwide ($ millions)	Louisiana ($ millions)
Total Expenditures, Consequences	**128,000**	**1,375**
Justice and Public Safety	43,000	495
Health	37,000	374
Education	29,000	361
Child and Family Assistance	10,000	58
Mental Health/Dev. Disabilities	8,000	71
State Workforce	677	16
Prevention, Treatment, Research	3,235	44

State governments spent $128 billion in 2005 on the consequences of alcohol, tobacco and other drug use while only $3 billion was spent on programs to prevent or treat substance use problems. In 2005 Louisiana spent $1.375 billion, about 17 percent of its budget, on the consequences of alcohol, tobacco and other drug use.[43] This included substance use-related expenditures in the following areas: Justice and Public Safety, $495 million, Health, $374 million; Education, $361 million; Child and Family Assistance, $58 million; Mental Health and Developmental Disabilities, $71 million. Louisiana spent about $44 million in 2005 on service designed to prevent and treatment substance use problems, about one-half percent of the state budget.

Cost of Alcohol-related Motor Vehicle Accidents

Cost of Alcohol-related Motor Vehicle Accidents in the Greater New Orleans Area, 2010 ($ millions)

Parish	Deaths	Injuries	Property	Total
Orleans	20.4	26.9	1.0	48.3
Jefferson	7.2	20.5	1.2	28.9
Plaquemines	3.6	1.1	0.1	4.8
St. Bernard	1.2	2.3	0.1	3.6
Metro Area	32.4	50.8	2.4	85.6

[42] These figures are for 2007; the figures for alcohol are projections based on the Consumer Price Index, not directly estimated, and are therefore only approximately correct.

[43] National Center on Addiction and Substance Abuse at Columbia University. *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets*. New York, 2009. http://www.casacolumbia.org/templates/publications_reports.aspx

Statewide	367.2	316.9	12.9	698.4

Alcohol-related motor vehicle accidents account for $700 million in economic costs statewide in 2010. Within the Metro Area, alcohol-related accidents generated $86 million in costs, with most of the costs resulting from accidents in Orleans Parish ($48 million). These figure do not include costs due to lost quality of life or pain and suffering.[44]

Benefit of Prevention and Treatment Services

Loren Scott and Associates reviewed numerous cost studies of alcohol and drug treatment for the Louisiana Department of Health and Hospitals, Office of Addictive Disorders.[45] Their analysis indicated that:

- Each additional dollar the State of Louisiana spends on addiction treatment will result in a reduction in future crime and health care costs of $3.69 to $5.19.
- Each additional dollar that the State of Louisiana spends on addiction treatment will reduce future *state expenditures* on criminal justice, medical care and public assistance by approximately $3.83.

There are numerous prevention strategies which can be targeted to different populations and specific problems in a variety of venues. A common venue for prevention services is primary and secondary schools. Louisiana allocates about $5 million in federal Block Grant funds to school-based prevention programs. Research staff at the Rand Corporation's Drug Policy Research Center evaluated the long-term benefits and costs of school-based prevention programs, reviewing numerous studies. Benefits included reductions in lost productivity, government costs and health care costs. Not included were decreases in pain and suffering and loss of life. Results included two estimates:[46]

- A "best estimate" indicated that every dollar spent on school-based prevention produced $5.60 in benefits.
- A very conservative estimate indicated that every dollar spent on school-based prevention produced $2.00 in benefit.

[44] Louisiana Highway Safety Research Group. Louisiana Traffic Records Data Report 2010. Louisiana State University, Baton Rouge, 2011.http://datareports.lsu.edu/Reports/SpecialReports/2010_FactBook.pdf Figure are taken from Table D2. Statewide figures are estimated by aggregating parish-level data and may under estimate statewide costs. Figures are based on methods developed by the National Highway Traffic Safety Administration and are adjusted for inflation using the Consumer Price Index.

[45] Scott, L. *Potential Cost Savings To The State Of Louisiana From The Expansion Of Substance Abuse Treatment Programs, Report Prepared for Department of Health and Hospitals, Office for Addictive Disorders.* Loren Scott & Associates, Inc., Baton Rouge, LA, 2003.

[46] Rand Drug Policy Research Center Research Brief: What Are the True Benefits of School-Based Drug Prevention Programs?, 2002. http://www.rand.org/content/dam/rand/pubs/research_briefs/2005/RB6009.pdf

Summary of Findings

The metro area (Orleans, Jefferson, St. Bernard and Plaquemines parishes) continues to recover from Hurricane Katrina which made land fall in 2005. As of the 2010 Census, the metro area as a whole was still 20 percent below its 2000 population while the City of New Orleans was 30 percent below its 2000 population.

The Gulf Coast High Intensity Drug Trafficking Area assessment indicates that cocaine, methamphetamine and prescription drugs are major threats. However, New Orleans stands out with a continuing threat from heroin.

Drug and public intoxication arrests in New Orleans have declined dramatically in the past 3 years, in part due to issue of summons in lieu of arrest. Nevertheless drug and alcohol arrests rates are twice the national rate. While violent crime and property crime is decreasing in New Orleans, crime rates are higher than the national rate and the homicide rate is 10 times higher. A recent analysis of New Orleans Police Department records revealed that half of homicide perpetrators and half of victims had prior drug arrests, although very few homicides were gang-related.

The Arrestee Drug Abuse Monitoring (ADAM) system for 2010 found that, across 10 major cities, between 50 and 85 percent of arrestees had recently used illicit drugs. An ADAM report for 2000 found that 69 percent of arrestees in New Orleans had recently uses illicit drugs; however, currently only between 10 and 15 percent of arrestees detained in the Orleans Parish Jail/Prison are identified as having an alcohol or drug use problem.

As many as 80 percent of Louisiana state prison inmates have substance use problems. Each year more than 15,000 inmates are released from state custody. As of December 31, 2011, there were over 800 state prisoners housed in the Orleans Parish Prison in anticipation of release to the community. Of these, 72 were enrolled in the Work Transition Program.

Results of the 2010 Louisiana Caring Communities Youth Survey indicate that 12 percent of 10th grade New Orleans students are engaging in binge drinking and 7 percent use marijuana. About one-in-ten 10th graders have been drunk of high at school in the past year, about 5 percent recently drove a car after drinking, and about 6 percent had themselves sold drugs in the past year. Finally, about 8 percent of 7 through 12th grade students, in addition to using alcohol or drugs, have experienced 3 or more symptoms of substance dependence, meaning that about 2,000 are in need of services for a substance use disorder.

Results of the 2008 National Survey on Drug Use and Health indicate that 7 percent of adults in the New Orleans area used an illicit drug in the past month while 29 percent of adults engaged in binge drinking in the past month (consuming 5 or more drinks on one or more occasions). One-in-ten adults (9.7%) experienced a substance use disorder in the past year. Based on SAMHSA's definitions, 9 percent of adults needed but did not receive treatment services in the past year.

Seventeen percent of *young adults* in the New Orleans area used an illicit drug in the past month, a rate more than twice that for all adults. About 40 percent of young adults engaged in binge drinking in the past month (consuming 5 or more drinks on one or more occasions), a rate over one-third higher than for adults as a whole. Eighteen percent of young adults experienced a substance use disorder in the past year, almost twice the rate for all adults. Based on SAMHSA's definition, almost 18 percent of young adults needed but did not receive treatment in the past year.

