Toward a State Drug Enforcement Strategy: A Multi-Sector Needs Assessment

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Ren Hafner, Operations Analyst, Statistical Analysis Center

Samuel Gonzales, Operations Analyst, Statistical Analysis Center

Stefanie Lopez-Howard, Statistical Analysis Center Director

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Introduction

Currently, the State of Georgia does not have an Office on Drug Policy – or similar body tasked with coordinating drug prevention, treatment, and enforcement efforts across the state. As the executive branch agency tasked with coordinating the multiple sectors that comprise the criminal justice system and the other social service agencies, the Criminal Justice Coordinating Council (CJCC) is poised to take on such a role and task. In CJCC's enabling statute, the agency is specifically tasked with maintaining a "research program in order to identify and define significant criminal justice problems and issues and effective solutions" (O.C.G.A. §35-6A-7(4)). The decline in state and federal funds for law enforcement and substance abuse/mental health treatment has forced us to re-examine how we approach drug crime. With this project, CJCC hopes to inform state policy and funding decisions about how to distribute health care and criminal justice dollars toward drug crime prevention and intervention.

The following needs assessment and state drug enforcement strategy sheds light on the numerous activities taking place around drug enforcement and treatment in the state. Moreover, the drug enforcement strategy seeks to bring cohesiveness and new methods to the current state of practice.

The Georgia SAC conducted a comprehensive, statewide needs assessment of various sectors to determine drug enforcement efforts and offender treatment needs. Specifically, SAC surveyed law enforcement, prosecutors, corrections and probation officers, judges, public defenders and community-based substance abuse service providers about what they are seeing with respect to drug use and crime. The survey data was supplemented with information from semi-structured interviews with members of each sector. The SAC interviewed 4 law enforcement personnel, 4 corrections personnel and 3 persons from each other sector. Finally, the SAC analyzed various secondary datasets. These data were further aggregated and mapped to see what kind of drug crime was prevalent in various areas of the state.

In particular, this needs assessment was designed to answer the following research questions:

- What are the drug trends in the State?
- What is the nature of the drug market in the respondent's area?
- What resources do they view as necessary or lacking to successfully combat drug crime and use in their area?
- What resources are readily available to combat drug crime and use in their area?
- Do agencies in their area collaborate to combat drug crime and assist drug users in their area? If so, what is the nature of that collaboration?

Summary of Findings

Drug Trends

Through our mixed method approach, we found that the market for cocaine/crack is steadily decreasing, which can be seen in the response to survey questions about drugs of choice post-2008 and through 4 of the 6 secondary data sources that we analyzed. We also find that the drug markets for methamphetamine and heroin are growing. Although to differentiate between these specific drugs is impossible in the UCR Part II data, almost every other data set showed increased drug seizures, incarcerations, overdose deaths and drug treatment episodes for meth and heroin. With respect to methamphetamine, we found that not only are cartels trafficking the drug, evidenced

through sector interviews and corrections data, but also that methamphetamine is still manufactured in Georgia.

Heroin is on the rise, which can be seen through the drug seizure data and the drug overdose data. However, the magnitude of the heroin problem pales in comparison to marijuana, cocaine and methamphetamine. The number of incarcerations for methamphetamine, which usually ranks below marijuana and cocaine in both use and distribution, are 10.4 times greater than incarcerations for narcotics, which include prescription medications and heroin. The amount of methamphetamine seized by Atlanta's High Intensity Drug Trafficking Area Program (HIDTA) and Multi-Jurisdictional Drug Task Forces (MJDTFs) in 2014 was 15.7 times that of heroin. Treatment for methamphetamine was 9 times that of heroin, but methamphetamine involved overdoses were only 2.7 times that of heroin.

What remains to be seen with respect to heroin is its relationship with prescription opiates, which are involved in the majority of overdose deaths in Georgia. In looking at the treatment episode data, we found some movement between heroin and prescription opiates with regard to primary drug identification, but we cannot conclude much more than a shift in primary drug of choice. The question still remains whether prescription drug users become heroin users or whether people use whichever opiates (heroin or prescription medications) are available.

Quick Facts from Secondary Data Sources

Unified Crime Reports Part II, 2003-2013

- 3% decrease in overall drug arrests
- 79% increase in arrests for marijuana possession
- 74% decrease in arrests for opium or cocaine (narcotics)
- Over half of the drug-related arrests in Randolph, Clayton, Lincoln, Montgomery, Walker, Bacon, Barrow and Gilmer are for the Sale or Manufacture of Drugs

Corrections Data, 2009-2013

- 50% decrease in cocaine incarceration
- 22% increase in methamphetamine incarcerations
- 7% increase in narcotics incarcerations, which includes heroin
- 68% of incarceration are due to supply side activities (Sales and Distribution, Possession with intent to sell, trafficking and manufacture of drugs)
- 91% of marijuana incarcerations are due to supply side activities

HIDTA and MJDTF Seizure Data, 2011-2014

- 42% decrease in cocaine seizures
- 786% increase in methamphetamine seizures
- 152% increase in heroin seizures

Drug Overdose Deaths, 2010-2013

- 11% decrease in cocaine involved deaths
- 36% increase in methamphetamine involved deaths
- 556% increase in heroin involved deaths
- Opiates represent 12% of all drugs identified through toxicology reports, but are associated with 65% of overdose deaths

Treatment, 2009-2013

- 37% decrease in cocaine treatment episodes
- 100% increase in methamphetamine treatment episodes
- 92% increase in heroin treatment episodes
- 10% of heroin abusers shift to prescription opiate treatment for their second criminal justice initiated treatment episode
- 5% of prescription opiate abusers shift to heroin for their second criminal justice initiated treatment episode

Georgia Poison Control Centers

- More than 80% decrease in bath salts and synthetic marijuana (K2) exposures since 2011
- 77% increase in Molly exposure in 2013

Highlights: Areas of Need

There are two distinct categories into which each sector's survey responses could be grouped. Law enforcement and corrections needs fit into a category of organizational needs, whereas the Judicial, Probation, Prosecution/Public Defenders and Treatment sectors focused more on access to resources.

Based on responses to the general survey questions, access to inpatient treatment or suitable treatment for chronic abusers, either more beds or increased affordability, was the leading identified need. Although access to drug treatment is available in some areas or for some people who can afford the price, it is not universal. Issues with access to treatment were highlighted in responses from the Judicial, Prosecution/Public Defender and Treatment sectors. Public defender respondents felt that there were very little sentencing options to meet the needs of drug offenders. Similarly, respondents from the treatment sector raised the need for more accountability courts, but many require residential treatment before they are admitted into the court. Treatment that fit the offenders' specific needs, such as those with co-occurring disorders was also highly recommended.

Respondents also highlighted the need to expand economic opportunities for offenders, including job opportunities for ex-drug offenders or job training and/or resources for those in treatment. Other wraparound resources for those in need of drug treatment were sober housing opportunities, transportation for work and treatment and post treatment follow-up.

Some indicated that a better collaboration between social services, community and criminal justice organizations was needed to combat drug abuse and crime. Responses to questions regarding the strength of community partner working relationships revealed that the two types of organizations with which respondents had the weakest relationships were workforce development agencies and life skills program providers. Moreover, respondents answered "not applicable" most frequently regarding their relationship with these two community partners, and we do not know if that is because they do not want, do not need, or do not have a relationship with workforce development and life skills program providers. Public defender respondents, in particular, identified better collaboration with treatment providers as the 3rd most frequently necessary resource and Prosecution respondents identified better collaboration with law enforcement for better evidence collection for their 2nd

The majority of judicial and prosecution/public defender sector respondents indicated that they had little or no access to assessments tools to identify offender drug problems or the likelihood of a drug offender's recidivating. Without tools like these, sentencing/treatment options that fit the offender's needs are difficult to ascertain

Both law enforcement and corrections respondents identified more staff, better staff pay, and increased staff retention as among the top resources necessary to combat drug use and crime. Law enforcement respondents indicated they needed more drug investigation unit officers or more patrol

officers. Both sectors also indicated a need for better surveillance equipment. Law enforcement also indicated that they needed more funding for training – specifically for drug investigation/interdiction, gang investigations, and community oriented policing. Finally, corrections expressed a need for cell phone blocking to mitigate cell phone use to coordinate drug and other illicit activity.

Introduction

Currently, the State of Georgia does not have an Office on Drug Policy – or similar body tasked with coordinating drug prevention, treatment, and enforcement efforts across the state. As the executive branch agency tasked with coordinating the multiple sectors that comprise the criminal justice system and the other social service agencies, the Criminal Justice Coordinating Council (CJCC) is poised to take on such a role and task. In CJCC's enabling statute, the agency is specifically tasked with maintaining a "research program in order to identify and define significant criminal justice problems and issues and effective solutions" (O.C.G.A. §35-6A-7(4)). The decline in state and federal funds for law enforcement and substance abuse/mental health treatment has forced us to re-examine how we approach drug crime. With this project, CJCC hopes to inform state policy and funding decisions about how to distribute health care and criminal justice dollars toward drug crime prevention and intervention.

Specifically, in the last three years the state of Georgia has embarked on a substantial criminal justice reform and justice reinvestment initiative with the passage of House Bill 1176 (HB 1176) in the 2012 legislative session. HB 1176 contained marquis policy shifts pertaining to the sentencing and management of the drug offender population in Georgia. Historically, drug sentences in Georgia were 1-20 year felony provisions. Additionally, there were little community treatment options. Given that year over year, 14% of new prison admits[1] are due to drug-related crime, HB 1176 established a class felony sentencing structure, additional treatment beds, and an accountability court grant program.

In the 2013 legislative session, Georgia continued its reform efforts with HB 242 (Juvenile Justice Reform) and HB 349. The former was a complete re-write of the juvenile justice code in Georgia. HB 349 created provisions for relaxing mandatory minimum sentencing provisions if both the prosecution and defense on a case are in agreement; and, it codified the Special Council on Criminal Justice Reform. As part of the reform effort, CJCC was tasked with managing the Accountability Court and Juvenile Justice Incentive Grant Programs. The agency also assists with staffing the Reform Committee, which is instrumental to determining future reform and policy efforts.

To begin assessing the scope of the drug crime problem in the state and to determine how to approach a drug enforcement strategy, the SAC conducted preliminary research. We analyzed Georgia Department of Corrections' (DOC) data regarding inmate admissions and the general population; and, we conducted semi-structured interviews with law enforcement and prosecutors. We also analyzed data from CJCC-funded multi-jurisdictional task forces.

DOC data revealed that between 2002 and 2011 the proportion of inmates admitted to DOC primarily for drug offenses declined.[2] In 2011, 14% (7,509 inmates) of inmates admitted to Georgia's prisons were incarcerated primarily for drug offenses. Between 2007 and 2011, drug offenders were most commonly convicted for possession of cocaine, followed by sale and distribution of cocaine.[3]

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[1] Georgia Department of Corrections (DOC), (2002-2011) Annual Reports. Retrieved from: http://www.dcor.state.ga.us/Research/Annual_FY_GDC_annual_reports.html. DOC (2002-2011), Annual Reports.
[2] DOC (2002-2011), Annual Reports.
[3] Ibid.

While drug offenders make up 14% of the total inmate population, they comprise one-third of the total probation population. In 2011, there were 53,238 drug offenders on probation. This astounding figure is almost equal to the total number of inmates in Georgia's prisons.[4] Drug offending is not the only cause for concern in the law enforcement and correctional systems. The most recently issued monthly profile of all of the inmates in DOC custody, at the time of authoring this report, showed that 25% (13,354) of male and 14% (549) of female inmates have some substance abuse issue.[5]

These staggering substance abuse and drug offense figures portend a tremendous burden on the criminal justice and community mental health systems. Various state, federal, and local law enforcement agencies are all working on investigation and pursuing drug crime in the state. While we did find some coordination – particularly between federal agencies and the GBI, no person with whom we spoke was able to articulate an overall structure for the way drug enforcement is done in Georgia.

Atlanta High-Intensity Drug Trafficking Area (HIDTA) generates the largest efforts with regard to interstate and international anti-drug trafficking enforcement in Georgia. Without equivocation, HIDTA, the National Guard, and the Georgia Bureau of Investigation (GBI) recognize the Atlanta-metro area as a major trafficking and drug distribution hub. The interstate highway system that intersects in Atlanta makes this city attractive for moving drugs from the border and the West coast to the north- and southeast. HIDTA's efforts to police the interstates coming into Atlanta via the Georgia Highway Enforcement Initiative in the State Patrol have proven somewhat successful. Trafficking organizations have recently been using alternate – less efficient – routes to bring drugs into Atlanta for redistribution throughout the eastern seaboard. HIDTA also reports that drug loads have become smaller to avoid the risk of having a larger load seized. [6]

Elsewhere in the state, drug enforcement is handled in either local police departments (for example, Dublin PD in Laurens County has a narcotics unit); via a GBI regional drug enforcement office if the case meets criteria or they are called in, or via CJCC-funded drug task forces.[7] In areas where task forces exist, they may be the only agency doing drug enforcement work. For example, ninety county Sheriff's Offices have canine capabilities for drug investigations and enforcement.[8]

Statewide, the Governor's Task Force on Marijuana Eradication has the very narrow mission of finding and eradicating locally grown marijuana in Georgia.[9] DEA Asset Forfeiture funds pay for the task force expenses including gear, helicopter maintenance, fuel, logistics of moving task force agency members (15 people in the core group) and other expenses. The task force has been in operation since 1984 and currently consists of seven agencies. In addition to the Governor's Task Force, the Georgia National Guard has a counter-narcotics unit that not only collaborates with the task force, but also provides logistical support to local agencies and HIDTA. The National Guard's services are available upon request, however, and may not be a consistent part of drug enforcement efforts throughout the state.

[4] DOC (2002-2011), Annual Reports.
[5] Georgia Department of Corrections (2013 March 1). Inmate Statistical Profile: All Active Inmates. Retrieved from: http://www.dcor.state.ga.us/Research/Monthly_Profile_all_inmates.html.
[6] Atlanta High Intensity Drug Trafficking Area (Atlanta HIDTA), 2011 Annual Report, Personal communication, Jack Killorin, Executive Director, Atlanta High Intensity Drug Trafficking Area Task Force, September 21, 2012.
[7] Georgia Bureau of Investigations, Inspector Chris Hosey, interview September 28, 2012.
[8] Personal Communication, Terry Norris, Executive Director, GA Sheriff's Association, October 16, 2012.
[9] Marijuana Eradication Task Force, interview with Commander Lt. Eddie Williams, September 24, 2012.

The trafficking and abuse of illicit drugs continue to constitute a dynamic and challenging threat to the State of Georgia, and the nonmedical use of controlled prescription drugs has become the state's fastest growing drug problem. It poses a significant drug threat and places a considerable burden on law enforcement and public health resources. The Prescription Drug Monitoring Program (PDMP) database became available to law enforcement, doctors and pharmacists beginning in January 2013 and is still operating with limited funding. More importantly, law makers added restrictions on how the database could be used, allowing only physicians, and pharmacists to review patients' prescription histories for controlled substances.

The abuse of synthetic designer drugs has emerged as a serious problem in the state as well. The abuse of synthetic cannabinoids, such as "K2" and "Spice", and synthetic cathinones, such as "bath salts", rapidly increased over the past few years, causing severe consequences to abusers. Georgia passed a law in May 2010 that banned specific chemical compounds and brands, yet many head shop owners continued to distribute alternative brands that contained synthetic cannabinoids that were not initially banned. In March 2012, Governor Nathan Deal signed a law that closed a loophole that synthetic marijuana distributors were exploiting. Georgia's new synthetic marijuana law, Senate Bill 370 (SB 370), bans all forms of synthetic cannabinoids and any possible future compounds or derivatives from being sold or possessed in Georgia. However, producers of synthetic marijuana have recently reformulated their product with chemicals not covered by SB 370. Moreover, some shop owners continue to keep the banned synthetics on hand, but hidden in the store, and sell it only to customers they trust.

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Methodology and Data Sources

Statewide Stakeholder Committee

As the project progressed, the SAC selected statewide stakeholder committee members – comprised of both persons who were identified as individuals within key agencies that interface with substance abusers, drug offenders, and their families.

The stakeholder committee consists of representatives from the following agencies:

- Accountability Court Judges
- Council of Juvenile Court Judges of Georgia
- Division of Family & Children Services
- Georgia Association of Chiefs of Police
- Georgia Bureau of Investigation
- Georgia Department of Behavioral Health and Developmental Disabilities
- Georgia Department of Corrections
- Georgia Department of Public Safety
- Georgia Gang Investigator's Association
- Georgia Narcotics Officers Association
- Georgia Public Defenders Standards Council
- Peace Officers Association of Georgia
- Prosecuting Attorney's Council of Georgia
- Georgia State Board of Pardons and Parole
- Governor's Office on Transition, Support, and Reentry

A total of four stakeholder meetings were held for this research project. The stakeholder committee provided invaluable insights and suggestions for this comprehensive needs assessment.

In an effort to address the scope of this project, this study is organized into two parts. First, we conducted an extensive series of interviews. Second, we created an online survey tool to gather more information from on-the-ground experts in each sector. These findings are discussed at-length in the online survey portion of the findings section.

Semi-Structured Interviews

In November 2013, CJCC hosted the project kickoff meeting. At the end of the meeting, attendees were asked to send the names of up to three persons who they thought were experts on drug use and crime trends in their field so that CJCC could randomly select persons for interviews. Attendees submitted 29 names for potential interviewees and 20 of those persons were randomly selected for an interview. Interviewees were experts on drug abuse and crime trends in their field, including Law Enforcement (4 interviewees), Corrections (2 interviewees), Court Judges (3 interviewees), Probation Officers (3 interviewees), Prosecution (3 interviewees), and Treatment Providers (3 interviewees). These interviewees also represent different jurisdictions of the state: 4 interviewees from Central Georgia (Cities of Forsyth, Macon, and Milledgeville), 1 interviewee from Southwest Georgia (City of Albany), 4 interviewees from Southeast Georgia (Cities of Statesboro, Savannah and Brunswick), 1 interviewee from South Georgia (City of Valdosta), 1 interviewee from East Georgia (City of Thomson), 4 interviewees from West of Georgia (Cities of LaGrange and Thomaston), and 4 interviewees from Atlanta Metropolitan Area including Cities of Jackson (Newton County), Atlanta and Marietta.

Semi-structured interview questionnaires were created in January 2014 and distributed to the stakeholder committee for comment and feedback. (Appendix A provides a list of interview questions.) From mid-February to mid-March 2014, the SAC conducted 18 interviews, which were recorded for transcription. Interviews lasted between 45 to 120 minutes. All tape recordings were sent for verbatim transcriptions and by the end of March, 2014 19 transcripts were returned to CJCC as Microsoft Word documents. The Operations Analyst and intern who conducted the interviews, proofread the transcripts for accuracy with the audio recordings and made necessary edits to reconcile differences. One of the selected interviewees was unavailable and no other interviews were scheduled due to time constraints. These same staff members identified the common themes, keywords, and phrases, which provided the basis for the coding schema. The coding schema was developed in early April 2014 and it included 41 categories based on 252 keywords or phrases.

Two different SAC staff, 4 total, were assigned to each of the 19 interviews to code them independently. The Operations Analyst who conducted all the interviews did not code any interviews. The coding process was managed through a log that included the agency interviewed, the interviewee's title, the sector the person represented, the interview date, the recording number, the recording length, who proof read the document and the staff assigned to the coding. Each staff member created a copy of the transcript with their codes and a file was also maintained with the original proofread transcript. The goal of this was to preserve the original transcript and to eliminate potential influence in the coding process between SAC staff.

Coding the interviews consisted of each assigned SAC staff independently reading and identifying key words or phrases that matched one or more of the 41 categories in the schema and marking it within the transcript as a "Comment" in Microsoft Word. Then one of the SAC staff members used the "Navigation" function in Microsoft Word to search and count how many times the interviewee made a point related to a category in the schema. These counts were recorded in the schema/log.

From the interview log, a sum of the total categorical responses identified by each coder was calculated for all six sectors (Corrections, Courts, Law Enforcement, Probation, Prosecution and Treatment). Drug types were grouped into 9 categories, and were separated from the rest of the themes in the schema. The remaining themes were summarized into 32 categories. For each interview, we summed the number of times both SAC staff members identified a particular theme. The top themes were then ranked based on these sums. We then classified each interviewee's response based on the top 3 drugs identified for each sector and the top 5 theme categories.

Through the coding process we identified a discrepancy with categorical responses coded as "Seller" and "User" characteristics. Originally the "Seller" characteristics theme ranked in the top 5 in all six sectors and the "User" characteristics theme ranked in the top 5 in three sectors. Upon reviewing the coded interviews, we identified 38 miscoded statements (33 "Seller" and 6 "User" characteristics) that needed to be switched (i.e. "Seller" to "User" or vice versa). Due to this issue, we discarded analysis of these themes for two sectors (Courts and Treatment) because it significantly decreased the categorical responses. In the remaining sectors (Corrections, Law Enforcement, Probation and Prosecution) the discrepancies were not significant enough to alter categorical rankings.

The time-consuming coding process then laid the ground work for SAC to brainstorm the online survey questions.

Online Survey

As part of the larger, comprehensive assessment of Georgia's drug enforcement and treatment strategy, the SAC implemented a survey of on-the-ground experts in each identified sector. Those experts came from law enforcement (sheriffs, police departments, GBI, DEA, U.S. Marshalls, and State Troopers), prosecution and public defense, corrections, probation, courts and substance abuse treatment providers. The goal of the survey was to help determine the best strategy for Georgia's future drug enforcement and treatment activities based on current issues and trends. The survey inquired about key areas including: communication, training, goals, resources and collaboration. The final survey consisted of 48 questions, which started with a series of general questions about substance abuse and drug crime in the respondent's service area.

Additional sector specific questions were asked following the general questions. We asked a series of similar questions in certain sectors so we could compare responses. However, distinct questions added great value to the survey, as each sector communicated resources, needs, and trends specific to their area. This also allowed us to draw statewide comparisons. The survey questions were administered electronically through a SPSS survey package using randomly generated usernames and passwords to ensure respondent confidentiality.

At the beginning of November 2014, stakeholder committee members emailed potential respondents in their sector to alert them about the survey's release. A total of 3,739 prospective participants were contacted. The message advised the participants that they would be receiving survey links and log-in credentials in the near future, informed recipients of the purpose of the study, and asked for their participation. The survey release email contained a summary of the survey project and a hyperlink with a username and password. The survey period extended through the entire months of December 2014 and January 2015, providing prospective participants two full months to respond. Stakeholders and CJCC staff sent reminders with contact information for SAC staff in case of questions/concerns. By the end of January 2015, 955 completed surveys were received, resulting in a response rate of 26%. Appendix B contains a list of all survey questions, and the specific sector response rate information is included in the table below.

Table 1. Response Rate by Sector

Sector	Number of Participants Responded	Number of People Surveyed	Response Rate
Correction	195	195	100%
Probation	213	243	88%
Public Defender	33	48	69%
Treatment and Prevention Provider	65	135	48%
Law Enforcement	194	664	29%
Courts	122	449	27%
Prosecution	133	2,005	7%
TOTAL	955	3,739	26%

Secondary Data Sources

Uniform Crime Report Part II Drug Arrest Data

The Georgia Uniform Crime Reporting (UCR) program is part of a nationwide, cooperative statistical effort administered by the Federal Bureau of Investigation. The UCR program collects data on known

offenses and persons arrested. These data are used in law enforcement administration, operation and management, as well as to indicate fluctuations in the level of crime throughout America.

Georgia has voluntarily participated in this program since 1975. The Georgia Crime Information Center receives monthly crime and arrest reports from more than 600 state and local law enforcement agencies. For this report we focused on UCR Part 2 drug arrests (codes 18a through 18h) from 2003 to 2013. The eight categories of drug offenses delineate between supply and demand activities that include the sale/manufacture or the possession of drugs. The drug classifications include opium or cocaine (18a, 18e), marijuana (18b, 18f), synthetic narcotics (18c, 18g), and other non-narcotics (18d and 18h). We did not receive any data on the possession of synthetic narcotics (18h), so it is not included in our analysis.

Georgia Department of Corrections Prison Intake and Contraband Arrest Data

The Georgia Department of Corrections (GDC) maintains its administrative records through a database named SCRIBE. For this report, we used intake data from 2009 to 2013 and contraband data from 2010 to 2013 that is maintained through the SCRIBE system. The intake data collection is part of a process that starts when convicted felons first enter the Georgia prison system through the Georgia Diagnostic and Classification State Prison in Jackson, Georgia. Here, new inmates go through medical and mental health screening and they are also evaluated to determine in which facilities they will serve their sentences. The contraband data that we used was for drug-related contraband arrests.

To better understand the nature of Georgia drug incarcerations, we conducted a text analysis on the primary drug offense variable. We split the text in the primary drug offense variable into two independent variables – one for primary drug and a second new primary offense variable. The new primary offense variable was comprised of one of the following categories: manufacture, possession, possession with the intent to distribute, sale and distribution, trafficking and other. The creation of the two variables allowed us to conduct specific drug conviction analysis and to create subcategories for drug possession and drug sales incarcerations so we could examine both supply and demand related incarcerations.

State Drug Seizure Data

The state drug seizure data is a combination of data sets that include drug seizures from Georgia High Intensity Drug Trafficking Area (HIDTA) and Multi-jurisdictional Drug Task Forces (MJDTF) from 2011 to 2014.

The HIDTA program is administered by the White House Office of National Drug Control Policy and supports Federal and Local law enforcement agencies' work to disrupt the illegal drug market. Our HIDTA data came from the Atlanta-Carolinas HIDTA program but only includes seizure data for Metro Atlanta, DeKalb County, the Georgia Domestic Highway Enforcement initiatives and task forces. The drug quantities are measured in grams or in Standard Drug Units, which equal one pill.

At the time of publication, CJCC funded 18 regional/county Multi-jurisdictional Drug Task Forces in Georgia with Edward Byrne Justice Assistance Act grants. Their goal is to enhance inter-agency collaboration to better enforce the Georgia Substance Control Act and to stay ahead of emerging drug trends. We used grant activity data for CJCC-funded MJDTFs. All MJDTF seizure data is measured in grams, which did not allow us to fully combine the two data sets because HIDTA measures prescription drug seizures and ecstasy in drug units of one pill.

Statewide Drug Overdose Data

The SAC obtained statewide drug overdose deaths data from the Georgia Bureau of Investigation's (GBI) Medical Examiner's Office (MEO), which provides toxicology screening and death investigation services to 152 counties; and, DeKalb, Fulton, Gwinnett and Cobb County Medical Examiner's Offices, which performed autopsies and toxicology for the remaining seven counties. The data included cases in which drug overdose was identified as the cause of death or a significant contributing factor in the death for the years 2010 through 2013. The drugs were identified through toxicology reports ordered during the autopsies. The data did not include toxicity level or, if multiple drugs were identified, which drug or drugs were the primary cause of death.

Drug Addiction Treatment Program Enrollment Data

The SAC obtained an extract of the Treatment Episode Data Set (TEDS) from the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), which maintains the data for the Substance Abuse and Mental Health Services Administration. The data we used includes criminal justice initiated drug treatment admissions from 2009 to 2013 in facilities that received State funding or Federal Block Grants from DBHDD.

DBHDD provided a random unique identifier for individuals who seek treatment so we were able to capture multiple treatment episodes for one person. We restructured the data from multiple cases into one treatment record for each individual. The restructure created a count for each treatment episode. The maximum number of treatment episodes captured for one individual was six. All analysis was done using the individual recoded information with the exception of summaries for Primary Drug Type, Marital Status, Education Level and Living Arrangements due the nature of this data varying between 2009 and 2013. For these four variable the analysis is based on the originally structured treatment episodes data and may include duplicate counts for individuals with multiple treatments.

Human Exposure on Synthetic Marijuana, Molly and Bath Salts

Since 1970, the Georgia Poison Center (GPC) has operated the 24-hour poison emergency treatment information service, providing assistance and expertise in the medical diagnosis and management of human and animal poisonings.

The GPC is housed at the Grady Health System and operates under the supervision of the Department of Pediatrics of Emory University School of Medicine. The Center is staffed with a dedicated group of highly trained professionals including physicians, toxicologists, registered nurses, registered pharmacists, health educators and computer specialists. The GPC was designated the official State poison center in 1976, when the Georgia Department of Human Resources (DHR) secured its non-profit funding.

A leader in poison prevention activities, the GPC is one of 57 centers nationwide. The center is the only one in Georgia and is certified and accredited as a Regional Poison Center by the American Association of Poison Control Centers (AAPCC). The AAPCC is the governing body and runs the centralized database for poison centers nationwide. The AAPCC compiles toxic exposure data in cooperation with poison centers and develops the national standards and certification process that ensure the quality of poison emergency services.

For our analysis we used human exposure call data during the period from 2010 to 2013, which included demographic and medical outcomes information.

Medical Outcome Definitions:[10]

No Effect: The patient did not develop any signs or symptoms as a result of the exposure.
Minor Effect: The patient developed some signs or symptoms as a result of the exposure, but they were minimally bothersome and generally resolved rapidly with no residual disability or disfigurement. A minor effect is often limited to the skin or mucus membranes (e.g., self-limited gastrointestinal symptoms, drowsiness, skin irritation, first-degree dermal burn, sinus tachycardia without hypotension, and transient cough).

Moderate effect: The patient exhibited signs or symptoms as a result of the exposure that were more pronounced, more prolonged, or more systemic in nature than minor symptoms. Usually, some form of treatment is indicated. Symptoms were not life-threatening, and the patient had no residual disability or disfigurement (e.g., corneal abrasion, acid-base disturbance, high fever, disorientation, hypotension that is rapidly responsive to treatment, and isolated brief seizures that respond readily to treatment).

Major Effect: The patient exhibited signs or symptoms as a result of the exposure that were life-threatening or resulted in significant residual disability or disfigurement (e.g., repeated seizures or status epilepticus, respiratory compromise requiring intubation, ventricular tachycardia with hypotension, cardiac or respiratory arrest, esophageal stricture, and disseminated intravascular coagulation).

Death: The patient died as a result of the exposure or as a direct complication of the exposure.

Not followed, judged as nontoxic exposure: No follow-up calls were made to determine the outcome of the exposure because the substance implicated was nontoxic, the amount implicated was insignificant, or the route of exposure was unlikely to result in a clinical effect.

Not followed, minimal clinical effects possible: No follow up calls were made to determine the patient's outcome because the exposure was likely to result in only minimal toxicity of a trivial nature. (The patient was expected to experience no more than a minor effect.).

Unable to follow, judged as a potentially toxic exposure: The patient was lost to follow-up, refused follow-up, or was not followed, but the exposure was significant and may have resulted in a moderate, major, or fatal outcome.

[10] The Georgia Poison Center used the medical outcome definitions set by the American Association of Poison Control Centers (AAPCC)

Findings

This section consists of our findings from the secondary data analysis, semi-structured interviews and the online survey.

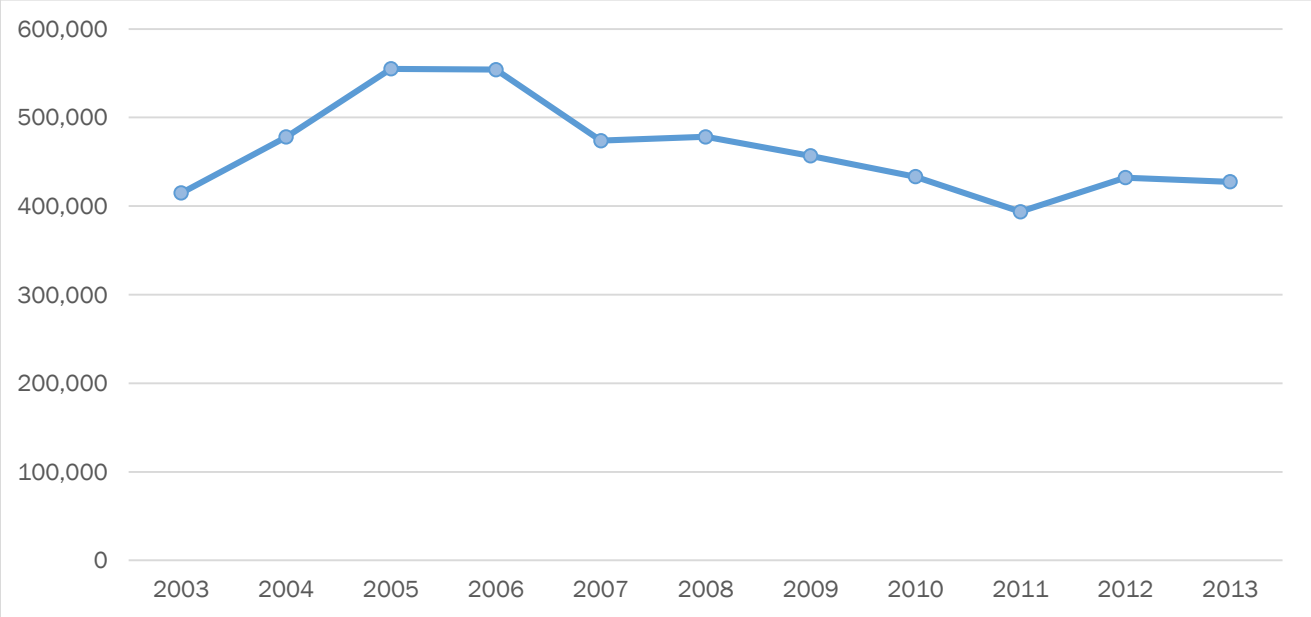
Public Safety

Uniform Crime Report Part II Drug Arrest Data

During the eleven year period, from 2003 to 2013, state and local law enforcement agencies made close to 5.1 million drug-related arrests. These arrests ranged from the sale and manufacture to the possession of controlled illicit substances. In these 11 years, City of Atlanta Police Department (APD) arrests accounted for 42% (2,149,429) of all drug-related arrests in Georgia. To conduct county analysis, APD arrests were split between DeKalb and Fulton counties. Based on the proportion of Atlanta's square mileage that falls within each county, we allocated 90% of arrests to Fulton County and 10% to DeKalb. When county police department arrests are factored in with APD's activity, Fulton (41%) and DeKalb (9%) counties accounted for half of all drug-related arrests (2,541,498) during this time period. As compared to the volume of arrests in Cobb County, which ranked third in arrest volume during this time, there were almost eight times as many arrests in Fulton and twice as many in DeKalb. One hundred and forty four of the 159 counties each accounted for less than 1% of all the drug-related arrests in this 11 year period.