Results of the 2010 Core Survey indicate that our college students in the Metro Area engaged in more alcohol and drug use, and experienced greater negative consequences, than students in the rest of the state, the southern states and even the nation as a whole. Our students were at higher risk and lower on protective factors. One-third (30%) of our college students drank alcohol 3 times a week or more over the last year and rates of drinking among underage students appear to be the same as for students as a whole. One-in-seven (14%) students smoked marijuana 3 times a week or more over the last year. Alcohol or drugs were involved in 60 percent of the cases of physical violence and over two-thirds of cases of forced sexual touching and unwanted intercourse. One-in-four college students (26%) reported driving under the influence of alcohol or drugs in the past year. One-quarter (26%) of students reported performing poorly on a test or school project due to their alcohol or drug use.

Based on the National Vital Statistics System, the rate of drug poisoning deaths in Louisiana in 2008 was twice the national rate. The alcohol-impaired driving death rate for Louisiana is 50 percent higher than the national rate. Orleans Parish ranked 7th in alcohol-related injury crashes behind 6 rural parishes. The Louisiana Pregnancy Risk Assessment and Monitoring System indicates for 2008 that 8.4 percent of infants were exposed to alcohol in the 3rd trimester. Louisiana reports cases to the National Child Abuse and Neglect Data System, but apparently does not record risk factors such as parental alcohol and drug problems. New Orleans hospitals are not participating in SAMHSA's DAWN-ED system for reporting drug-related emergency room visits.

The economic and social costs of alcohol and drug use totaled $428 billion nationally in 2007. Louisiana state expenditures on the consequences of alcohol, drug and tobacco use totaled $1.375 billion in 2005 while only $44 million was spent on prevention, treatment and research to address these problems. The cost of alcohol-related motor vehicle accidents in the metro area was $86 million in 2010; costs just for New Orleans were $48 million. A study commissioned by the Louisiana Department of Health and Hospitals indicated that each additional dollar spent on treating addiction will result in a $3.83 reduction in state expenditures on criminal justice, medical care and public assistance. A review of studies of school-based prevention programs indicated a benefit-cost ratio between $2.00 and $5.60.

XIV. ii. Principles of Drug Demand Reduction:

- Drug demand reduction requires a shared vision implemented with common methods and an unambiguous, consistent drug-free messages.
- Drug abuse is preventable.
- Prevention—a proactive process of building healthy individuals, families, and communities--is the key to reducing drug demand.
- The environment, laws, government policies, and social norms have a direct impact on the level of drug demand in a community, especially among its most vulnerable members—children and adolescents.
- Alcoholism and drug dependence are chronic illnesses, and the path to recovery often includes temporary episodes of relapse.
- Treatment is effective, with results that are equal to and often better than those for other chronic illnesses such as diabetes, asthma, and hypertension.
- Success requires the active involvement of recovering individuals, families and friends, and concerned citizens of all ages.
- The illegal drug trade and the misuse of legal and illegal substances result in serious harm to individuals, communities, and the public. Enforcement must be supported in the effort to protect the community's residents and administer appropriate sanctions.
- Activities to improve public health and actions to enhance public safety are complementary.
- Drug demand reduction strategies must be driven by local communities and tailored to their unique needs.
- Community-based actions and coalitions are critical. Coalitions are effective when they operate within a coordinated system that includes prevention, treatment and enforcement/criminal justice.
- The strategy must use approaches with proven effectiveness and include measurable outcomes. Selection of programs and activities must be based on objective data and research.
- The capacity to share common data elements across entities and integrate the collection, analysis and reporting of data is essential.
- Performance must be continually monitored and improved to ensure the best possible results at the least possible cost.
- The strategy must be supported by adequate fiscal, human, and information technology resources.

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XIV. iii. THE THREE PILLARS OF DRUG DEMAND REDUCTION: PREVENTION TREATMENT AND ENFORCEMENT

Prevention: Stopping drug use before it starts and intervening to prevent first use from becoming regular use.

Prevention – stopping drug use before it starts –remains at the core of national efforts to reduce drug abuse and is central to an effective drug demand reduction effort. Prevention is the proactive process of building healthy individuals, families and communities. The most cost-effective way to promote safe and healthy communities as well as address drug abuse and its devastating consequences is to convince our youth to never try drugs. This is not an easy task, but the future of our youth depends upon it. Research confirms that if youth make it to age 21 without developing a drug abuse problem, they are unlikely to ever do so.[1] This is based on brain research showing a particularly at-risk stage during adolescence for the development of drug abuse disorders.[2] It follows that the earlier the age of first substance use, the more likely the individual is to develop a lifelong substance abuse problem. So, delaying the age of initiation of drug use provides youth a better chance of living a life free of drug abuse.

Although prevention is often seen as having only a focus on youth, effective prevention actually addresses the entire life span. It is a truism that the most effective prevention happens at home and parents are the most influential person in a child's (or young person's) life. Hence, prevention must be aimed at both parents and children. The environment plays a role in youth attitudes towards alcohol and drugs. Laws (and their enforcement), policies and social/cultural norms have a direct impact on the level of drug demand in a community – especially among youth Research also points to a number of risk and protective factors reflected in the home, school and community that influence youth regarding substance use. Consequently, prevention programs that reach young people in a range of settings (home, school, faith communities) have a stronger impact than those limited to only one setting.[3] Finally, alcohol, tobacco and other drug use by youth is strongly influenced by adult use of these substances. [4] Effective prevention programs should use evidence-based practices, target youth and their parents, focus on risk factors, be sensitive to the environment and cover a range of domains in young people's lives.

The Central Role of Parents and Families

The first – and most effective -- line of defense against substance abuse is in the home with the family. Parents play a key role in preventing drug and alcohol use and abuse because they are the first and most important continuing influence on the behavior of children and adolescents. Youth seek guidance from their parents and look for their parents to set limits on their behavior. This fact is often obscured by rebelliousness, risk-taking behavior and the assertion of

[1] Office of National Drug Control Policy. (2010). National Drug Control Strategy. Washington, D.C.: U.S. Government Printing Office

[2] Squeglia,L., Schweinsburg, A.D., Pulido, C., & Tapert, S.F. (2011). Adolescent binge drinking linked to abnormal spatial working memory brain activation. Retrieved from http://www.ncbi .nlm.nih.gov

[3] Office of National Drug Control Policy. (2010). National Drug Control Strategy. Washington, D.C.: U.S. Government Printing Office

[4] Office of National Drug Control Policy. (2010). National Drug Control Strategy. Washington, D.C.: U.S. Government Printing Office

independence of the teenage years, but most youth actually and ultimately listen to the messages that parents convey. Two thirds of youth ages 13-17 report that concern about losing their parent's pride and respect is one of the most important reasons why they do not do drugs. [5] Families that effectively communicate information about the risks and unacceptability of drug use provide protection to their children from drug use. Family dinners are a good way of staying engaged with your children and fostering communication about the dangers of underage drinking and drug use. Parents today have a tremendous challenge overcoming the messages received by their children through advertising, music, videos, social networks, television and movies concerning the use of alcohol, tobacco and other drugs. Many parents' attitudes are colored by their own past drug experimentation or abuse. They sometimes overlook their role as being the wall between their children and alcohol and drugs. Other times parents are playing catch up on the constantly changing drug scene and are virtually ignorant of the dangerous substances available today – substances such as Spice, bath salts, new designer drugs and prescription drugs. For prevention efforts to succeed, providing drug information to parents is absolutely essential.