From year-to-year the number of arrests varied substantially. Georgia had experienced a 16.1% increase in drug-related arrests in 2005, however, the statistics had a drastic 14.5% decline in 2007. Overall, Georgia had experienced a 3% increase of drug-related arrests from 2003 to 2013 and since 2008 arrests have not fluctuated by more than 10% in either direction.

Figure 1. Number of Drug Arrests, 2003-2013



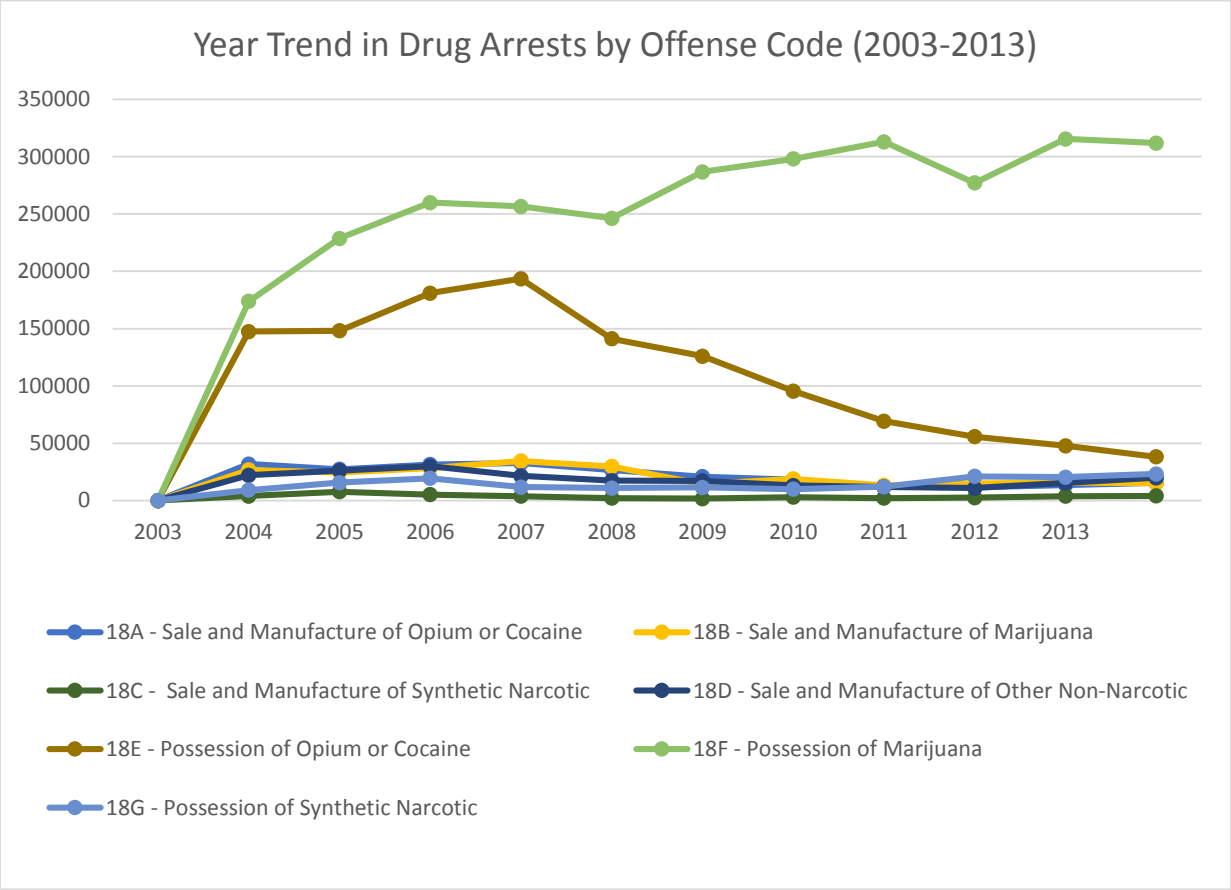
Georgia county level drug arrests data was much similar to the statewide picture. From year-to-year the number of arrests varied substantially with no consistent trend. Some counties such as Forsyth

saw increases in arrests from 29 in 2003 to 6,043 in 2013, which equaled to an over 20 thousand percent increase in arrests.

Type of Offenses

Of the drug-related arrests in Georgia from 2003 to 2013, 58% (2,967,341) were due to marijuana possession and 24% (1,243,423) were due to opiate or cocaine possession. Marijuana possession arrests steadily increased by 79% during this period and arrests due to Opium and Cocaine possession declined by 74%. Arrests attributed to possession accounted for 86% of all drug-related arrests, and arrests made due to the sale or manufacture of drugs accounted for just 14%. The largest increase in arrests resulted from the possession of synthetic narcotics, which grew from 9,141 to 23,224 arrests or a 154% change.

Figure 2. Year Trend in Drug Arrests by Offense Code, 2003-2013



Top Ten Jurisdictions by Drug Offenses

The table below illustrates the top 10 counties with highest arrest rates for individuals who sell/manufacture or possess drugs from 2003 to 2013. The majority of arrests were reported in counties located near the metropolitan areas. Cobb was the only county that made the top-ten list for all seven offenses, followed by Fulton County (6 offenses) and Chatham County (5 offenses).

Fulton County ranked first for sale/manufacture (18A) and possession of cocaine or opium (18E) and possession of marijuana (18F). Clayton County ranked first for two offenses, the sale and manufacture of marijuana (18B) and the sale and manufacture of other non-narcotic drugs (18D).

Whitefield County ranked first in the sale and manufacture of synthetic narcotics (18C) and Cobb ranked first in arrests related to the possession of synthetic narcotics (18G).

Table 1. Top Ten Jurisdictions by Drug Offenses

Ranking	18A Sale and Manufacture of Opium or Cocaine	18B Sale and Manufacture of Marijuana	18C Sale and Manufacture of Synthetic Narcotics	18D Sale and Manufacture of Other Dangerous Non-Narcotics	18E Possession of Opium or Cocaine	18F Possession of Marijuana	18G Possession of Synthetic Narcotics
1	Fulton	Clayton	Whitfield	Clayton	Fulton	Fulton	Cobb
2	Muscogee	Fulton	Fulton	Fulton	DeKalb	DeKalb	Douglas
3	Richmond	Houston	Cobb	Bibb	Richmond	Cobb	Bartow
4	DeKalb	DeKalb	Jones	Cobb	Cobb	Richmond	Whitfield
5	Chatham	Chatham	Hall	Gwinnett	Chatham	Chatham	Hall
6	Troup	Fayette	Douglas	Muscogee	Laurens	Bibb	Rockdale
7	Cobb	Bibb	Richmond	Whitefield	Lowndes	Muscogee	Houston
8	Lowndes	Muscogee	Chatham	DeKalb	Clarke	Douglas	Cherokee
9	Coweta	Cobb	Gilmer	Barrow	Bibb	Gwinnett	Henry
10	Houston	Richmond	Banks	Gordon	Spalding	Henry	Jackson

Age

Fifty-eight percent (2,940,040) of all arrestees were individuals 15 to 29 years of age. Those 20 to 24 years of age were arrested at much higher frequencies than any other age group. These arrestees accounted for 32% (1,648,161) of all drug-related arrests. The second largest age group at 15% (769,409) of those arrested were 15 to 19 years of age. When looking at the age distribution of arrests for possession and the sale/manufacture of drugs, arrests clearly tend to decrease as arrestee age increased beyond 25 years old. For arrests attributed to possession of Marijuana and Cocaine/Opium (18E and 18F), those 20 to 24 years of age were arrested at least 2 and 2.6 times more often than other age groups.

Offense by Age over Time

Arrests for the manufacture/sale of cocaine and opium decreased in every age group except for those 60 to 64 years old, which increased by 7%. By comparison, possession of cocaine or opium arrests declined for every age group by at least 60%. Arrests related to the sale or manufacture of

marijuana increased for those 10 to 14 years of age (35%)[11] and those 60 and older (53%). Arrests for marijuana possession increased for every age group over the age of 10, but a steeper increase (180%) occurred for those 55 and older. Arrests for synthetic narcotics had one of the fastest rates of growth for those 55 and older, with an increase of 433% for the sale/manufacture and 939% for possession. The increase in arrests for synthetic narcotics coincide with a

Gender

Overall, males accounted for two-thirds of drug-related arrests in the past 11 years. However, the highest proportion of drug arrests that are female are for opium/cocaine possession and synthetic narcotics possession where females represent 38% and 35% of the total arrests for that drug category.

Race

Close to 99% of arrestees were either African Americans (72%, 3,688,952) or Caucasians (27%, 1,392,708). African Americans were the only racial group for which the number of arrests declined (5% decrease) from 2006 to 2013. There were 15,186 fewer arrests for African Americans; whereas, there were 27,406 more Caucasians arrested in this time frame, a 23% increase. Interestingly, arrests of Asian and Native American persons increased even more sharply, by 44% and 48%, respectively, as compared to Caucasians. However, arrestees from these two racial groups represented less than 0.31% of all drug arrests in Georgia.

The types of crimes for which persons of different races were arrested tended to differ. Caucasians comprised the majority of arrests related to the possession (83%) and manufacture or sale (78%) of synthetic narcotics. African Americans were arrested more often for the possession and the sale or manufacture of opium/cocaine (78%, 83%), and marijuana (71%, 73%).

Gender and Race

When looking at gender and race together, African American males accounted for 47% (2,417,537) of all drug-related arrests, followed by African American females (25%, 1,271,415), Caucasian males (19%, 978,905) and Caucasian females (8%, 413,803) were third and fourth most frequently arrested. For all races and genders, the only two groups for which the number of arrests declined were African American females (-7%) and males (-4%). For female Caucasians, Asians and Native Americans, the growth in drug-related arrests outpaced males in their respective racial groups by at least 10%.

Arrests and Population

To better understand the magnitude of drug-related arrests, we calculated the arrests per 100 residents for each county. During 2003 to 2013, on average 24 residents were arrested for drug crimes per 100 residents in each county. Fifty-one counties exceeded this average and the top ten were listed in the table below. Fulton, Twiggs and Richmond were the only counties to exceed 100 arrests per 100 residents with 213, 123 and 102 arrests. Of these 10 counties, Fulton (Atlanta)

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[11] Of note, findings from Georgia's Youth Risk Behavior Survey indicate that any marijuana usage (used one or more times during life) has consistently, though minimally, declined among high school students between 2003 and 2013 (from 38% to 36%). By comparison, the percentage of middle school students who report ever using marijuana has remained constant at around 10-11% during that time period. *See,* Georgia Department of Public Health (2013). Youth Risk Behavior Survey Results, Georgia High School Survey: Trend Analysis Report. Retrieved from: http://dph.georgia.gov/sites/dph.georgia.gov/files/2013_HS_YRBS_TrendReport.pdf. 25 June 2015; and also, Georgia Department of Public Health (2013). Youth Risk Behavior Survey Results, Georgia Middle School Survey: Trend Analysis Report. Retrieved from: http://dph.georgia.gov/sites/dph.georgia.gov/files/2013_MS_YRBS_Trend_Report.pdf. 25 June 2015.

Richmond (Augusta), Bibb (Macon) and Douglas (Atlanta Metro) made the top-ten list for at least 3 different types of drug-related arrests.

Based on the 2013 Census data, the average county population was 43,342 if DeKalb, Fulton, Gwinnett and Cobb counties were excluded (62,844 otherwise). Five of the counties with the highest arrests per 100 residents had populations well below the state average and do not include a major city in their jurisdiction. Nine of the top ten counties have at least one major interstate running through them. The percentage of drug sale/manufacture arrests was 8% lower than the state average, however, the percentage of drug possession arrests were 8% above the state average.

Table 2. Top Ten Counties with the Highest Arrest per 100 Residents, 2003-2013

Ranking	County	Population	Arrests Per 100 Residents
1	Fulton	984,293	213
2	Twiggs	8,481	123
3	Richmond	202,003	102
4	Dooly	14,304	96
5	Spalding	63,829	82
6	Bibb	154,721	82
7	Monroe	26,984	74
8	Taliaferro	1,703	73
9	Butts	23,361	72
10	Douglas	136,379	72

County Difference in Possession and Sale and Manufacture

In 69% (109) of Georgia counties, possession accounted for three quarters of all drug-related arrests. In only 11 counties, arrests due to sale or manufacture of drugs exceeded 50%. The top-ten counties for the number of arrests for possession and for sale or manufacture of drugs are listed in the Table 4 below.

Table 3. Top Ten Counties for Drug Possession and Sale or Manufacture Arrests, 2003-2013

Ranking	County	% of Arrests for Possession	County	% of Arrests for Sale or Manufacture
1	Burke	98%	Randolph	86%
2	Marion	97%	Clayton	75%
3	Telfair	97%	Lincoln	71%
4	Madison	97%	Montgomery	67%

Ranking	County	% of Arrests for Possession	County	% of Arrests for Sale or Manufacture
5	Talbot	95%	Walker	64%
6	Grady	95%	Bacon	63%
7	Paulding	95%	Barrow	57%
8	Henry	94%	Gilmer	57%
9	Peach	94%	Jefferson	55%
10	Newton	94%	Lanier	52%

Map Analysis

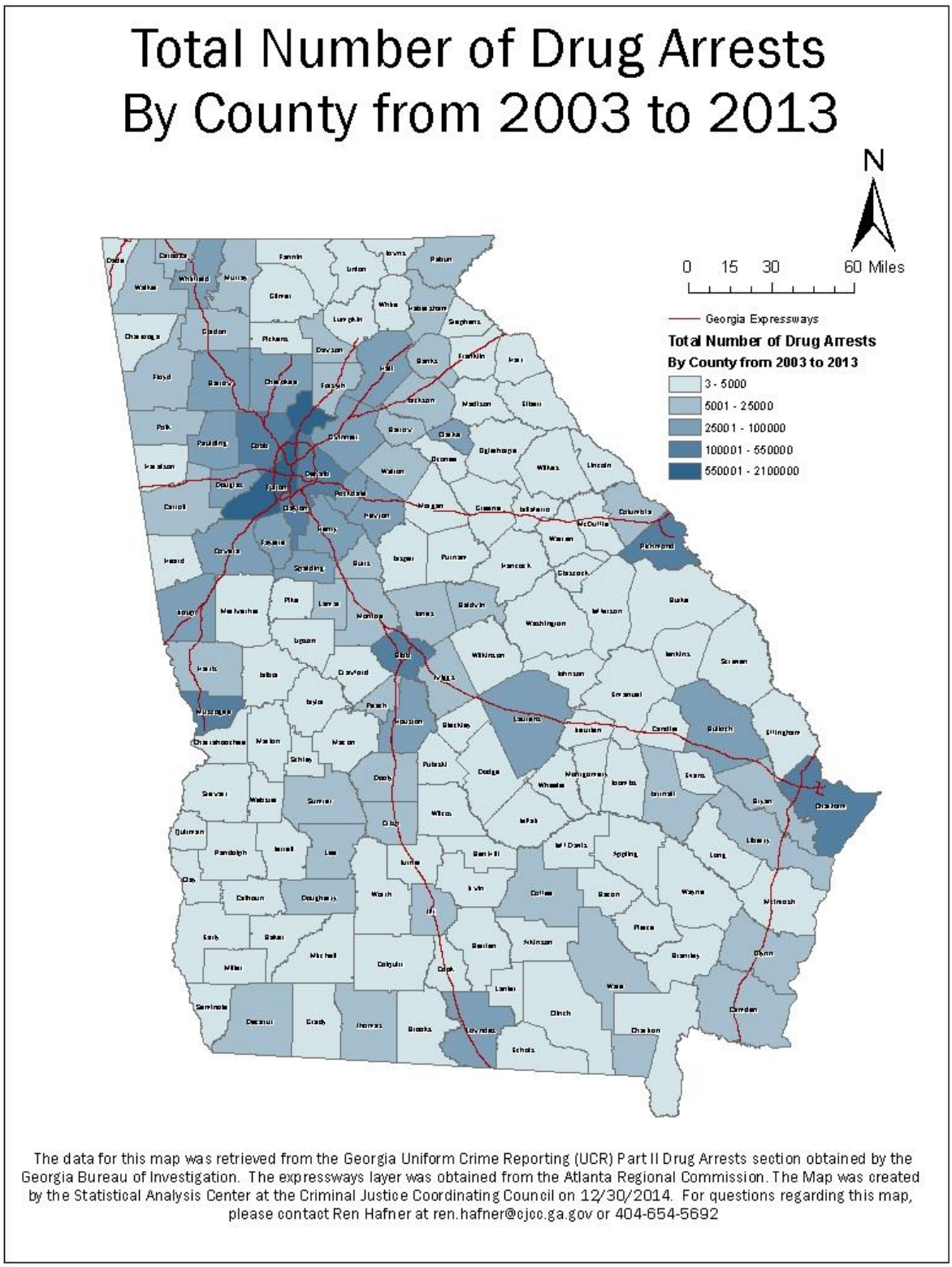
Generally, all drug-related arrests from 2003 to 2013 were concentrated along Georgia's interstate corridors. These included I-75 from Ringgold to Macon, I-85 from I-185 to South Carolina and State Route 400 (US 19) North of Atlanta. While arrests for marijuana occurred more frequently around the interstate corridors, arrests for opium or cocaine were distributed throughout the state. Arrests for synthetic narcotics and non-narcotic drugs were concentrated in the northwestern portion of Georgia.

Two patterns emerged in our descriptive spatial analysis. First, arrests for possession were much higher in counties near or in metropolitan areas with the exception of synthetic narcotics. Second, arrests for the sale or manufacture of drugs occurred at higher frequencies along interstates, highways and rural counties. For example, the largest number of marijuana arrests occurred in the major metropolitan areas of Georgia, which included the cities of Atlanta (Fulton, DeKalb and Cobb), Augusta (Richmond), Savannah (Chatham), Columbus (Muscogee), and Macon (Bibb). Comparatively, the county with the most arrests due to the sale or manufacture of marijuana was Clayton County. Anecdotally we heard during interviews with law enforcement and prosecutors that Clayton County is a hub for stash houses used to store drugs in transit. Generally, increased arrests due to the sale or manufacture of marijuana followed Georgia's major highways.

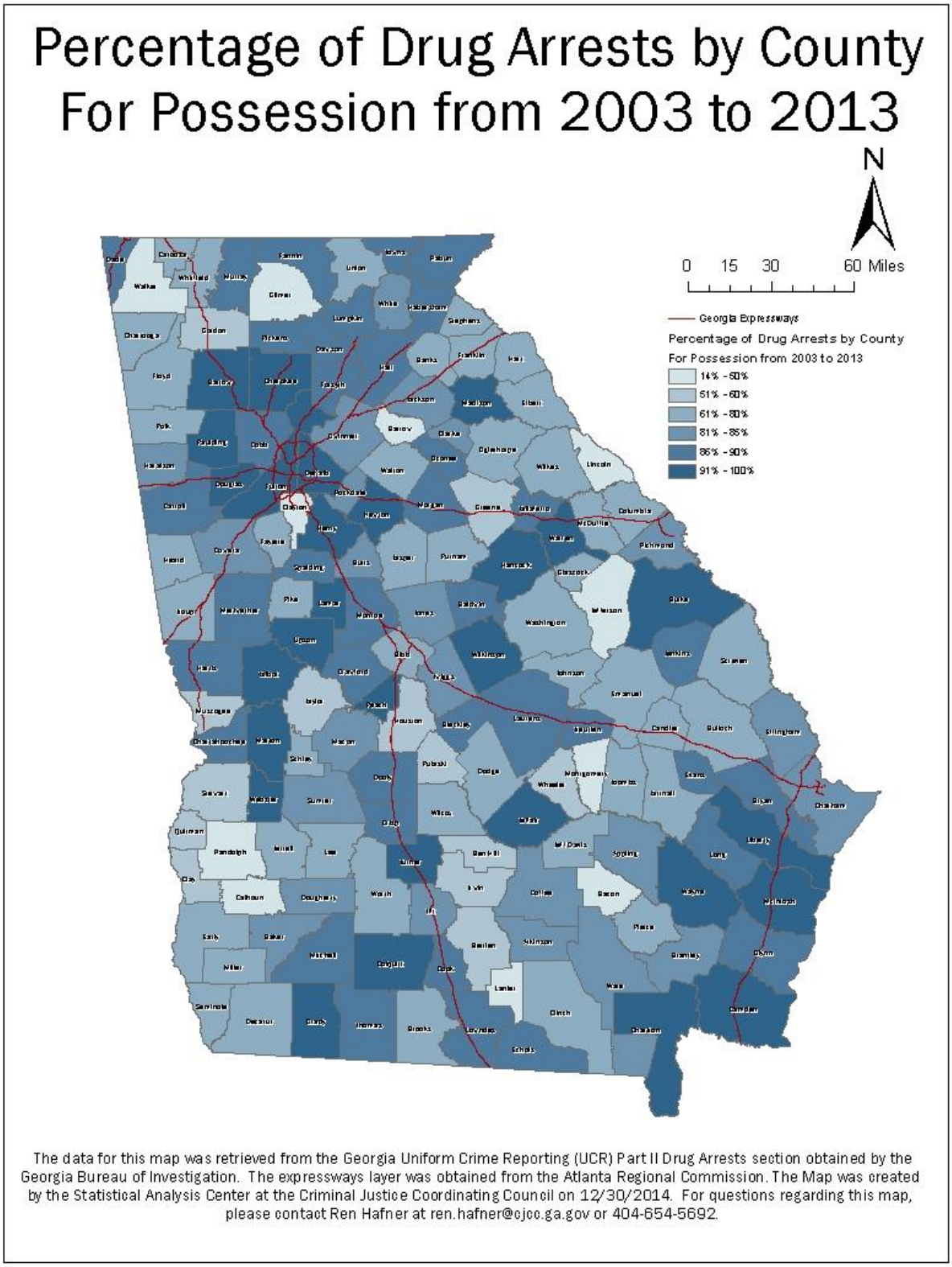
Arrests for possession and sale/manufacture of synthetic narcotics were most concentrated in the northwestern half of the state, with the epicenters of Cobb (possession) and Whitfield (Sale/Manufacture) Counties. Higher rates of arrests for the sale or manufacture of synthetic narcotics also occurred in Chatham and Richmond counties.

UCR Part II Maps

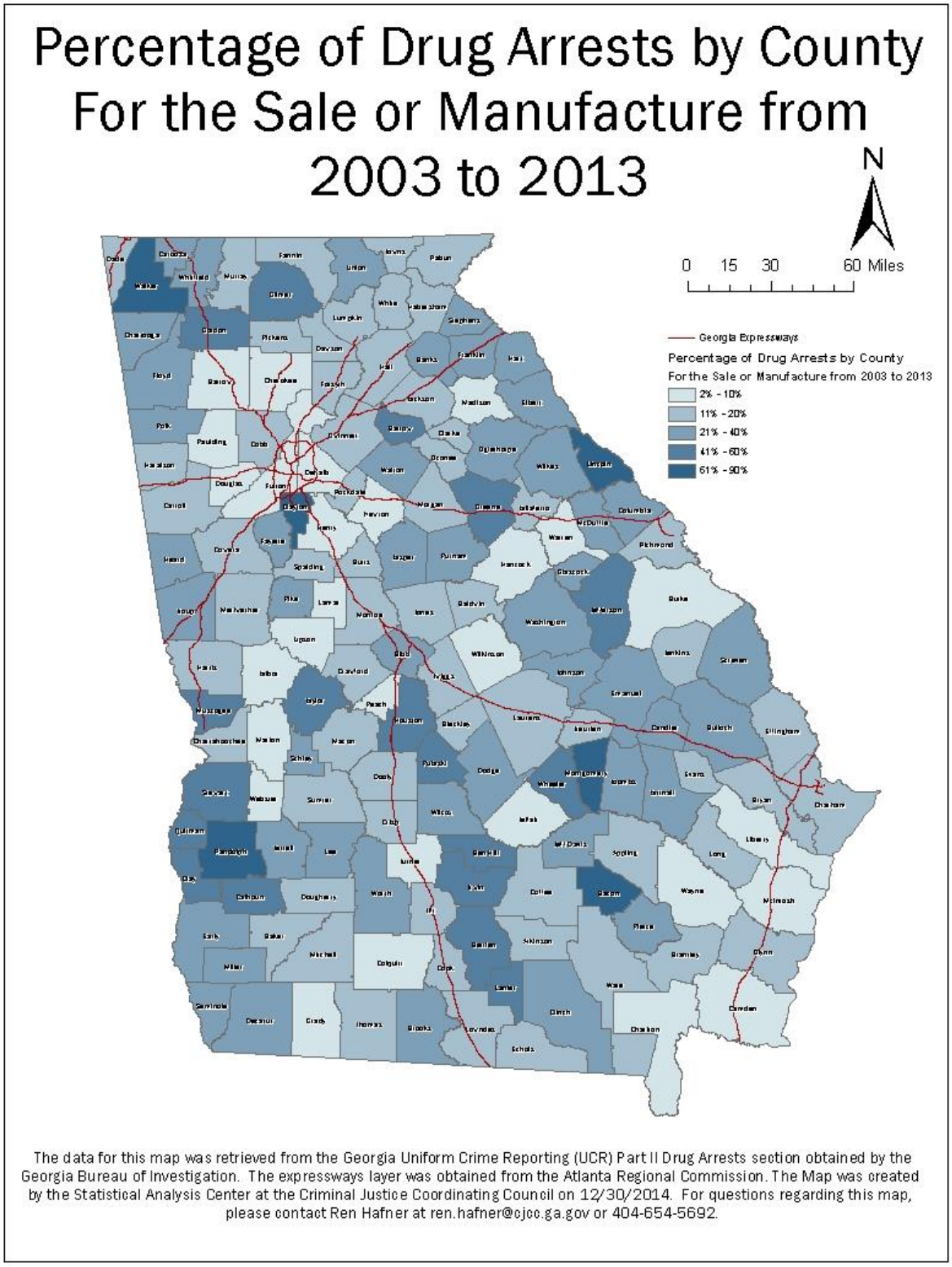
Map 1. Total Number of Drug Arrests by County, 2003- 2013



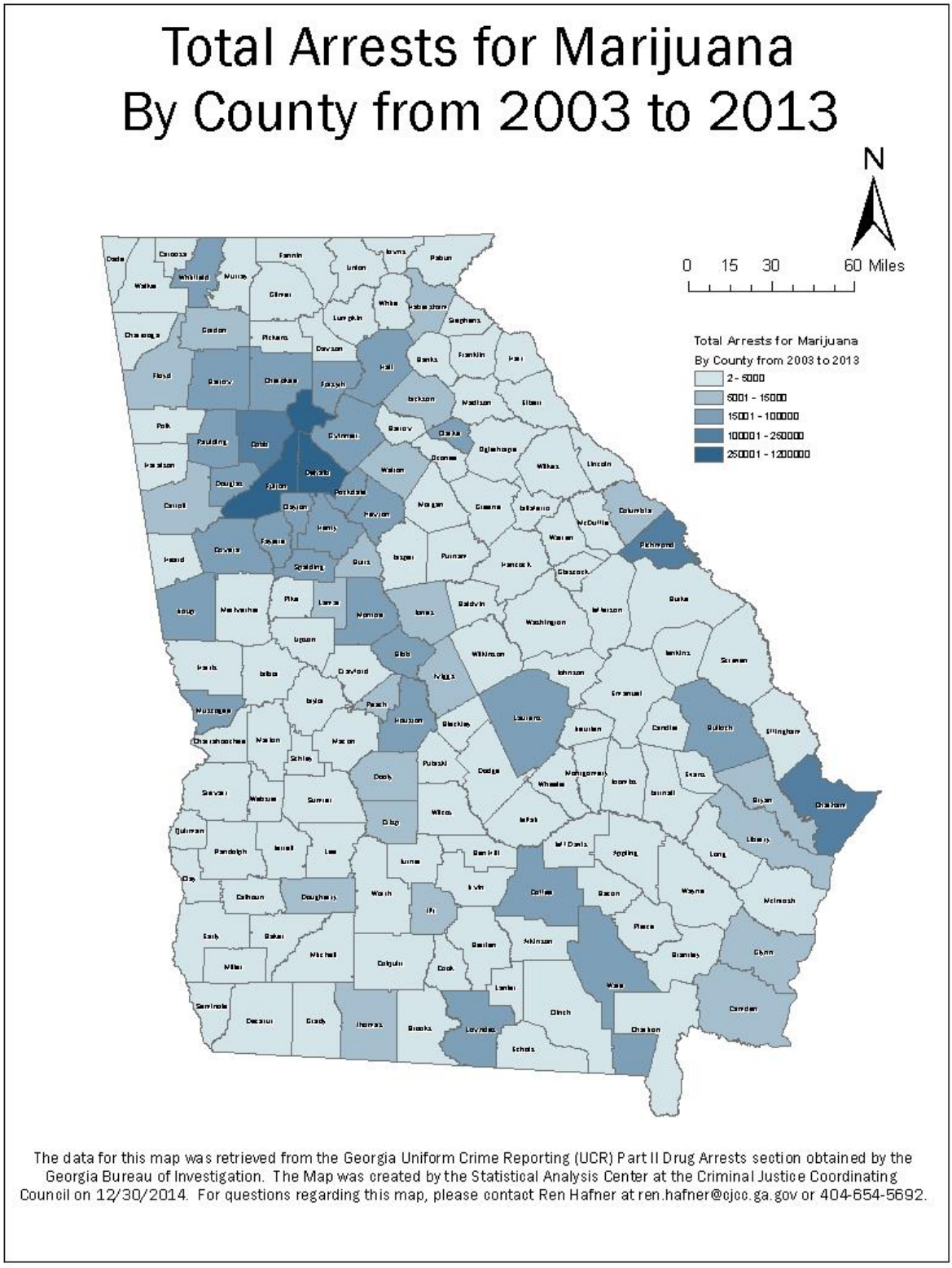
Map 2. Percentage of Drug Arrest by County for Possession, 2003-2013



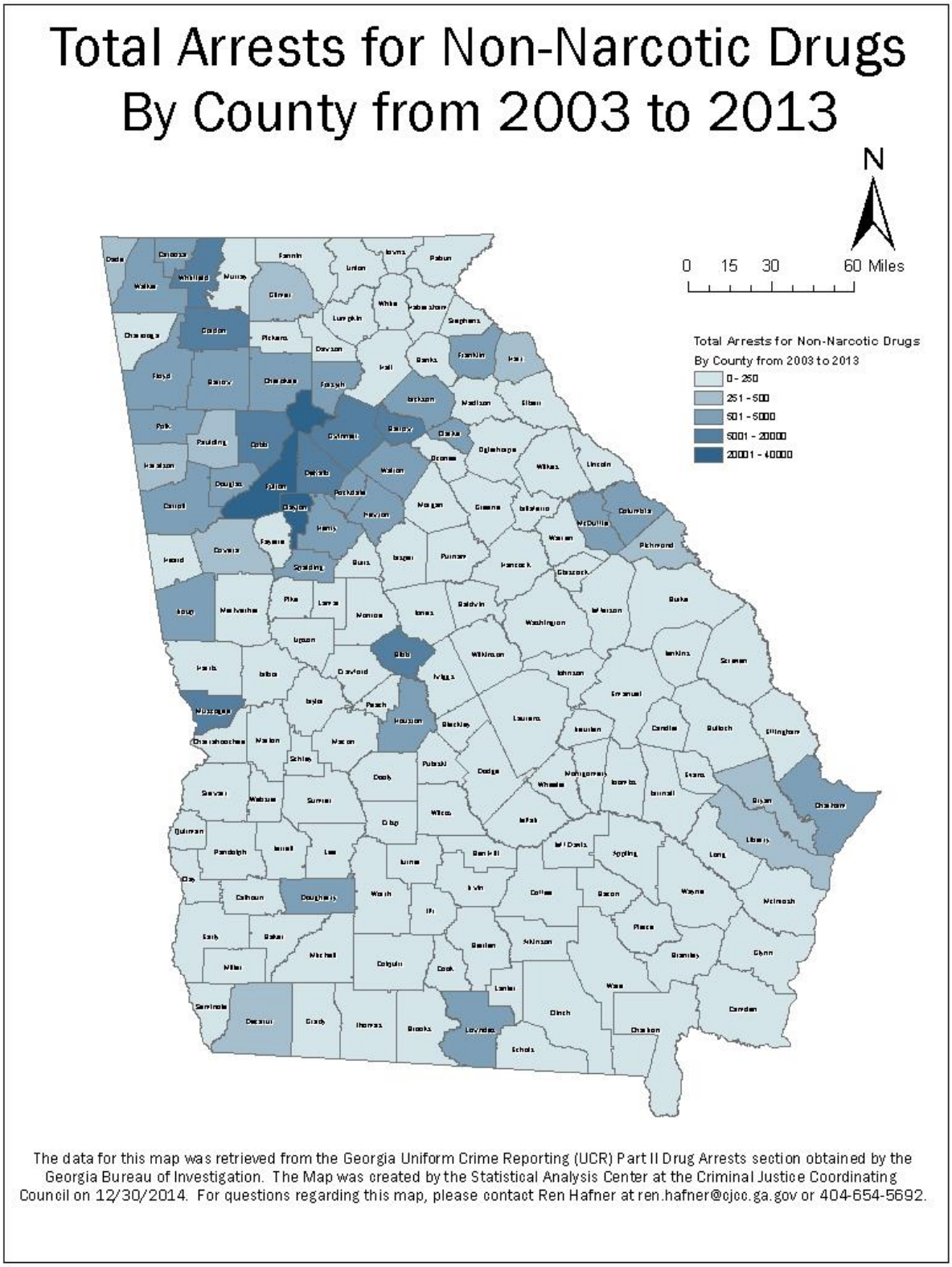
Map 3. Percent of Drug Arrests by County for the Sale of Manufacture, 2003-2013