Parental Awareness and Responsibility

Families can reduce the effects of peer, school and community risks by employing several strategies, including parental monitoring, family bonding, effective communication, quality family time and personal responsibility/accountability. Parental monitoring means knowing your child's friends and their parents and knowing where your child is at all times (especially after school). It also means establishing curfews, enforcing rules and not leaving children unsupervised or without an adult. These techniques are time-tested by responsible parents and help reduce the chances that children will engage in the use of alcohol or drugs. Finally, parental example is a determinant of adolescent drug use. Children of parents who abuse drugs face heightened risks of developing substance abuse problems themselves. Every day, these young people receive conflicting messages about substance abuse. It is especially critical for these young people to receive prevention messages from schools, faith-based organizations and the community.

Research from the National Center on Addiction and Substance Abuse (CASA) and others consistently indicate that parents hold the important key to their children's decision of whether or not to smoke, drink or use drugs. Nearly four times as many teens (37.7 percent) who say their parents would neither approve nor disapprove of their smoking one or more packs of cigarettes a day are current smokers compared to teens who say their parents would strongly disapprove (10.6 percent). Also, twice as many teens (33 percent) who say their parents would neither approve nor disapprove of their having one or two alcoholic drinks nearly every day currently use alcohol compared to teens who say their parents would strongly disapprove (15.9 percent). Nearly four times as many teens (22.8 percent) who say their parents would neither approve nor disapprove of their trying marijuana once or twice are current marijuana users compared to teens who say their parents would strongly disapprove (5.7 percent). Forty-nine percent of teens who never used marijuana credit their parents with their decision. [6]

[5] Office of National Drug Control Policy (2005) Keeping your teens drug free: A family guide. Retrieved from web site http://www.theantidrug.com /pdfs/resources/general/General_Market_Parent_Guide.pdf

[6] The National Center on Addiction and Substance Abuse At Colombia. (1999). *Teen/Parent Drug Survey Report*. Retrieved from http://www.fact.on.ca/newpaper/co990830.htm

Risk and Protective Factors

One of the most important developments in the evolution of prevention science has been the identification of risk and protective factors. Risk factors are conditions or variables that increase the likelihood of drug and alcohol use. Protective factors are conditions or variables that help safeguard youth from exposure to risk and reduce the potential for involvement with substance use. Interventions designed to reduce risk factors and increase protective factors have been shown to yield immediate and long term results.[7]

Risk factors can influence drug abuse in several ways. The more risks a child is exposed to, the more likely the child will abuse drugs. Some risk factors may be more powerful than others at certain stages in development, such as peer pressure during the teenage years; just as some protective factors, such as a strong parent-child bond, can have a greater impact on reducing risks during the early years. An important goal of prevention is to change the balance between risk and protective factors so that protective factors outweigh risk factors.[8] Studies have shown that the more protective factors a youth has, the less likely that he/she will use, abuse, or become dependent on drugs.[9]

Examples of Risk and Protective Factors [10]
Figure 4-1

Risk Factor	Domain	Protective Factors
Early aggressive behavior	Individual	Self-control
Lack of parental supervision	Family	Parental monitoring
Substance abuse	Peer	Academic competence
Drug availability	School	Anti-drug use policies
Poverty	Community	Strong neighborhood attachment

Perceptions of Harm from Substance Use Among Adolescents

Adolescents' attitudes about the risks associated with substance use are often closely related to their substance use, with an inverse association between drug use and risk perceptions (i.e., as the prevalence of risk perceptions decreases, the prevalence of drug use increases). As such, providing adolescents with credible, accurate, and age-appropriate information about the harm associated with substance use is a key component in prevention programming. [11]

[7] U.S Department of Health and Human Services, Substance Abuse and Mental Health Service Administration. (2001). Principles of Substance Abuse Prevention. DHHS Publication No. (SMA) 01-3507
[8] National Institute on Drug Abuse . (2010). U.S. Department of Health and Human Services. Retrieved from web site http://drugabuse.gov/prevention/risk.html
[9] National Institute on Drug Abuse .(2003). Preventing drug use among children and adolescents: A research-based guide for parents, educators and community leaders. NIH Publication No. 04-4212 (A)
[10] National Institute on Drug Abuse. (2010).U.S. Department of Health and Human Services. Retrieved from web site http://drugabuse.gov/prevention/ri.sk.html
[11] National Institute on Drug Abuse. (2011). Monitoring the future: Report and overview of adolescent drug use. Retrieved from website http://www.drugabuse.gov/related-topics/trends-statistics/monitoring-future

Perception of Risk: Students are more likely to smoke, drink or use drugs when they believe that the harm associated with use is low. For example, teens who believe there is no risk or only a slight risk of harm in smoking marijuana once a month are six times likelier to be current marijuana users than teens who believe there is a moderate or great risk of harm (18.5 percent vs. 3.1 percent). [12]

Student Substance Use Rises with Lower Perceptions of Harm

Students are more likely to smoke, drink or use drugs when they believe that the harm associated with use is low. According to Monitoring the Future, the proportion of young people using any illicit drug has been rising over the past three years, due largely to increased use of marijuana—the most widely used of all the illicit drugs. [13]Teens who believe that there is no risk or only a slight risk of harm in smoking marijuana once a month are six times likelier to be current marijuana users than teens who believe there is a moderate or great risk of harm (18.5 percent vs. 3.1 percent). [14] The Director of the White House Office of Drug Policy made the following reflections regarding escalating marijuana use by youth:

> The increases in youth drug use reflected in the Monitoring the Future Study are disappointing. Mixed messages about drug legalization, particularly marijuana, may be to blame. Such messages certainly don't help parents who are trying to prevent kids from using drugs. The Obama administration is aggressively addressing the threat of drug use and its consequences through a balanced and comprehensive drug control strategy, but we need parents and other adults who influence children as full partners in teaching young people about the risks and harms associated with drug use, including marijuana.[15]

The Influence of Substance Use on Adolescent Brain Development

Adolescence is a unique period in neurodevelopment. Alcohol and marijuana use are common. Recent research has indicated that adolescent substance users show abnormalities on measures of brain functioning, which is linked to changes in neurocognition over time. Abnormalities have been seen in brain structure volume, white matter quality, and activation to cognitive tasks, even in youth with as little as 1–2 years of heavy drinking and consumption levels of 20 drinks per month, especially if >4–5 drinks are consumed on a single occasion. Heavy marijuana users show some subtle anomalies too, but generally not the same degree of divergence from

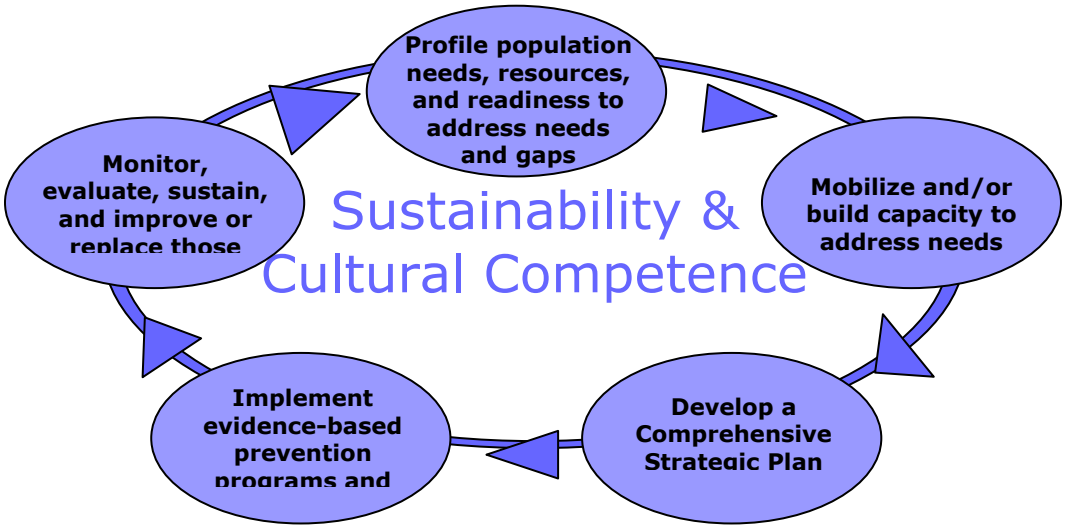
[12] National Institute on Drug Abuse. (2011). Monitoring the Future. Retrieved from website http://www.drugabuse.gov/related-topics/trends-statistics/monitoring-future
[13] National Institute on Drug Abuse. (2011). Marijuana use continues to rise among youth. Retrieved from website http://www.drugabuse.gov/related-topics/trends-statistics/monitoring-future
[14] National Institute on Drug Abuse. (2010). Monitoring the Future. Retrieved from website http://www.drugabuse.gov/related-topics/trends-statistics/monitoring-future
[15] Office of National Drug Control Policy. (2010). Monitoring the Future Survey Press Release. Retrieved from http://www.whitehouse.gov/ondcp

demographically similar non-using adolescents.[16]

The Strategic Prevention Framework (SPF)

Figure 4-2 Strategic Prevention Framework[17]

The Strategic Prevention Framework (SPF) is a public health-based framework consisting of five elements for building local capacity to effectively address substance use and abuse and its consequences. It consists of: 1. Conducting a needs assessment 2. Mobilizing and/or building community capacity 3. Developing a comprehensive strategic plan 4. Implementing evidence-based prevention programs 5. Monitoring the process and evaluating its effectiveness. The SPF is designed to impact population level change and is built on outcomes based prevention focusing on both consumption and its consequences. Additionally, it addresses prevention needs for the lifespan rather than just a particular group. [18]



Implementation of the Strategic Prevention Framework will make New Orleans ultimately more likely to succeed in reducing drug abuse and drug abuse related problems in communities. The process provides a road map for successful comprehensive community plans to foster sustained long term change.

Evidence-Based Practices

[16] Squeglia,L., Schweinsburg, A.D., Pulido, C., & Tapert, S.F. (2011). Adolescent binge drinking linked to abnormal spatial working memory brain activation. Retrieved from http://www.ncbi.nlm.nih.gov
[17] Florida Center for Prevention Research. (2007). Retrieved from web site (http://fcpr.fsu.edu/sarg/sarg_manual /phase_1/phase_1.php)
[18] Florida Center for Prevention Research. (2007). Retrieved from web site http://fcpr.fsu.edu/sarg/sarg_manual phase_1/phase_1.php)

It is important to identify and implement programs, policies and practices that are known to be effective in preventing and reducing substance abuse for the particular population and problem identified. Scarce resources are too valuable to risk on unproven interventions or intervention known to be ineffective. However, research has proven that there are many proven strategies from personal skill building to family bonding activities to community awareness and mass media campaigns that provide measurable outcomes toward drug demand reduction. When determining which evidence-based prevention practices to implement, it is critical that scientifically defensive principles are utilized in order to ensure that services are innovative, effective and are aimed at reducing the risk factors and increasing the protective factors linked to drug use and related problem behavior. If the practice does not address the risk and protective factors or contributing conditions, then it cannot be expected to impact drug use. [19]

Drug Free Workplace

According to the 2007 National Survey on Drug Use and Health, 75% of all current illicit drug users aged 18 or older are employed. [20] The high incidence of drug abuse in the workplace is a detriment to both productivity and safety of the employees, businesses and communities. We know that absenteeism is higher for users as are workplace accidents and disciplinary actions. Additionally, theft, personnel turnover, and workers' compensation claims are higher – all costly to business. Moreover, drug abuse in the workplace lowers morale overall and destroys the trust of other employees. Drug free workplaces are best achieved by private businesses with support from the government and the community. They are a product of initiative, good management, worker incentives and education. In order for such programs to be successful, there must be; formal, written policy, employee education, supervisor training, access to assistance/treatment and drug testing. With drug free workplace programs in place, employees spread healthy norms and behaviors not only in the workplace, but also in their families and communities. Businesses will see an increase in productivity, employee health, morale and ultimately profits.[21]

A critical component of a drug demand reduction strategy is to support drug free workplaces and seek to increase their number. A typical concern of businesses throughout the country when seeking employees is an inability to find a sufficient number who can pass a drug test so that they can be employed and retained. Partnerships with city government and the business community, promoting the benefit of a drug free workplace, reinforces on going prevention efforts in communities. Youth would get the message that being drug free is an essential factor in getting and keeping a job.

Prevention and the Media-and Social Networks

In no other area of drug control is publicity and media exposure more important than prevention. Raising awareness and educating youth and adults about the dangers of underage drinking and

[19] Substance Abuse and Mental Health Services Administration. (2001). Guide to Evidence based practices: Principles of substance abuse prevention DHHS Publication No. SMA 09-4343

[20] Substance Abuse and Mental Health Services Administration. (2008). Results from the 2007 National Survey on Drug Use and Health: National Findings. DHHS Publication No. SMA 08-4343.

[21] Substance Abuse and Mental Health Services Administration. Drugs in the workplace: What an employer needs to Know. Retrieved from web site (http://www.workplace.samhsa.gov/WPWorkit/pdf/why_you_should_care_about_having_a_drug_free_workplace_fs.pdf)

drug use are concepts that must be reinforced by ad campaigns and public service announcements. Surveys consistently show that the majority of adolescents received drug prevention messages through the media, school and parents. [22] Prevention social networks provide another opportunity for prevention messaging. School and community prevention activities can receive heightened awareness from notes, blogs, tweets and email messaging. Anti-drug Face book pages can provide yet another source for today's technology savvy youth to view prevention information. This is a frontier ripe for conveying facts to dispel the rumors and myths about the general acceptance of drug use in our culture. Drug demand reduction efforts that partner with youth, school communities, parent organizations, businesses and the media effectively utilize evidence based principles and practices to communicate prevention messages that clearly and consistently express the community's standard of "No use of illegal drugs and no abuse of legal drugs."