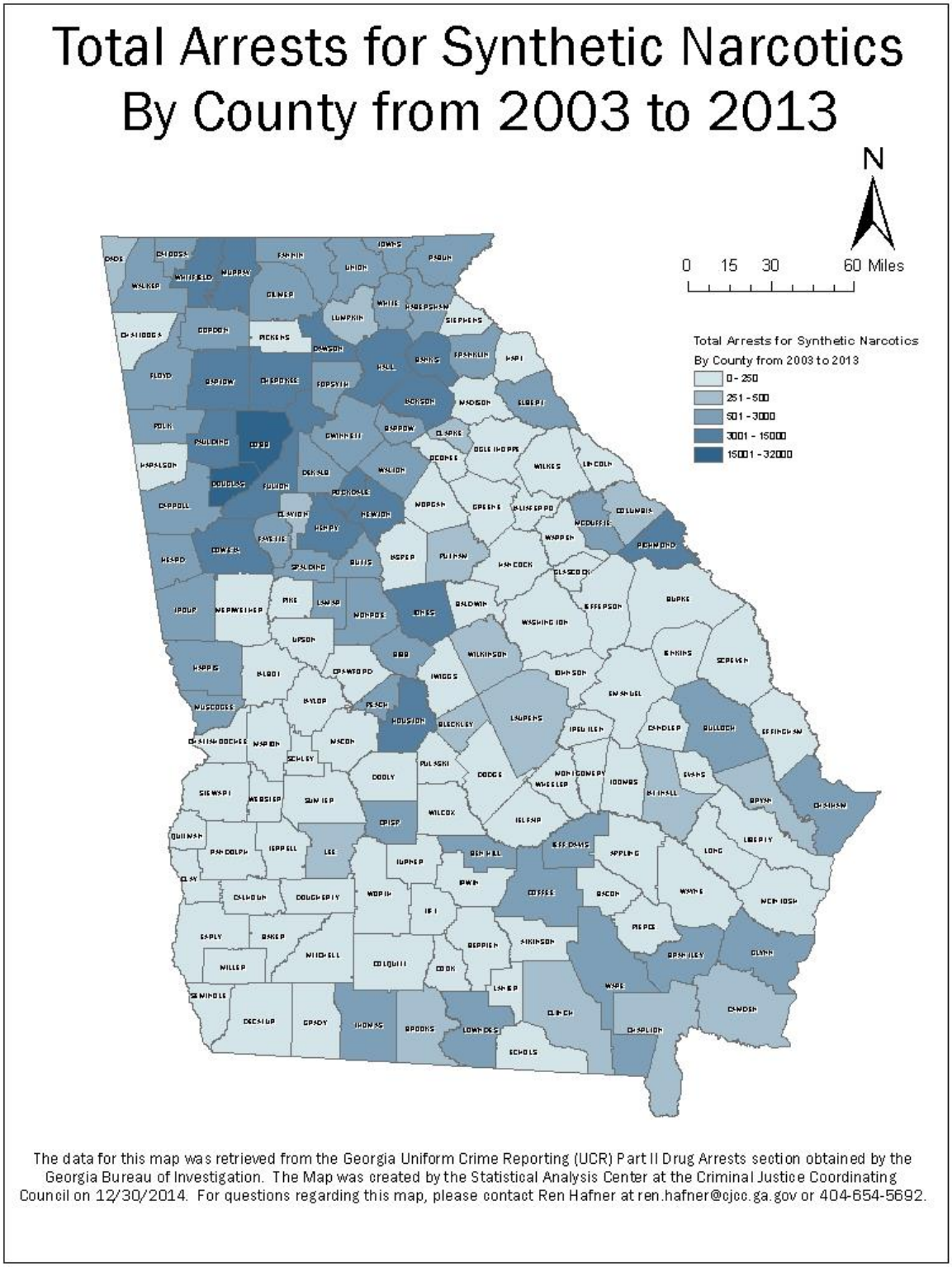
Map 4. Total Arrests for Marijuana by County, 2003-2013



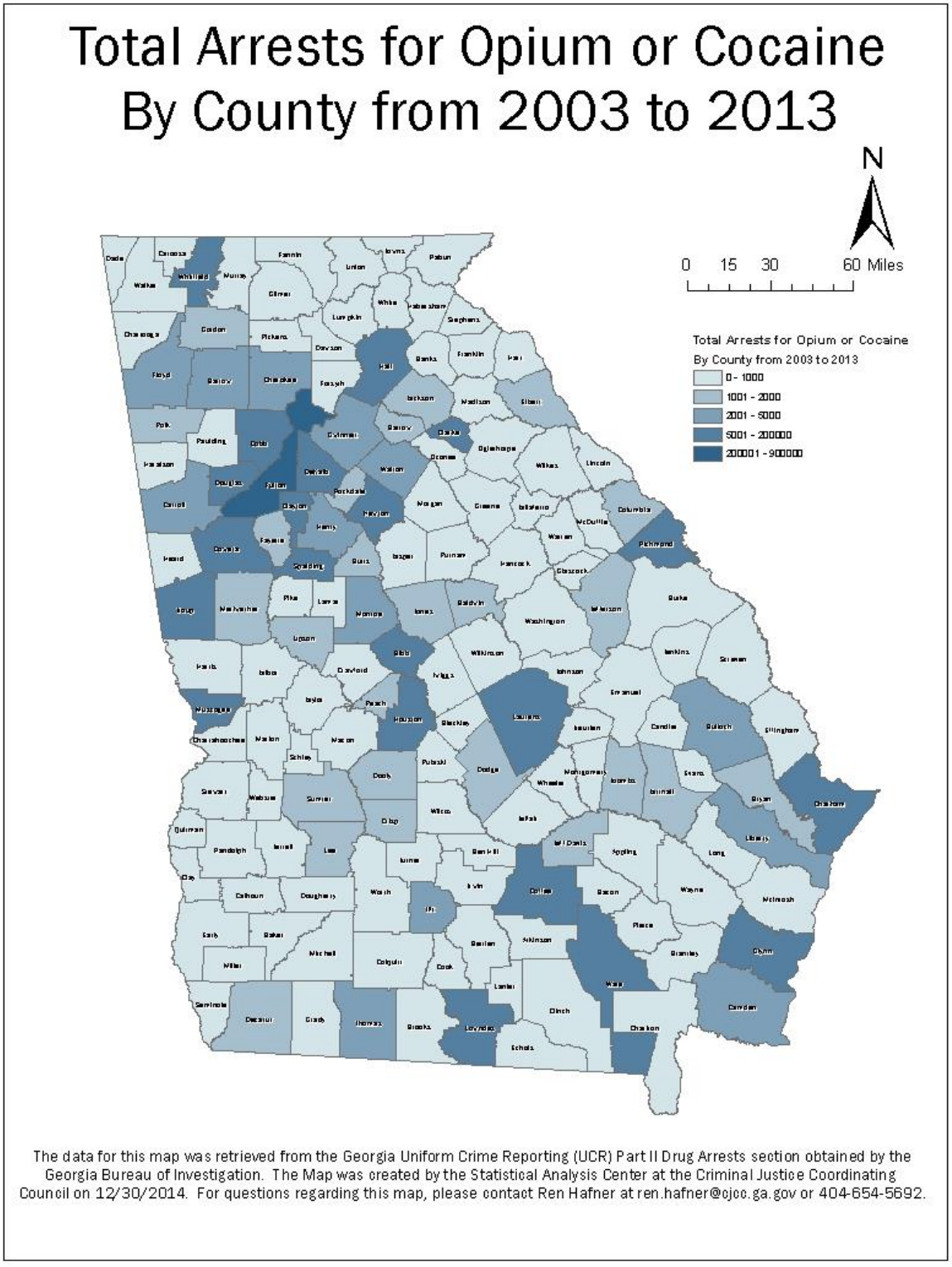
Map 5. Total Arrest for Non-Narcotic Drugs by County, 2003-2013



Map 6. Total Arrests for Synthetic Narcotics by County, 2003-2013



Map 7. Total Arrests for Opium of Cocaine by County, 2003-2013

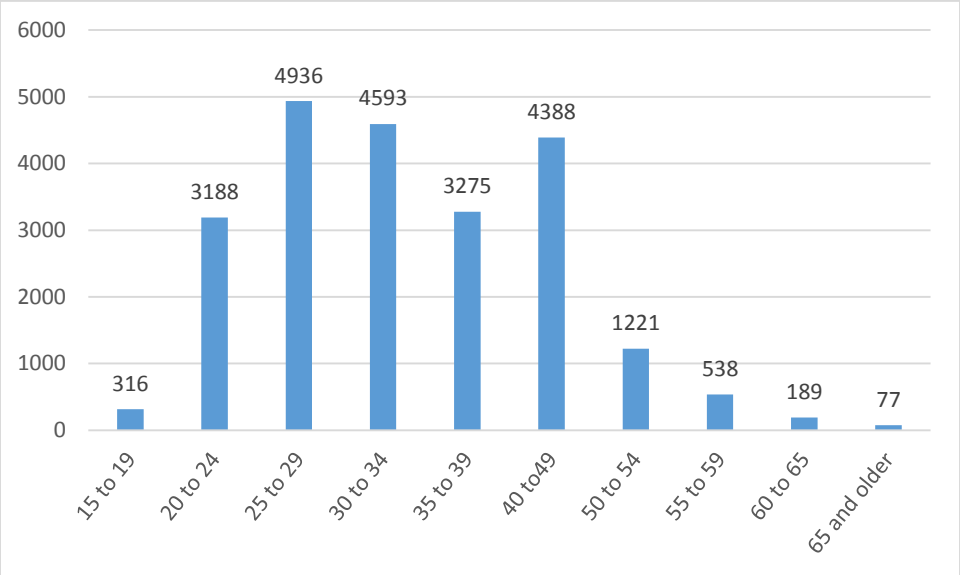


Department of Corrections Prison Intake and Contraband Arrest Data

Intake Analysis

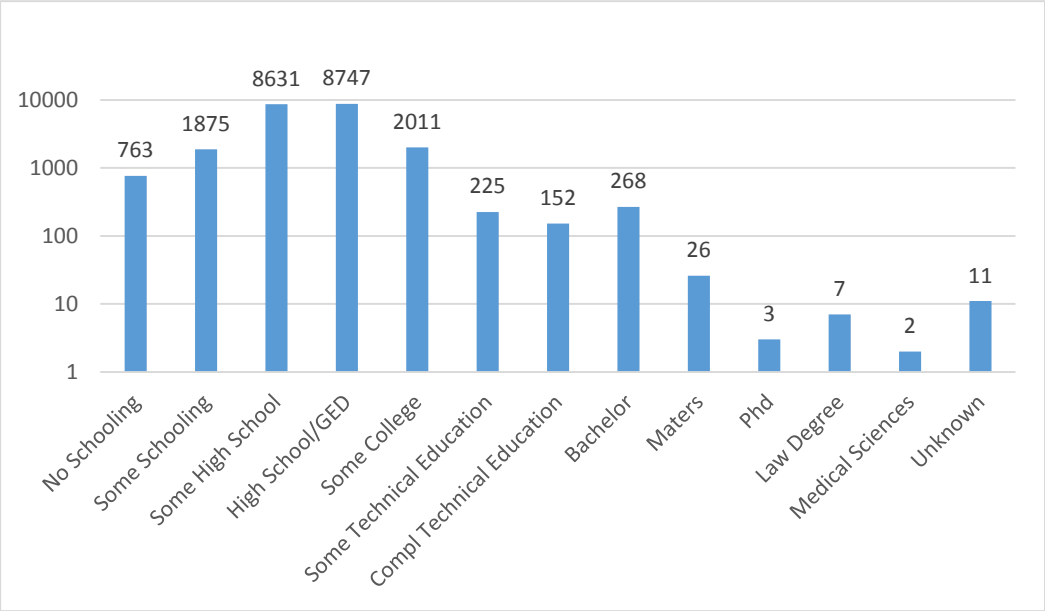
During a four year period, from 2009 to 2013, close to twenty-three thousand (22,721) people were processed in Georgia prisons for drug-related crimes. Cocaine (41%, 9,336) marijuana (22%, 4,965) and methamphetamine (21%, 4,671) related convictions represented 84% of incarcerations. Ninety percent (20,380) of those in Georgia Prisons were between the ages of 20 to 49 year old.

Figure 3. Age at Incarceration, 2009-2013



Fifty-eight percent (13,165) of those incarcerated were African American, 36% (8,110) were Caucasian and 6% (1,349) identified as Hispanic. Only thirteen percent (2,944) of this population were women and males comprised the overwhelming majority at 87% (19,777). Seventy percent of those sent to prison during this period were for new sentences and 30% were for parole, probation or residential substance abuse treatment revocations. For 53% (12,034) of the people this was their first incarceration in Georgia. Fifty percent (11,385) of those incarcerated for drug-related crimes did not have a high school diploma and 88% never went to college or never attended a technical school. Less than half of one percent (306) of those incarcerated for drug-related crime had completed a Bachelor's or Professional degree.

Figure 4. Educational Level at Time of Intake, 2009-2013



From 2009 to 2013 there was one clear trend with the number of incarcerations for specific drugs. Cocaine incarcerations decreased between 12% and 20% each year for the 5 year period, which resulted in a 50% decrease overall. Incarcerations for other drugs, such as methamphetamine and narcotics (excluding cocaine) varied sporadically, but they both increased on average by 22% for methamphetamine and 7% for narcotics.

Table 5. Incarcerations by Drug Type

Drug Type	2009	2010	2011	2012	2013	Total
COCAINE	2,546	2,103	1,809	1,598	1,280	9,336
Marijuana	962	956	1,059	1,001	987	4,965
METH -AMPHETAMINE	843	840	998	962	1,028	4,671
NARCOTICS	85	91	86	96	91	449
MDMA / ECSTASY	34	42	37	19	29	161
Paraphernalia	14	11	10	12	9	56
EPHEDRINE	6	11	8	8	3	36
AMPHETMINE	9	0	1	1	3	14
LSD	2	0	0	2	1	5
COUNTERFEIT DRUGS	0	0	1	0	0	1
Other	61	78	68	76	79	362

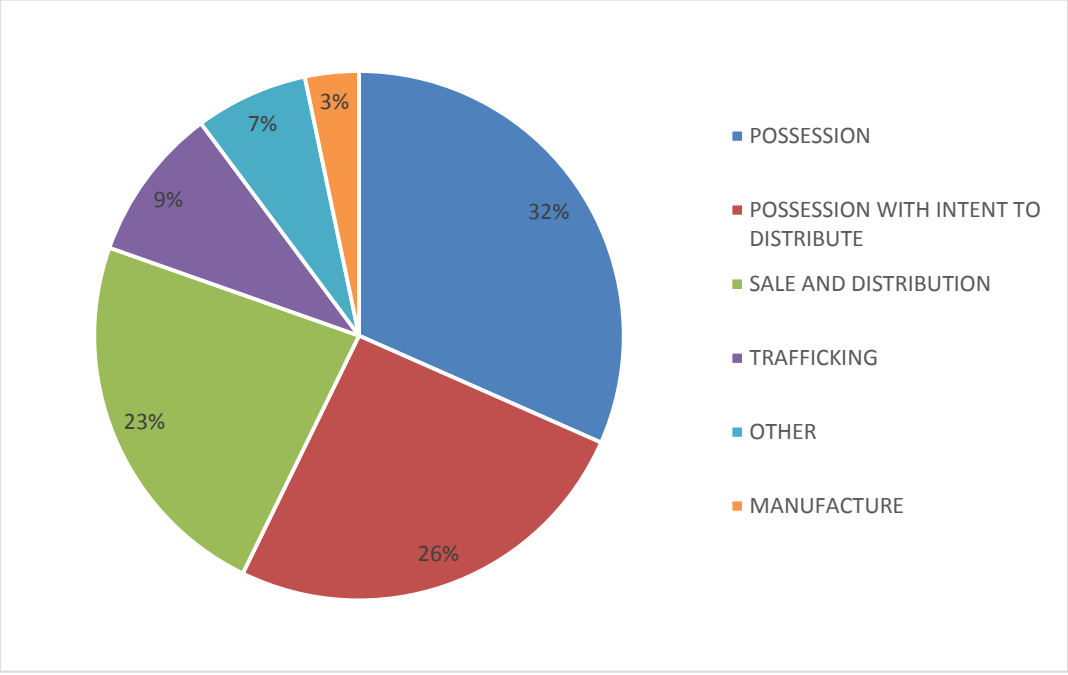
Drug Type	2009	2010	2011	2012	2013	Total
Unknown	685	495	488	463	534	2,665
Total	5,247	4,627	4,565	4,238	4,044	22,721

Table 6. Percent Change in Incarceration by Drug Type (Top 5 Drugs Responsible for Incarceration)

Drug Type	2009	2010	2011	2012	2013	Total
COCAINE	-	-17%	-14%	-12%	-20%	-50%
Marijuana	-	-1%	11%	-5%	-1%	3%
METH -AMPHETAMINE	-	0%	19%	-4%	7%	22%
NARCOTICS	-	7%	-5%	12%	-5%	7%
MDMA / ECSTASY	-	24%	-12%	-49%	53%	-15%

We expanded the Georgia Department of Corrections possession and sales data to include manufacturing, possession with intent to distribute and trafficking. This altered the total number of possession incarcerations because possession with intent to distribute is associated with the supply side of the drug market. According to GDC intake data from 2009 to 2013, possession with the intent to distribute represented 40% (5,821) of all possession incarcerations. Therefore, incarcerations for supply side drug offenses actually represented 68% (15,537) of incarcerations during this period. This can be seen in the next four cross tabulations that look at type of drug, race, age and educational level according to the type of drug conviction.