Treatment, Recovery and Rehabilitation

Understanding Addiction

Addiction is defined as a chronic, relapsing brain disease characterized by compulsive drug seeking behavior and use, despite harmful consequences according to the National Institute of Drug Abuse.[23] Drug addiction is considered a brain disease because drugs change the structure of the brain and how it works: all behavior patterns result from the activity of the nervous system and brain, meaning changes to the nervous system and brain changes behavior. These changes can be long lasting and undermine a person's ability to correctly prioritize behavior, including whether or not to take drugs. The effects of drugs on the brain explain why drug addiction is often characterized by compulsive, dysfunctional drug use that continues in the face of extremely negative consequences.[24] Because of the way drug use alters the structure and function of the brain, drug addiction is regarded as comparable to other diseases like heart disease. Both drug addiction and heart disease "disrupt the normal, healthy functioning of the underlying organ, have serious harmful consequences, are preventable, treatable, and if left untreated, can last a lifetime."[25] The compulsive behavior and impaired impulse control that characterizes addiction is similar to features of other mental illnesses. In fact, the Diagnostic and Statistical Manual of Mental Disorders (DSM), the definitive resource of diagnostic criteria for all mental disorders, includes criteria for substance use disorders.

The initial decision to take drugs is usually voluntary and can occur for a variety of reasons. Many people start using drugs as a way of self-medicating and, depending on drug pharmacology, because drugs make them feel good; increase rewarding effects; increase self-confidence and increase energy (e.g., from psychostimulants like cocaine and

[22] National Institute on Drug Abuse . (2010). U.S. Department of Health and Human Services. Retrieved from web site http://drugabuse.gov/prevention/risk.html

[23] National Institute on Drug Abuse. (2011) Retrieved from web site (http://www.drugabuse.gov/Research Reports/Prescription/glossary.html)

[24] National Institute on Drug Abuse. (2009). Principles of drug abuse treatment: A Research-Based Guide. NIH Publication No. 09-4180.

[25] American Psychiatric Association. (2000). Diagnostic and Statistical Manual of Mental Disorders*: DSM-IV-TR.* Washington, D.C,: American Psychiatric Association.

methamphetamine); or cause relaxation; satisfaction; or euphoria (e.g., from opiates like heroin or oxycodone). Some individuals with depression or mental illness may use drugs to relieve negative, painful feelings. Others may use drugs simply because they are curious about experiencing new things or taking risks.[26]

There is a clear, clinical difference between addiction (dependence) and abuse and the DSM distinguishes between the two. Drug dependence, as defined by the DSM, is synonymous with the term "addiction" as it is used throughout the *Strategy*. Substance dependence is defined as a cluster of three or more of the seven symptoms listed in the box below. The essential feature of substance dependence is a combination of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that can result in tolerance, withdrawal, and compulsive drug-taking behavior.[27] In contrast to the criteria for substance dependence, the criteria for substance abuse do not include tolerance, withdrawal, or a pattern of compulsive use. Instead they include only the harmful consequences of repeated use.[28] Essential to substance abuse is a maladaptive pattern of recurrent substance use leading to clinically significant impairment or distress, and as manifested by recurrent and significant adverse consequences related to the repeated use of substances.[29]

Addiction is a treatable disease. Individuals can overcome addiction, counteract the damaging effects of drugs and regain control of their lives. Comprehensive drug treatment is effective at stopping drug use and helping people return to healthy, productive lives. However, addiction is a chronic disease typically characterized by occasional relapses. This fact means that a single experience in treatment may not be enough to affect total abstinence for a lifetime. Treatment episodes that do not result in complete and long-lasting abstinence should be regarded as incomplete successes rather than failures since treatment involves changing deeply embedded psychological and social behaviors.[30] Relapses are not unusual, so addiction must be approached like other chronic illnesses. In fact, relapse rates are comparable to those seen in other chronic medical diseases that have both physiological and behavioral components like diabetes, hypertension and asthma. [31]

Effective treatment consists of a set of thirteen treatment principles developed by the National Institute on Drug Abuse. These principles advocate for treatment services to be tailored to address each individual's unique needs. Consistent with this idea, this strategy promotes prompt access to individualized, evidence-based treatment services to individuals and their families and treating the family as a unit. Additionally, addiction often impacts many different aspects of a

[26] National Institute of Drug Abuse. (2010). Drugs, brains and behavior: The science of addiction. NIH Publication 10-5605

[27] American Psychiatric Association. (2000). Diagnostic and Statistical Manual of Mental Disorders*: DSM-IV-TR.* Washington, D.C,: American Psychiatric Association.

[28] American Psychiatric Association. (2000). Diagnostic and Statistical Manual of Mental Disorders*: DSM-IV-TR.* Washington, D.C,: American Psychiatric Association.

[29] American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders*: *DSM-IV-TR.* Washington, D.C,: American Psychiatric Association.

[30] National Institute of Drug Abuse. (2010). Drugs, brains and behavior: The science of addiction. NIH Publication 10-5605

[31] National Institute of Drug Abuse. (2010). Drugs, brains and behavior: The science of addiction. NIH Publication 10-5605

person's life, so effective treatment programs must offer comprehensive services to meet the psychiatric, medical, social, vocational/educational and legal needs of the individuals they serve.

Barriers to Treatment

There is a stigma attached to substance abuse that often hinders treatment. In our society, many people view substance abuse as failure of personal will or character. Those who avoid treatment often do so because they perceive that their friends and neighbors will think less of them. Additionally, they may fear a negative effect on employment prospects. Abstinence and recovery is viewed simply as a matter of strong will. The truth is that while will and character both play a part in every effort to deal with substance abuse, they are rarely sufficient in themselves to allow a lasting recovery. Based on years of research, we now know that recovery from addiction must include a recognition and understanding of not only psychological factors, but also of environmental influences. This is why it is critical to educate the public about the nature of addiction as a disease from which people can successfully recover. In this way, we can reduce the stigma and discrimination associated with addiction and remove some of the barriers.

Initial screening and assessment of individuals with a substance abuse problem is one way to break down barriers to treatment. What if we could stop drinking and substance abuse before it became serious enough to reach the criminal justice system? The concept developed by SAMHSA in 2008 known as Screening, Brief Intervention and Referral to Treatment (SBIRT) promises to help identify and refer to treatment those in need of services for substance abuse.
Primary care providers, emergency room physicians and other health care venues screen patients to assess their alcohol and drug use. If they are at risk of developing a serious problem, they receive a brief intervention that focuses on raising their awareness of substance abuse and motivating them to change their behavior. Patients who need more extensive treatment receive referrals to specialty treatment programs. This program, piloted in three states, has shown to be effective in reducing drinking and substance abuse problems.[32] This program has potential to be a game-changer. It begins to involve primary health care providers in helping to screen and identify those with potential substance abuse problems and referring them to treatment. The *Strategy* advocates for New Orleans to adopt a system similar to SBIRT.
Co-Occurring Disorders

Many people diagnosed with a substance use disorder -- either dependence or abuse – are also diagnosed with mental disorders. Conversely, many people diagnosed with mental disorders are also diagnosed with a substance use disorder. Compared with the general population, individuals diagnosed with mood or anxiety disorders are about twice as likely to also suffer from a substance use disorder. Likewise, individuals diagnosed with substance use disorders are roughly twice as likely to also be diagnosed with mood or anxiety disorders. [33] When two disorders or illnesses occur in the same person, simultaneously or sequentially (one after another), they are called comorbid.[34] Individuals who simultaneously have one or more substance use disorders as

[32] Substance Abuse and Mental Health Service Administration. (2009). Retrieved from web site http://store.samhsa.gov/shin/content//SAM09-176/SAM09-176.pdf
[33] National Institute on Drug Abuse. (2010). Comorbidity: Addiction and Other Mental Illnesses .NIH Publication No. 10-5771.
[34] National Institute on Drug Abuse. (2010). Comorbidity: Addiction and Other Mental Illnesses .NIH Publication No. 10-5771.

well as one or more mental disorders are said to have co-occurring disorders.[35] It is clear that drug abuse can cause symptoms of mental illness just as mental illness can lead to drug abuse. Both substance abuse disorders and other mental illnesses may be caused by common and overlapping risk factors based on neurological deficits, genetic vulnerabilities and trauma. [36] Because of the high rate of co-occurrence between substance use disorders and other mental illnesses, there is a need for a comprehensive approach to intervention that identifies, evaluates, and treats each disorder at the same time. Treating co-occurring disorders concurrently with a broad spectrum of behavioral therapies (alone or in combination with medications) leads to more positive outcomes for individuals with these conditions. Unfortunately, only a small percentage of individuals with co-occurring disorders receive comprehensive services that address both disorders simultaneously. [37]

In New Orleans, separate "parallel" treatment systems address substance use disorders and other mental illnesses despite the high rate of co-occurrence between these conditions. Not only are services for substance use disorders and mental illnesses separated from each other, but they are also separated both structurally and functionally from the general healthcare system. As a result, individuals in need of general health care, substance use treatment, and treatment for mental illness often have to interact with at least three separate delivery systems. Under such a fragmented and disconnected healthcare system, individuals with co-occurring disorders are passed back and forth between different providers, government agencies, and organizations without any processes in place to ensure coordination and planning across systems. Legal and organizational prohibitions against sharing health information and treatment records worsen the problem. [38] In order to address the fragmented system of care head-on, the *Strategy* advocates for the implementation of a comprehensive, continuous, and integrated system of care as a way of organizing services for individuals with co-occurring substance use and mental disorders that encompasses the health and behavioral health systems, which are composed of city and state governmental and private agencies, organizations, and individuals who are stakeholders in providing patient care. This requires the integration of health care providers, social welfare providers, the criminal justice system and substance abuse treatment providers working collaboratively to adequately address the needs of those with co-occurring disorders.

Law Enforcement and Supply Reduction

Supply Reduction

The primary role of law enforcement in the drug control strategy is to reduce the supply of illegal drugs available in New Orleans. Through enforcement actions, law enforcement officers work to decrease illicit drug activity while deterring the potential for future illicit drug activity. Law enforcement actions also bring to treatment those who otherwise would not seek help.

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[35] National Institute of Drug Abuse. (2010). Comorbidity: Addiction and Other Mental Illnesses .NIH Publication No. 10-5771.
[36] Florida, Executive Office of the Governor. (2009). *Florida's Drug Control Strategy.*
[37] Florida, Executive Office of the Governor. (2009). *Florida's Drug Control Strategy.*
[38] Institute of Medicine. (2006). Improving the quality of Health care for mental and substance use conditions: Chasm Series. Committee on Crossing the Quality Chasm: Adaption to Mental Health and Addictive Disorders. Washington, D,C,: National Academy Press.

By deterring if possible, compelling into treatment and punishing when necessary, law enforcement is a key partner in our efforts to reduce demand for drugs. Community policing keeps our neighborhoods safe and provides a strong defense against those who deal drugs and poison our citizens. It is clear that strong, consistent enforcement of current laws and swift and certain consequences for drug crimes serves as a strong deterrent to drug use. Partnerships between enforcement and community organizations helps to roll back the availability of drugs.

Clearly, the criminal justice system plays an important role in reducing drug use and its consequences. Incarceration is often the appropriate response to drug offenses – especially those involving violence or trafficking. In many instances, it is only through contact with law enforcement and the courts that some come to grips with their own addiction and the consequences of that addiction. Intervention by law enforcement is often a first and necessary step that leads a person to treatment. Responsible drug control policy is not soft on crime. In fact, the first step in recovery and rehabilitation begins with being held accountable for your actions. However, for crimes driven by an underlying substance abuse addiction, incarceration will only lead to the individual continually cycling in and out of the system unless the addiction is treated. Without treatment, a drug-related offender will undoubtedly return to another cycle of drug abuse, crime and incarceration.

According to the Office of National Drug Control Policy, two of the best indicators of reduced drug supplies and disrupted drug markets are higher drug prices and decreased drug purity. High drug prices discourage consumption. Research indicates that raising the price of addictive substances lowers the rate of first time use or initiation, while policies that lower the price of addictive substances tend to increase first time use or initiation rates. Law enforcement operations that raise the price of drugs support our prevention efforts by making initiation into drug use more difficult.[39] Drug users respond to the high price of illegal drugs in the same way they respond to the price of other addictive drugs like alcohol and tobacco – they use less. Even heavy drug users are usually rational consumers, and when law enforcement disruptions cause prices to spike too high or drug supplies to become erratic, they may be more likely to seek drug treatment.[40] So, as enforcement efforts on illegal drugs succeed, prices go up and demand goes down.

Breaking the Cycle of Drugs and Crime -- Drug Courts and Other Diversionary Programs

Drug courts work to stop the 'revolving door" in our criminal justice system. Simply put, drug courts significantly reduce crime, produce better treatment outcomes and are more cost effective than other criminal justice strategies. The National Association of Drug Court Professionals found that adult drug courts reduce crime rates anywhere from 8- 26%.[41] Drug courts also reduce recidivism. In a 2003 National Institute of Justice study, drug court graduates had a 16.4%

[39] Office of National Drug Control Policy. (2006) National Drug Control Strategy. Washington, D.C.: U.S. Government Printing Office.
[40] Office of National Drug Control Policy. (2002 and 2005) National Drug Control Strategy. Washington, D.C.: U.S. Government Printing Office.
[41] Florida Supreme Court. Office of the State Courts Administrator. (2010). Retrieved from Florida Supreme Court web site www.flcourts.org

recidivism rate after one year compared to 43.%% of cases handled in the traditional method. [42] Finally, they are cost effective. The cost of annual drug treatment is much less than the cost of the local jail or state prison.