Figure 5. Percent of Primary Offense Subcategories, 2009-2013



With cocaine, marijuana and methamphetamine, the majority of incarcerations resulted from convictions for supply side activities within the drug market. This is best illustrated with marijuana, where 9% (449) of incarcerations were due to possession as compared to 91% (4,516) for the sale, trafficking or possession with intent to distribute. Fifty-nine percent (2,749) of methamphetamine incarcerations were due to supply side activities, and 24% (666) of that was due to the manufacture of the drug (the largest number of total manufacture arrests). Trafficking incarcerations for cocaine and methamphetamine were also higher than for any of the other drugs. The majority of convictions for narcotics, ephedrine and LSD were for possession and for other demand activities such as possession of paraphernalia.

Table 7. Drug by Primary Offense, 2009-2013

Drug Type	MANUFACTURE	POSSESSION	POSSESSION WITH INTENT TO DISTRIBUTE	SALE AND DISTRIBUTION	TRAFFICING	OTHER	Totals
COCAINE	0	3964	1615	2753	1004	0	9336
MARIJUANA	0	449	2909	1349	258	0	4965
METH - AMPHETAMINE	666	1922	935	473	675	0	4671
NARCOTICS	0	305	0	99	45	0	449
MDMA/ ECSTACY	0	68	0	23	70	0	161
PARAPHENALIA	0	56	0	0	0	0	56
EPHEDRINE	0	36	0	0	0	0	36
AMPHETAMINE	0	0	0	0	14	0	14
LSD	0	4	0	1	0	0	5
COUTERFIT DRUGS	0	0	0	1	0	0	1
OTHER	0	0	362	0	0	0	362
UNKNOWN	81	380	0	562	75	1567	2665
Totals	747	7184	5821	5261	2141	1567	22721

Table 8. Percent of Incarcerations by Primary Offense 2009-2013

Drug Type	% Demand	%Supply	% Total	Total Demand	Total Supply
COCAINE	42%	58%	41%	3964	5372
MARIJUANA	9%	91%	22%	449	4516
METHAMPHETAMINE	41%	59%	21%	1922	2749
NARCOTICS	68%	32%	2%	305	144
MDMA/ECSTACY	42%	58%	1%	68	93

Drug Type	% Demand	%Supply	% Total	Total Demand	Total Supply
PARAPHENALIA	100%	0%	0%	56	0
EPHEDRINE	100%	0%	0%	36	0
AMPHETAMINE	0%	100%	0%	0	14
LSD	80%	20%	0%	4	1
COUNTERFIET DRUGS	0%	100%	0%	0	1
OTHER	0%	100%	2%	0	362
UNKNOWN	14%	27%	12%	380	718

The majority of those incarcerated for drug-related crimes were African American. Those convictions primarily consisted of possession with the intent to distribute and the sale/distribution of drugs, which represents 36% (8,138) of the total incarcerations from 2009 to 2013. Almost half (646) of all Hispanics incarcerated for drug-related crimes in Georgia were due to trafficking convictions, but they only represented 6% (1,349) of all drug incarcerations. Among Caucasian inmates, supply and demand incarcerations were more evenly distributed with 43% (3,499) for demand activities and 46% (3,718) for supply.

Table 9. Race by Primary Offense, 2009-2013

Race	MANUFACTURE	POSSESSION	POSSESSION WITH INTENT TO DISTRIBUTE	SALE AND DISTRIBUTION	TRAFFICKING	OTHER	Total
Asian	2	20	23	7	9	5	66
Black	38	3408	**4047**	**4091**	957	624	13165
Hispanic	6	249	324	80	**646**	44	1349
Native American	4	3	3	1	0	0	11
White	**696**	3499	1417	1080	525	893	8110
Other	1	4	7	1	4	1	18
Unknown	0	1	0	1	0	0	2
Total	747	7184	5821	5261	2141	1567	22721

Table 10. Percent of Incarcerations for Supply or Demand Primary Offense by Race, 2009 to 2013

Race	% Demand	%Supply	% Total	Total Demand	Total Supply
Asian	30%	62%	0.29%	20	41
Black	26%	69%	58%	3408	9133
Hispanic	18%	78%	6%	249	1056
Native American	27%	73%	0.05%	3	8
White	43%	46%	36%	3499	3718
Other	22%	72%	0.08%	4	13
Unknown	50%	50%	0.01%	1	1

The rate of supply-related as compared to demand-related incarcerations was highest among those 15 to 19 years of age. In this age group, supply-side convictions accounted for 74% (222) of those incarcerations. The comparative rate of supply-to-demand related incarcerations steadily declined for each age group until inmates reached age 54 and older. (See Table 11 below). At this age (55 to 59 years of age) supply-related incarcerations increased by 7% as compared to demand-related convictions. For those ages 60-65, the percentage of supply-related incarcerations as compared to demand-related increased by 5%. For all age groups, supply-related offenses comprised the larger proportion of offenses for which individuals were convicted. However, for the 50-54 age group, conviction offenses were evenly divided between demand and supply-related activities.

Nevertheless, the corrections data indicate that supply-related activities are a young person's game. Between the ages of 15 and 34, inmates convicted primarily of felony drug offenses are more than twice as likely to be incarcerated for a supply-side crime as a demand-related crime. For those ages 50-59, the likelihood of being incarcerated for demand or supply-related drug crime is almost equal. These figures are in line with findings from another CJCC study that Applied Research Services (ARS) conducted using computerized criminal history. In that study, ARS found as supply-side drug enforcement takes hold and drugs become increasingly difficult to procure, new participants will be barred from the markets due to high prices.[12] As the corrections data demonstrate, demand-related offenses are concentrated at higher age groups – suggesting those who likely to remain in the market are chronic abusers who have amassed a significant enough criminal history to warrant incarceration.

Table 11. Age Category by Primary Offense, 2009-2013

Age Category	MANUFACTURE	POSSESSION	POSSESSION WITH INTENT TO DISTRIBUTE	SALE AND DISTRIBUTION	TRAFFICING	OTHER	Totals
15 to 19	1	80	123	85	13	14	316
20 to 24	64	823	1114	804	207	176	3188
25 to 29	127	1317	1425	1234	479	354	4936
30 to 34	151	1268	1296	1089	503	286	4593
35 to 39	143	1023	782	665	422	240	3275
40 to49	184	1815	755	902	385	347	4388
50 to 54	52	560	187	261	65	96	1221
55 to 59	21	214	91	141	36	35	538
60 to 65	3	67	37	50	21	11	189
65 and older	1	17	11	30	10	8	77
Totals	747	7184	5821	5261	2141	1567	22721

[12] Applied Research Services (2013). Georgia Drug Arrest Trends: The Supply-Side Model of Drug Interdiction in Georgia. Retrieved from http://cjcc.georgia.gov/sites/cjcc.georgia.gov/files/Georgia%20Drug%20Arrest%20Trends_9.30.13.pdf. 25 June 2015.

Table 12. Percent Incarceration for Supply and Demand by Age Categories, 2009-2013

Age Categories at Admission	% Demand	% Supply	% Total	Total Demand	Total supply
15 to 19	26%	74%	1%	80	222
20 to 24	27%	73%	14%	823	2,189
25 to 29	29%	71%	22%	1,317	3,265
30 to 34	29%	71%	20%	1,268	3,039
35 to 39	34%	66%	14%	1,023	2,012
40 to49	45%	55%	19%	1,815	2,226
50 to 54	50%	50%	5%	560	565
55 to 59	43%	57%	2%	214	289
60 to 65	38%	62%	1%	67	111
65 and older	25%	75%	0%	17	52

Contraband Analysis

Between 2010 and 2013, 566 civilian and corrections staff had been arrested for contraband related offenses in Georgia's correctional facilities. Eighty-three percent (469) of those arrested are civilians and 17% (97) are staff. By far, Tobacco and Marijuana with 275 and 251 seizures from 2010 to 2013 are the two leading drugs within Georgia prisons. They account for 87% of seizures.

Table 13. Number Arrest for Contraband in Georgia Prisons

Arrests	2010	2011	2012	2013	Totals
Civilian	11	147	201	110	469
Staff	5	17	32	43	97
Total	16	164	233	152	565
% Change Civilian	-	1236%	37%	-46%	-26%
% Change Staff	-	240%	88%	34%	153%

Table 14. Total Number of Drug Seizures by Year

Drugs / Contraband	Total Seizures 2010	**Total Seizures 2011**	Total Seizures 2012	Total Seizures 2013	Totals
Tobacco	3	92	101	79	275
Marijuana	8	72	100	71	251
Methamphetamine	0	2	4	10	16
Prescription medication	0	5	8	2	15
Paraphernalia	0	2	7	4	13
Cocaine	0	1	10	0	11

Drugs / Contraband	Total Seizures 2010	**Total Seizures 2011**	Total Seizures 2012	Total Seizures 2013	Totals
Alcohol	0	1	3	2	6
Ecstasy	0	1	3	0	4
Crack Cocaine	0	1	0	0	1
Other	2	9	4	0	15
Totals	13	186	240	168	607

Drug Seizure Data

The amount of drugs seized through the Multi-Jurisdictional Drug Task Forces (MJDTFs) and the High Intensity Drug Trafficking Area Program (HIDTA) can vary substantially from year to year. The variation can be due to a number of issues, such as fluctuation in the number of operating MJDTFs and the type of cases they decide to pursue during a year, but the data do provide an opportunity to find patterns and emerging trends.

Of note, over the past four years methamphetamine seizures have increased. Seizures in 2012 and 2013 increased by 401% and 493%, respectively, though this activity leveled off somewhat in 2014 with a 183% increase. The total percentage change in this four year period is a staggering growth of 786%.

Another drug of concern is heroin, where the amount seized had held relatively steady until 2013, and in 2014 the amount seized increase by 216% with an average increase of 152% over the four year period. The relative consistency of seizures during this period with the dramatic increase in the most recent collection period warrants continued surveillance to confirm whether this was an anomalous year. Finally, cocaine seizures steadily decreased each year from 2011 to 2014, with a 42% total decrease.

Table 15. Total Drugs Seized by MJDTF and HIDTA Initiatives in Georgia

Total Drug Seizures (MJDTF and HIDTA Combined)	2011	2012	2013	2014
Marijuana (g)	11,091,402	20,078,473	4,885,799	6,019,614
Cocaine (g)	1,316,247	1,233,378	906,553	757,587
Methamphetamine (g)	87,483	438,725	655,034	775,197
Marijuana Plants (g)	498,866	219,501	585,487	340,590
Heroin (g)	19,648	19,204	15,658	49,514
Crack (g)	8,867	3,715	2,755	12,316
Total Drug Seizures (Incompatible Reporting)	**2011**	**2012**	**2013**	**2014**
Prescription Medications, MJDTF (g)	112,938	91,944	85,055	0
Prescription Medications, HIDTA (D.U.)	210	425,107	407	219

Total Drug Seizures (Incompatible Reporting)	2011	2012	2013	2014
Ecstasy/MDMA, MJDTF (g)	713	1,544	717	1,605
Ecstasy/MDMA, HIDTA (D.U.)	3,600	0	1,000	*Data inconsistent

Public Health

Georgia Drug Overdose Data

According to the Centers for Disease Control, "Drug overdose was the leading cause of injury death in 2013" nationwide.[13] Although this is not the case yet for Georgia, the volume of drug overdose deaths is quickly approaching that of motor vehicle deaths, a commonly used comparison. From 2010 to 2013, there were 4,174 drug overdose deaths reported to medical examiner offices across the state. Sixty-six percent (2,762) of the deaths involved only prescription drugs, 19% (777) involved only illicit drugs and 12% (532) involved a combination of both prescription and illicit drugs.

Overall, drug overdose deaths decreased by 3% over these four years, but the number of deaths attributed to illicit drugs increased by 19% and those attributed to a combination of drugs increased by 28%. A troubling finding is that the growth in overdose deaths involving illicit drugs was primarily driven by heroin (556% increase) and methamphetamine (36% increase), which adds to our suspicions of growing demand for these in the drug market. On the other hand, prescription drug overdoses decreased by 12%, with an 8% decrease alone in 2013 – an encouraging finding.

Figure 6. Georgia Overdose Deaths Compared to Motor Vehicle deaths.

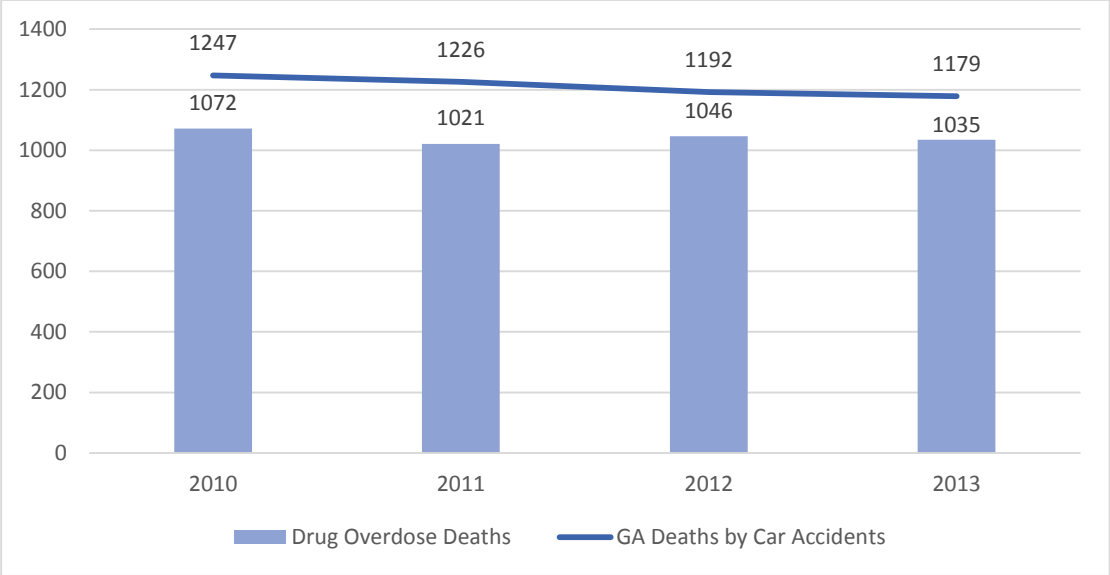


Table 16. Drug Classification and Percent Change by Year

Deaths From:	2010	2011	2012	2013	Totals
Rx	725	703	694	640	2,762
Illicit	189	166	198	224	777
Both	121	126	130	155	532

[13] Centers for Disease Control (2015). Prescription Drug Overdose Data. Retrieved from: http://www.cdc.gov/drugoverdose/data/overdose.html. 20 April 2015.

Unknown	37	26	24	16	103
Total Overdose Deaths	**1,072**	**1,021**	**1,046**	**1,035**	**4,174**
%Change Rx	-	-3%	-1%	-8%	-12%
% Change Illicit	-	-12%	20%	13%	19%
% Change Both	-	4%	3%	19%	28%
% Change Unknown		-30%	-8%	-33%	-57%
% Change Total Deaths	-	-5%	2%	-1%	-3%

Medical examiners' toxicology reports identified 183 different drugs in decedents' bodies, with an average of 2.5 drugs consumed per decedent. The 20 most frequently used drugs shown in Figure 2 accounted for almost 74% of the confirmed drugs in the decedents' bodies. Alprazolam, Oxycodone, Methadone, Hydrocodone and Cocaine accounted for 40% of all drugs found in decedents. The presences of these five drugs decreased by 8% between 2010 and 2013, which was primarlily driven by a 24% decrease in methadone related deaths.