There are model programs for diversionary programs for low-level drug possession crimes. For example, the Seventh Judicial Circuit in Florida offers a program for non-violent first and second time drug offenders known as the Anti-Drug Initiative (ADI) Level 1 Program. The brief intervention treatment approach developed by the local Stewart-Marchman-Act Behavioral Healthcare consists of two individual counseling sessions and four group sessions over a six-week period coupled with random drug testing. Successful completion results in no filing on the referring charge by the State Attorney's Office. Failure to attend a scheduled session or any continued drug use results in removal from diversion status. The client pre-pays the $400 cost. A total of 9,812 people have been served by the program since its inception in November 1999. An online version of the program was begun in February 2009. Clients participate in an online intake session followed by six online treatment sessions monitored by a program staff member. Random urinalysis is also required. The cost of this service to the client is $300. Data collected on client participation and outcomes over more than seven years demonstrate the effectiveness of the ADI Level 1 intervention. Completion rates are very high, with approximately 90% of those discharged completing the program. One year re-arrest data based on a sample of 7,874 individuals discharged through June 2008 showed that only 25% of those who successfully completed the program were re-arrested in the year following treatment compared to 39.69% of those who did not complete the program. [43]

Youth Access to Alcohol

Restricting the retail availability of alcohol to minors is an important part of New Orleans's efforts to prevent underage drinking. Limiting youth access to alcohol, in general, is effective in preventing and reducing underage drinking and related problems. [44] Reduced retail availability generally results in lower alcohol consumption and associated problems. Enforcement of underage drinking requires joint law enforcement efforts between police and state agents as well as cooperation from the business community. Responsible beverage service and sales programs implement a combination of outlet policies, manager training and server training to minimize the provision of alcohol to minors. Outlet policies that advance the goal of responsible service include requiring clerks or servers to check identification for all customers appearing to be under the age of 30, and requiring all servers to be over 21. Training and education programs for owners, managers, and servers help them avoid illegally selling alcohol to underage or intoxicated patrons. These programs help owners, managers, and servers understand state and local alcohol policies, heighten their awareness of the consequences for violating these policies, and provide them with the skills they need to comply with these policies. Training and education

[42] National Institute of Justice, U.S. Department of Justice. (April 2003) 2000 Arrestee Drug Abuse Monitoring: Annual Report. Washington, D.C.: U.S. Government

[43] Florida's Partners in Crisis and Florida Substance Abuse and Mental Health Corporation. (2009). Successful Strategies for Diverting People with Mental Illnesses and Substance Abuse Disorders from the Florida's Criminal Justice System. Retrieved from web site (http://flpic.org/files/documents/2009111810353659.pdf)

[44] National Research Council and Institute of Medicine. (2004). Reducing Underage Drinking: A Collective Responsibility. Committee on Developing a Strategy to Reduce and Prevent Underage Drinking, Richard J. Bonnie and Mary Ellen O'Connell, editors. Washington, D.C.: The National Academies Press.

programs also teach servers how to identify fake identification cards and intoxicated customers and respond appropriately. Responsible beverage service programs reduce the number of intoxicated customers leaving a bar, decrease the number of car crashes, and reduce the likelihood of sales to minors.[45]

In addition to the commercial sources, underage youth are able to obtain alcohol from a variety of social sources. Surveys and focus groups of minors indicate that the majority of youth consume alcohol obtained through friends, acquaintances, family members, and other adults who buy or provide alcohol to them. Younger youth rely on parents or family members for alcohol more than older youth, who tend to use friends and adult strangers. Use of commercial sources appears to be much higher among college students, though parties, friends, and adult purchasers are still the most frequent sources of alcohol among college students and older adolescents. A large percentage of college-age minors report that they do not pay for alcohol, often because they drink at parties where someone else has supplied the alcohol. Since young people obtain alcohol from multiple sources, it is important that efforts to reduce underage access address social availability through friends, parents, and strangers, as well as commercial access. An important part of the New Orleans effort to reduce social access involves communicating strong norms regarding the unacceptability of adults providing alcohol to minors or facilitating underage drinking.

Reducing Prescription Drug Diversion

The illegal diversion of prescription drugs is the fastest growing drug threat in the United States today. Diversion is the illegal movement of prescription drugs for non-medical use. Prescription drug abuse poses the single greatest drug-related threat to the health and safety of Americans since crack cocaine. It attacks our community just like illegal street-level drugs and results in the very same negative consequences – overdoses, burglary, DUI, fraud and violent crime. In the state of Florida, prescription drug overdoses kill seven Floridians every single day – a tragic number five times greater than state deaths from all illicit drugs combined. New Orleans can take aggressive steps now to prevent this problem from migrating down Interstate 10 from Florida.

How are these prescription drugs being diverted from their intended use? According to the 2009 National Survey on Drug Use and Health (NSDUH), 70% of those who use prescription drugs non-medically get their drugs from friends and family members.[46] Not surprisingly, patients receiving medications from a single doctor is the next most frequent source, followed by those who are "doctor shoppers" visiting multiple doctors to receive pain killers. Stolen, forged, or counterfeit prescription forms are yet another way to illegally acquire narcotics for non-medical use. Finally, pain clinics (operating as "pill mills") and street dealers are the bottom feeders – literally -- as the sources for diverted pharmaceuticals. Among young people, prescription drug abuse is the second most abused illegal drug after marijuana.

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[45] National Research Council and Institute of Medicine. (2004). Reducing Underage Drinking: A Collective Responsibility. Committee on Developing a Strategy to Reduce and Prevent Underage Drinking, Richard J. Bonnie and Mary Ellen O'Connell, editors. Washington, D.C.: The National Academies Press
Office of National Drug Control Policy. (2011). National Drug Control Strategy. Washington, D.C: U.S Government Printing Office.

[46] Office of National Drug Control Policy. (2011) National Drug Control Strategy. Washington, D.C.: U.S. Government Printing Office.

Because prescription drugs are prescribed by a doctor, they carry an air of legitimacy. Many pain-killing drugs are used safely and legally by people who require medications to relieve pain and improve quality of life. However, many of these pain killing drugs are powerful addictive narcotics with great potential for abuse. Oxycodone, hydrocodone and benzodiazepines – all controlled substances under law -- are just a few of the most abused prescription drugs. Addiction to oxycodone is almost completely equivalent to addiction to heroin and the treatment protocols are eerily similar. In short, prescription pain killers are both powerful and addictive and should never be used non-medically.

Prescription diversion cases are some of the most difficult cases for local law enforcement to investigate. Since it often involves collusion between a physician and a patient, acquiring evidence and proof is a complex, time-consuming process. Other local law enforcement officials around the country have had success in preventing this epidemic and its negative consequences. They have begun forming diversion units to target the illegal diversion of prescription drugs. Additionally, they have partnered with state and federal officers to aggressively pursue this new threat.

The widespread social availability of prescription drugs is sometimes the product of individuals who use only a fraction of the medication they are prescribed. Later, when a friend or family member complains of pain or discomfort, the former patients might share or sell their leftover medication. Providing a controlled substance to a friend or family member is a serious criminal offense, but doing so could possibly lead to an overdose or initiate a severe addiction. Furthermore, the very presence of easily accessible, unused prescriptions may provide an open opportunity for a friend or family member who might be inclined to take them without asking.

Part of the solution to this problem depends on public commitment to quickly and safely dispose of unused prescriptions. Prescription drugs are available in many homes, and by making sure to closely monitor and properly dispose of unused medications, parents can have a significant and immediate impact by reducing the availability of prescription drugs. Another part of the solution also lies with the medical community, since it is important for prescribers to be aware of the abuse potential of prescription medications and to only dispense the amount of a controlled substance that is medically necessary. Patients must also be educated about the legal and social consequences of providing prescription drugs to friends or family members. [47] The Drug Enforcement Administration's National "Take Back" Initiative results in the safe and proper disposal in unwanted or expired medications and helps to educate adults about the importance of properly securing medicines in their homes.