Figure 7. Top 20 Drugs by Total Occurences, 2010-2013

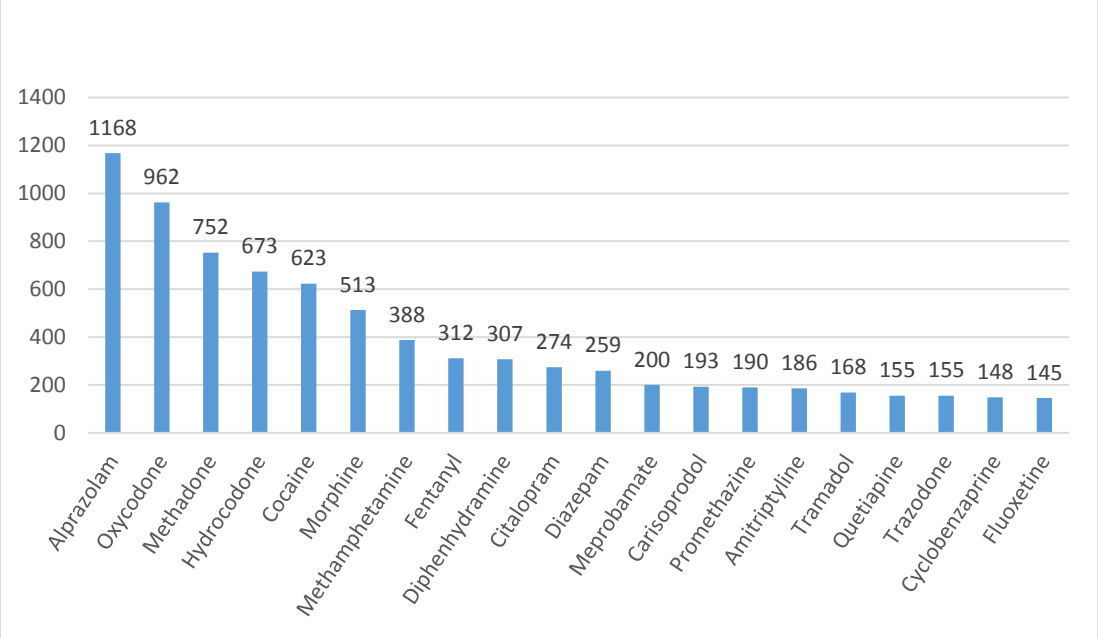


Table 17. Top 5 Drugs Found in Overdose Deaths, 2010-2013

Type of Drug	2010	2011	2012	2013	% Change
Alprazolam (Anxiety Medication, Xanax)	284	310	288	286	0.7%
Oxycodone (Narcotic Pain Reliever)	238	254	234	236	-0.8%

Methadone (Narcotic Pain Reliever)	191	201	215	145	-24%
Hydrocodone (Narcotic Pain Reliever)	178	167	161	167	-6%
Cocaine (Stimulant, Illicit)	169	148	155	151	-11%

In the past 4 years there was a considerable increase in heroin overdoses, from 9 deaths in 2010 to 59 in 2013. Heroin ranked second highest in the percent growth at 556% during this period. Other drugs that had an 175% or more increase were Phentermine (appetite suppressant), 1,1-difluoroethane (Canned air propelant), Midazolam (Benzodiazepine), Propranolol (beta-blocker), Nortriptyline (antidepresant), and Probanolol (blood pressure medication). Of concern with respect to heroin is that it is an illicit drug and the number of deaths in which it was present was 5 to 19 times that of the other drugs listed in Table 18.

Table 18. Top 5 Drugs with the Larges Growth in Deaths, 2010-2013

Type of Drug	2010	2011	2012	2013	% Change
Phentermine (Stimulant Appetite suppressant)	1	7	9	7	600%
Heroin (Narcotic, Illicit)	9	33	41	59	556%
1,1-Difluoroethane (Canned Air)	1	1	2	3	200%
Midazolam (Benzodiazepine)	1	1	1	3	200%
Propranolol (Blood Pressure Medication)	4	3	4	11	175%

Age

Individuals ages 25 to 54 made up 72% (3,014) of the drug overdose deaths. Interestingly, there was an 89% increase in deaths for those over the age of 65 and a 13% increase in deaths among those aged 55 to 64 from 2010 to 2013. The type of drugs most frequently found in toxicology reports were consistent across age categories and were primarily prescription opiate medications.

Three of the top 5 drugs found in decedents of age categories starting at 15 years old or older were alprazolam, oxycodone and methadone. Methadone was the only drug in the top 5 for all age categories. Our analysis found Methadone in 24% of the children who died under the age of 15, whereas it was found for only 5% to 11% of decedents in older age groups. Methadone was the only drug that contributed to multiple deaths (6) of children under the age of 15, therefore it is the only drug listed for this age group in Table 19. Nineteen other drugs contributed to the deaths of those younger than 15 years old but there was only one recorded case for each over a 4 year period.

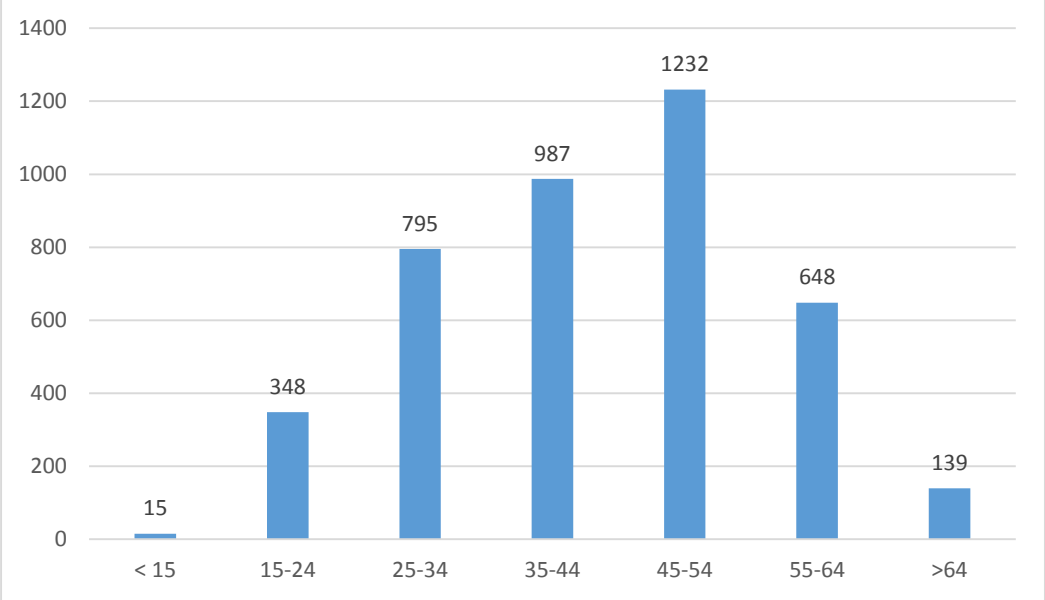
Alprazolam was the number one drug found in decedents aged 15 to 64. Cocaine was among the top 5 drugs found in decedents aged 25 and older. The only other illicit drugs found with sufficient

frequency numbers to rank in the top 5 were heroin for those 15 to 24 years old and methamphetamine for those 25 to 34 years old.

Table 19. Top 5 Drugs Contributing to Overdose Death by Age Categories, 2010-2013

<15	15-24	25-34	35-44	45-54	55-64	65+
Methadone	Alprazolam	Alprazolam	Alprazolam	Alprazolam	Alprazolam	Hydrocodone
-	Methadone	Oxycodone	Oxycodone	Oxycodone	Oxycodone	Alprazolam
-	Oxycodone	Methadone	Methadone	Cocaine	Hydrocodone	Oxycodone
-	Morphine	Cocaine	Hydrocodone	Hydrocodone	Cocaine	Cocaine
-	Heroin	Methamphetamine	Cocaine	Methadone	Methadone	Methadone

Figure 8. Overdose Deaths by Age Group, 2010-2013



Gender, Race and Manner of Death

Males (2,417) outnumbered females (1,757) in drug overdose deaths, which averaged 58% to 42% between 2010 and 2013. By far, Whites accounted for the majority of deaths (85%, 3,558) and African Americans, the next largest racial group affected, accounted for 13% (560). Those of Asian, Hispanic and Native American decent represented close to 2% (50) of the total deaths during this period.

Accidental overdose was the leading cause of drug-related deaths at 86% (3,604) and suicide was second at 10% (412). For all racial groups, accidental overdoses accounted for the majority of deaths, but for Asian and Native American populations, suicide represented 31% and 25% of deaths, respectively. Suicide by overdose was highest among those less than 15 years old (13%) and for those 65 and older at 23%. Women were slightly more likely to be ruled a suicide overdose death at 13% compared to men at 8%.

Seventy-seven percent of females overdosed on prescription drugs compared to 58% of males. Prescription drugs accounted for all deaths of individuals from Native American decent. The majority

(54%) of African Americans overdosed on illicit drugs during this period. Hispanics were more likely to die from prescription drugs, but a substantial percentage (37%) succumbed to illicit drugs.

Table 20. Percentage of Overdose Deaths by Race and Manner of Death, 2010- 2013

Race	Accident	Homicide	Natural	Suicide	Undetermined	Total %
Asian	63%	6%	0%	31%	0%	100%
African American	87%	1%	2%	6%	4%	100%
Hispanic	87%	0%	0%	10%	3%	100%
Native American	50%	0%	0%	25%	25%	100%
White	86%	0%	0%	10%	3%	100%

Table 21. Percentage of Overdose Deaths by Age Category and Manner of Death, 2010-2013

Age Categories	Accident	Homicide	Natural	Suicide	Undetermined	Total
< 15	27%	27%	0%	13%	33%	100%
15-24	93%	0%	0%	6%	1%	100%
25-34	91%	0%	0%	6%	2%	100%
35-44	86%	0%	0%	10%	3%	100%
45-54	86%	0%	0%	10%	3%	100%
55-64	82%	0%	1%	13%	4%	100%
>64	71%	0%	0%	23%	6%	100%

Table 22. Percentage of Overdose Deaths by Gender and Manner of Death, 2010-2013

Sex	Accident	Homicide	Natural	Suicide	Undetermined	Total
F	82%	0%	1%	13%	4%	100%
M	90%	0%	0%	8%	2%	100%

Table 23. Percentage of Overdose Deaths by Race and Drug Type, 2010-2013

Race	Both	Illicit	Rx	Unknown	Total
Asian	13%	31%	56%	0%	100%
African American	10%	54%	35%	1%	100%
Hispanic	17%	37%	47%	0%	100%
Native American	0%	0%	100%	0%	100%
White	13%	13%	71%	3%	100%

Race	Both	Illicit	Rx	Unknown	Total
Other	0%	0%	50%	50%	100%

Table 24. Percentage of Overdose Deaths by Age Category and Drug Type, 2010-2013

Age Categories	Both	Illicit	Rx	Unknown	Total
< 15	7%	20%	73%	0%	100%
15-24	16%	20%	62%	1%	100%
25-34	19%	22%	57%	2%	100%
35-44	13%	15%	70%	2%	100%
45-54	11%	19%	67%	3%	100%
55-64	8%	20%	71%	2%	100%
>64	3%	14%	78%	5%	100%

Table 25. Percentage of Overdose Deaths by Gender and Drug Type, 2010-2013

Sex	Both	Illicit	Rx	Unknown	Total
F	11%	9%	77%	4%	100%
M	14%	26%	58%	2%	100%

Combination of Drugs

Sixty percent (2,506) of the decedents had 2 or more drugs in their system at the time of death. Of the top ten drugs found most often in combination, 4 were opioids, 2 are benzodiazepines, and 1 each of an anti-histamine, anti-depressant and a stimulant (cocaine) (See Table 26).

Alprazolam was found in 28% of drug overdose deaths and 46% of those where a combination of drugs were identified. Ninety- eight percent (1,143) of drug overdoses with Alprazolam were found in combination with at least one other drug. Almost a third of overdose deaths in which drugs were used in combination included Alprazolam either with Oxycodone (466) or Methadone (308). These combinations account for 48% of all Oxycodone involved deaths and 41% of all Methadone involved deaths. The third drug often found in combination was Hydrocodone – most frequently with Alprazolam. The combination of Hydrocodone and Alprazolam contributed to 304 overdose deaths, which represented 45% of all deaths involving hydrocodone.

Even illicit drugs such as cocaine are used in combination with Alprazolam. Forty-nine percent (307) of deaths attributable to cocaine were in combination with another drug – most frequently Alprazolam (91). By comparison, heroin was used much less frequently in combination with other drugs according to the overdose death reports. The drug most frequently used in combination with herion was cocaine with 34 cases out of 142 or 24%. As compared to prescription drugs, illicit drugs are used in combination far less frequently (about 50% of the time) than prescription drugs (70% to 100% of the time, depending on the drug).

Table 26. Drug Overdose Combinations, 2010-2013

Drug	Total	Total Combo	% Combo	1st Combo	2nd Combo	3rd Combo
Alprazolam *(Benzodiazepine)*	1168	1143	98%	Oxycodone (466)	Methadone (308)	Hydrocodone (304)
Oxycodone *(Semi-synthetic Opioid)*	962	823	86%	Alprazolam (466)	Hydrocodone (158)	Methadone (111)
Hydrocodone *(Semi-synthetic Opioid)*	673	599	89%	Alprazolam (304)	Oxycodone (158)	Methadone (90)
Methadone *(Synthetic Opioid)*	752	532	71%	Alprazolam (308)	Oxycodone (111)	Hydrocodone (90)
Morphine *(Opioid)*	513	401	78%	Alprazolam (162)	Oxycodone (85)	Hydrocodone (76)
Cocaine	623	307	49%	Alprazolam (91)	Oxycodone (75)	Morphine (55)
Diphenhydramine *(Antihistamine)*	307	280	91%	Alprazolam (102)	Oxycodone (84)	Hydrocodone (72)
Citalopram *(Antidepressant)*	274	259	95%	Alprazolam (108)	Oxycodone (83)	Hydrocodone (69)
Diazepam *(Benzodiazepine)*	259	259	100%	Oxycodone (95)	Alprazolam (92)	Hydrocodone (71)
Fentanyl (Synthetic Opioid)	312	235	75%	Alprazolam (87)	Oxycodone (65)	Hydrocodone (50)
Heroin (Opioid)	142	67	47%	Cocaine (34)	Alprazolam (18)	Methamph-etamine (10)
Methamphetamine	388	199	51%	Alprazolam (69)	Oxycodone (46)	Amphetamine (41)

Opiate Analysis

That opiates play an integral role in overdose deaths is clear, because they accounted for over two thirds (65%, 2,726) of deaths in Georgia from 2010 to 2013. Only 10 opiates were identified among the 183 total drugs found in toxicology reports. This means that 12% of drugs identified in toxicology reports played a significant role in 65% of overdose deaths.