Drunk and Drugged Driving

The drunk and drugged driving threat is increasingly responsible for crashes, injuries and fatalities. Individuals operating motor vehicles under the influence of drugs – especially marijuana and prescription drugs – are becoming a major danger. These drivers display all the same sort of impairment and slow reactions seen in drunk drivers. Unfortunately, there is currently no simple test like the breathalyzer to determine impairment. That determination must

[47] Florida, Executive Office of the Governor. (2009) Florida's Drug Control Strategy.

be made by a trained Drug Recognition Expert (DRE) for a prosecution to hold up in court. Even with a DRE testifying, convictions are difficult. Drugged driving should be a priority equal to that of drunk driving for law enforcement action.

Working in Concert with Prevention and Treatment Efforts

Law enforcement can gain efficiencies in routine enforcement activities by partnering with the Greater New Orleans Drug Demand Reduction Coalition. As drug specific criminal activity occurs in a certain part of the city, law enforcement can provide information to the coalition concerning the type of drugs present there. Based on that information, drug prevention messages and activities can be more effectively focused and targeted to prevent future drug use. This routine exchange of information can help prevention efforts throughout the city and can serve as opportunities for intervention and referral to treatment. Similarly, coalition leaders, prevention and treatment professionals can point out to law enforcement areas of drug activity or underage alcohol sales made known to them through their outreach in the community. In this way, the relationship is mutually beneficial in working to reduce illegal drug activity and underage drinking in New Orleans. Additionally, both law enforcement and prevention leaders can join efforts to reduce drunk and drugged driving.

X1V. IV. BIOGRAPHY OF CONSULTANTS

JAMES R. MCDONOUGH

James R. McDonough was the Director of Strategy for the Office of National Drug Control Policy, (1996-1999) the White House agency that leads the nation's efforts to reduce drug abuse and its consequences on the American people. He was a key player in the conceptualization, planning and execution of national drug policies to reduce the demand for and cut the supply of illegal drugs in America. From 1999 to 2006, he was the Director of the Florida Office of Drug Control. Appointed by the Governor, he was responsible for the coordination of all State efforts to decrease drug abuse and its consequences in Florida. From 2006-2008, He was the Secretary of the Florida Department of Corrections, the third largest state prison system in the nation with over 95,000 inmates, 150,000 probationers, and 28,000 cadre and a budget of roughly 2.5 billion dollars. From February to June of 2008 he served by appointment of Louisiana Governor Bobby Jindal as the transformation team leader to address serious problems concerning mental illness, drug addiction, and developmental disabilities among the population of New Orleans and its surrounding three parishes that had persisted and worsened in the aftermath of Hurricane Katrina. He is a graduate of the Massachusetts Institute of Technology and the United States Military Academy. He holds a number of awards from both his civilian and military experiences. Among them are the Distinguished Service Medal, Bronze Star for valor, two additional awards of the Bronze Star, the Purple Heart, the Combat Infantryman's Badge, and the Army's Ranger Tab. He is the author of many professional articles and has published three books; Platoon Leader (also a movie), The Defense of Hill 781, and The Limits of Glory.

BRUCE D. GRANT

Bruce Grant is a consultant on substance abuse issues, veterans issues and leadership management improvement for government entities and private sector partners. He served as Director of the Florida Governor's Office from 2009-2011 where he directed state drug policy initiatives to reduce substance abuse through prevention, treatment, and law enforcement. He served as Assistant Secretary to the Florida Department of Corrections CEO for 3500 probation officers and administrative support staff throughout the state of Florida and managed a budget of over $200 million. He served as a Colonel in the United States Army. He was Deputy Director of Provincial Reconstruction Team in Iraq from 2005-2006, where his mission was to establish democratic governmental processes and institutions, implement an effective rule of law, provide economic incentives, and execute an infrastructure reconstruction budget and project prioritization system in the province. He served as Chairman of the Leon County drug prevention coalition and chairman of the State Advisory Council, Veteran's Jail Diversion and Trauma Recovery Program. He received a M.A. in Public Administration from the University of Puget Sound, Tacoma Washington; received a B.S. in Engineering, from the U.S. Military Academy, West Point New York; and attended the Executive Management College, Maxwell Air Force Base, Alabama and the U.S. Army War College, Carlisle, Pennsylvania. He is currently enrolled and pursuing a Ph.D. in Public Administration from Florida State.

WENDIE VELOZ

Wendie Veloz represented the Department of Health and Human Services and SAMHSA on the Strong Cities Strong Communities (SC2)-Community Solutions Team for the City of New Orleans. Through this initiative She coordinated several key projects for the City of New Orleans' Health Department including the compilation of a behavioral health resource guide and the facilitation of a 120 participant meeting with behavioral health local stakeholders to increase communication and coordination across the behavioral health system. She is a Presidential Management Fellow (PMF) in 2006 at the Department of Health and Human Services (DHHS) - Substance Abuse and Mental Health Services Administration (SAMHSA) as a Grants Project Officer in the Crisis Counseling and Technical Assistance Program where she worked on disaster behavioral health programs. She has worked with communities across the U.S. to promote sustainable systemic change by integrating local juvenile justice, mental health, education and early childhood efforts and promoting sustainable partnerships. In 2010 she completed the Centers for Disease Control and Prevention (CDC) - International Experience and Technical Assistance Program (IETA). She completed a Master's Degree in International Social Welfare for Immigrants and Refugees at Columbia University School of Social Work in New York in 2006. Through Columbia University, Wendie completed a 5 month independent policy research and analysis project in Rakai, Uganda. She conducted qualitative interviews with school officials, parents, students and the Minister of Education of Uganda regarding the current state of the school system and the Universal Primary Education policy. While at Columbia Wendie worked at STEPS to End Family Violence as a child therapist with children exposed to domestic violence.

DAVID G. EVANS

David Evans is an attorney in private practice. From 1990-1992, he was a research scientist with the New Jersey Division of Alcoholism and Drug Abuse, Department of Health. From l984-l990, he was the manager of the New Jersey Intoxicated Driving Program, New Jersey Department of Health. He was the Coordinator of Justice Programs with the Division of Alcoholism, New Jersey Department of Health. He was a Trial Attorney in the New Jersey Office of the Public Defender, Newark, New Jersey. He taught courses on alcohol, drugs and crime at the John Jay College of Criminal Justice, New York, New York. He is the executive director of the Drug Free Schools Coalition, which advocates for drug free schools and student drug testing and the Executive Director of the National On-Site Testing Association. He is special advisor to the World Federation Against Drugs; Special Advisor to the Drug Free America Foundation and Save our Society from Drugs. He is the author of numerous books and articles on drug testing and drug free workplace programs and treatment and has made numerous media appearances. He is the recipient of a number of awards, including, McGovern Award, June, which recognizes innovations in drug abuse prevention that will reduce illegal drug use throughout the nation; the New Jersey Bar Association; Mother's Against Drunk Drivers; Intoxicated Drivers Resource Centers Directors Association; Outstanding Speaker of the Year" by the American Association for Clinical Chemistry; Daughters of the American Revolution Gold Medal for Scholarship and Leadership. He is an emergency medical technician with the Amwell Valley First Aid and Rescue Squad. He received a BA in Sociology from Westminster College, and a graduate of Rutgers Law School and taught courses on alcohol, drugs, crime, and the law at Rutgers University.