Figure 9. Opiate and Other Drug Overdose Deaths by Year

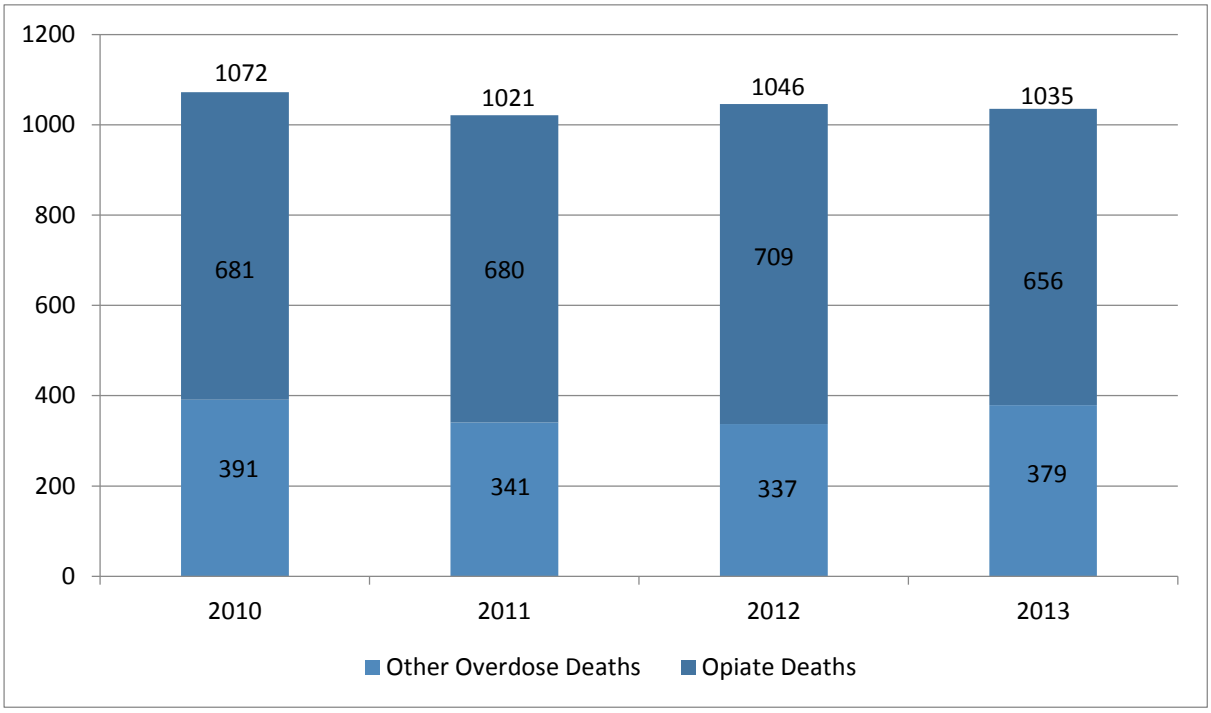
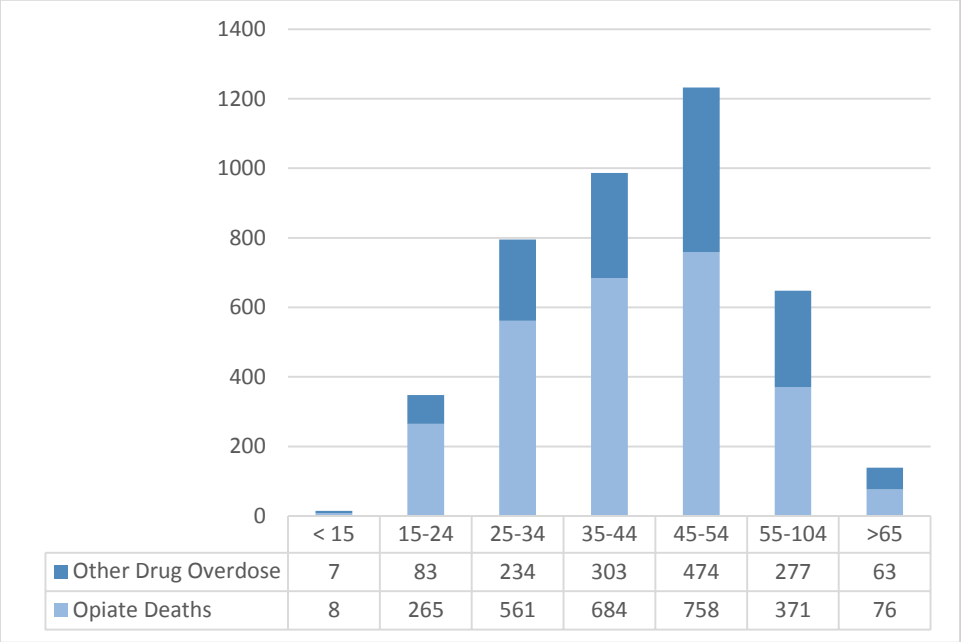


Table 27. All Opiates found in Georgia Overdose Deaths, 2010-2013

Opiate	Drug Type	Schedule
Codeine	Rx	2
Fentanyl	Rx	2
Heroin	Illicit	1
Hydrocodone	Rx	2
Hydromorphone	Rx	2
Methadone	Rx	2
Morphine	Rx	2
Oxycodone	Rx	2
Oxymorphone	Rx	2
Tapentadol	Rx	2

The percentage of opiate-related overdose deaths is highest among those 15-24 years of age at 76% of all overdoses. For those older in 65, opiate-related overdoses accounted for 55% of these deaths. Opiate overdose deaths also represented three quarters of overdose deaths for whites and two-thirds of overdoses for Hispanics. The racial group with the smallest proportion of opiate-related overdose deaths was African Americans for whom opiates are involved in just 32% of overdose deaths. About two-thirds of the drug overdose deaths included an opiate for both men and women (67% and 64% respectively).

Figure 10. Opiate and Other Drug Overdose Deaths by Age Category, 2010-2013



	< 15	15-24	25-34	35-44	45-54	55-104	>65
Other Drug Overdose	7	83	234	303	474	277	63
Opiate Deaths	8	265	561	684	758	371	76

Not only are many drugs being used in combination, but also many opiates are used in combination. Just over a quarter (26%, 706) of all opiate-related deaths have more than one opiate identified in the decedent's body in toxicology reports. By comparison, for all other overdose deaths, 17% are found to have multiple opiates identified in their system.

On the positive side, between 2010 and 2013 Georgia experienced a 4% total decrease in opiate deaths. Although over that four year period total drug overdose deaths decreased by 3%, overdoses for other drugs increased by 12%. This trend should be monitored since the use of the Georgia prescription monitoring program became mandatory in 2013.

Table 28. Opiate and Other Drug Overdose Deaths by Year

	2010	2011	2012	2013	Total
Opiate Deaths	681	680	709	656	2726
Other Rx Deaths	391	341	337	379	1448
Total Rx Deaths	1072	1021	1046	1035	4174
Car Accidents	1,247	1,226	1,192	1,179	4,844
Opiate Deaths % Change	-	0%	4%	-7%	-4%
Other Drug Deaths %Change	-	-13%	-1%	12%	-3%

Map Analysis

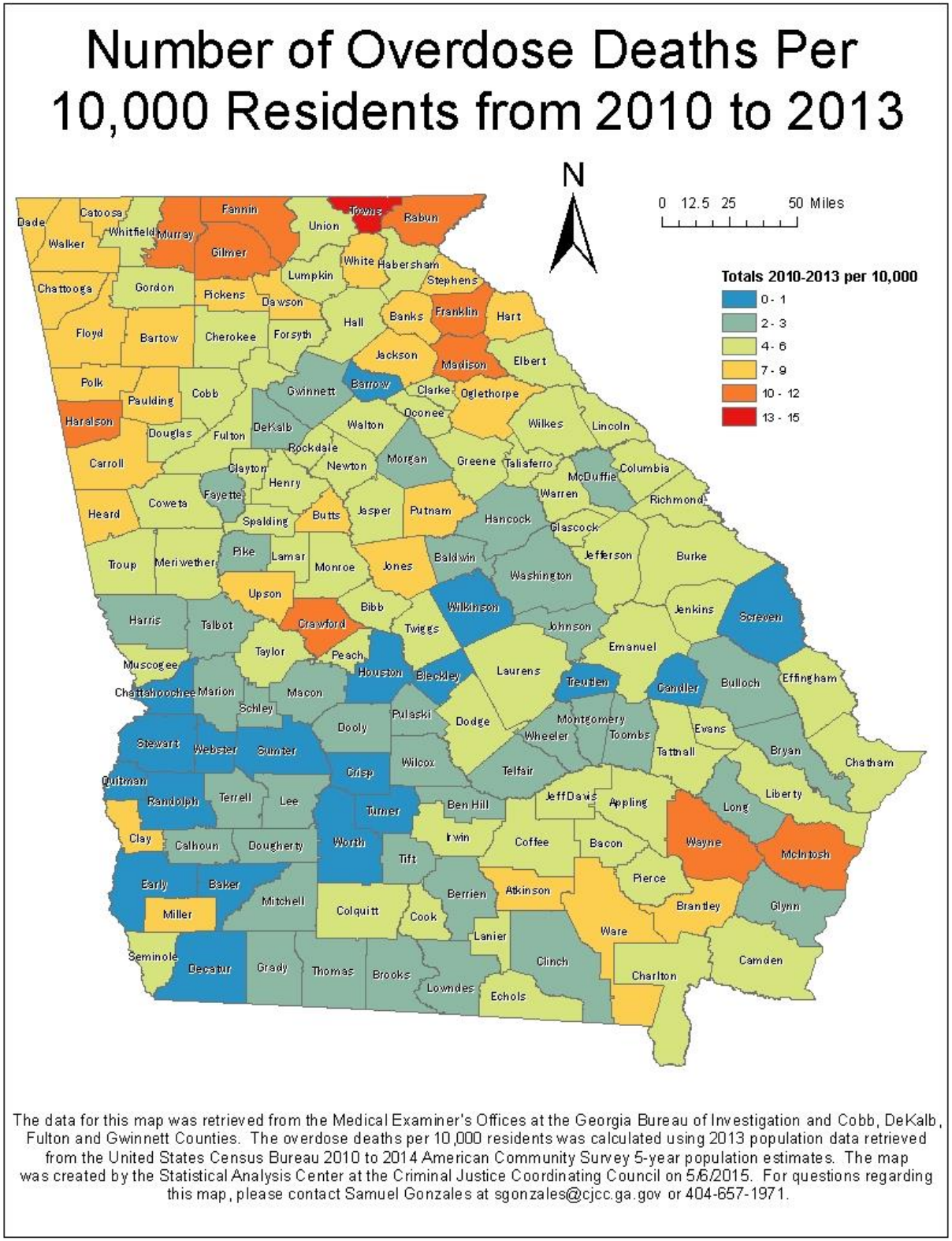
Larger numbers of overdose deaths were reported in northwestern counties of the state and in major metropolitan areas. Nine counties did not report any cases to medical examiner's offices during the study period. The top ten counties that reported drug overdose deaths were Fulton (494), Cobb (329), Gwinnett (241), DeKalb (179), Clayton (117), Cherokee (116), Richmond (112), Henry (103),

Hall (94) and Chatham (90). However, when the data are normalized by populations, the counties with the highest rate of overdose deaths are more rural counties like Towns, Haralson and Fannin (See Table 29)

Table 29. Total Overdose Deaths and Overdose Deaths / 1000 Residents, 2010-2013

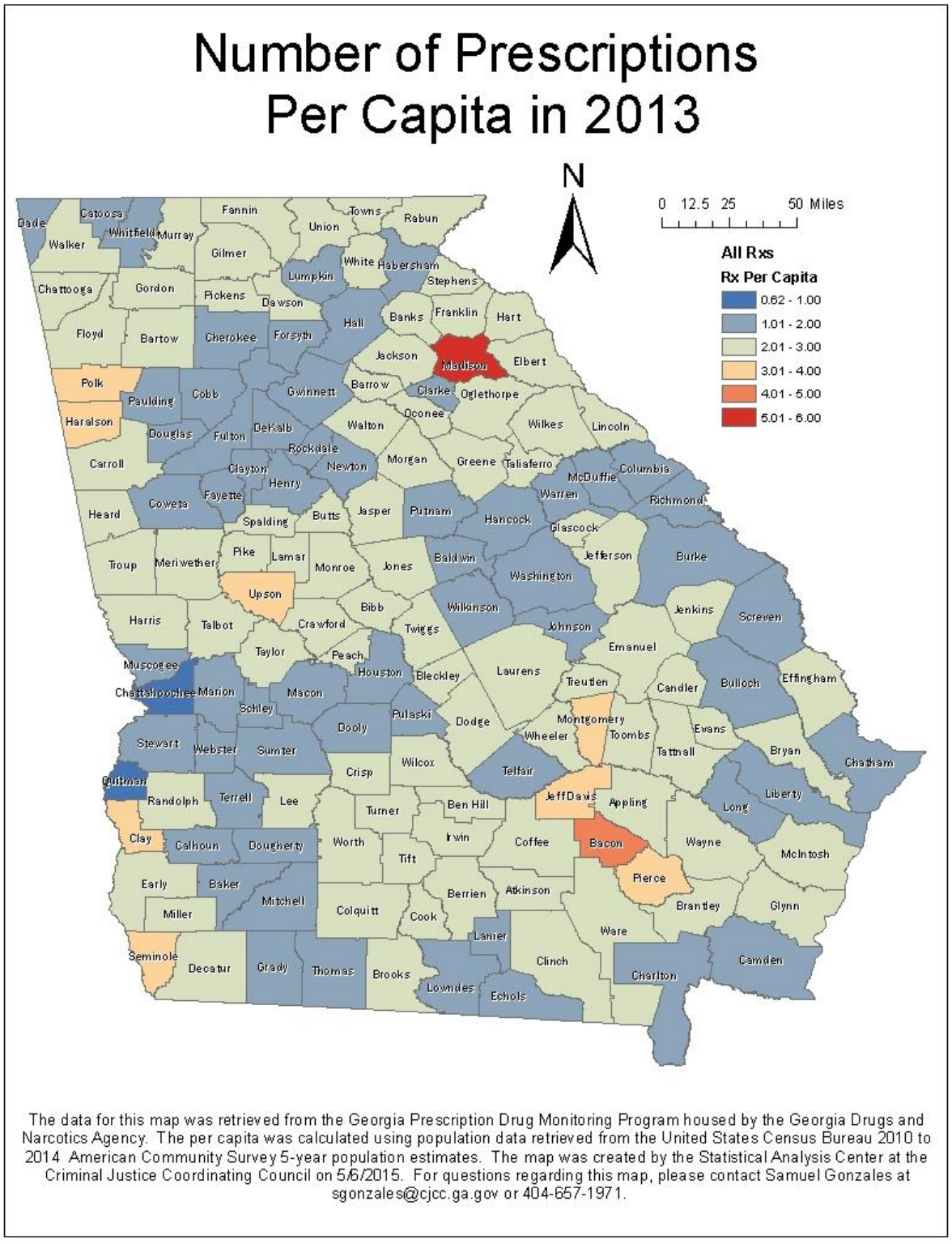
Ranking	County	Total Overdose Deaths	County	Overdose Deaths / 10,000
1	Fulton	494	Towns	13.95
2	Cobb	329	Haralson	11.94
3	Gwinnett	241	Fannin	11.37
4	DeKalb	179	Wayne	10.98
5	Clayton	117	Rabun	10.46
6	Cherokee	116	Franklin	10.43
7	Richmond	112	Madison	9.87
8	Henry	103	Murray	9.67
9	Hall	94	Crawford	9.61
10	Chatham	90	Gilmer	9.44

Map 9. Normalized Number of Overdose Deaths per 10,000 Residents



The data for this map was retrieved from the Medical Examiner's Offices at the Georgia Bureau of Investigation and Cobb, DeKalb, Fulton and Gwinnett Counties. The overdose deaths per 10,000 residents was calculated using 2013 population data retrieved from the United States Census Bureau 2010 to 2014 American Community Survey 5-year population estimates. The map was created by the Statistical Analysis Center at the Criminal Justice Coordinating Council on 5/6/2015. For questions regarding this map, please contact Samuel Gonzales at sgonzales@cjcc.ga.gov or 404-657-1971.

Map 10. Number of Prescriptions per Capita in 2013[14]



The data for this map was retrieved from the Georgia Prescription Drug Monitoring Program housed by the Georgia Drugs and Narcotics Agency. The per capita was calculated using population data retrieved from the United States Census Bureau 2010 to 2014 American Community Survey 5-year population estimates. The map was created by the Statistical Analysis Center at the Criminal Justice Coordinating Council on 5/6/2015. For questions regarding this map, please contact Samuel Gonzales at sgonzales@cjcc.ga.gov or 404-657-1971.

[14] The number of prescriptions filled per county is bases on the location of the pharmacy

Drug Addiction Treatment Program Enrollment Data

From 2009 to 2013 there were 34,300 drug treatment admissions for 30,053 individuals in publicly funded drug rehabilitation facilities. The majority of people (88%, 26,531) received treatment only one time during this period and 3,522 (12%) people sought treatment multiple times. While treatment admissions for marijuana, alcohol and cocaine/crack (Table 30) decreased during this time period, there was at 90% to 100% increase in treatment admissions for methamphetamine, heroin, other opiates and methadone. Treatments for benzodiazepines also increased substantially by 63%.

Table 30. Treatment Episodes by Drug, 2009-2013

Drug - Top 5	2009	2010	2011	2012	2013	Totals
Marijuana/Hashish	2,761	2,640	2,380	2,240	2,051	12,072
Alcohol	2,467	2,289	2,516	2,339	1,938	11,549
Cocaine/Crack	1,079	870	842	832	682	4,305
Methamphetamine	323	378	398	542	647	2,288
Other Opiates and Synthetics	162	206	252	297	311	1,228
Benzodiazepines	54	61	95	86	88	384
Heroin	36	49	47	54	69	255
Non-Prescription Methadone	20	19	19	28	38	124
Total Top 8 Drugs	6,902	6,512	6,549	6,418	5,824	32,205
Total Treatments	7,259	6,893	6,959	6,884	6,305	34,300

Table 31. Percent Change in Treatment Episodes by Drug, 2009-2013

Drug - Top 5	% Ch 2009	% Ch 2010	%Ch 2011	%Ch 2012	% Ch 2013	Totals
Marijuana/Hashish	-	-4%	-10%	-6%	-8%	-26%
Alcohol	-	-7%	10%	-7%	-17%	-21%
Cocaine/Crack	-	-19%	-3%	-1%	-18%	-37%
Methamphetamine	-	17%	5%	36%	19%	100%
Other Opiates and Synthetics	-	27%	22%	18%	5%	92%
Heroin	-	36%	-4%	15%	28%	92%
Benzodiazepines	-	13%	56%	-9%	2%	63%
Non-Prescription Methadone	-	-5%	0%	47%	36%	90%

Seventy percent (20,905) of individuals admitted to drug treatment were male. Thirty percent (9,148) were female. Admissions were split almost equally between Whites and Black/African Americans, who comprised of 95% (28,533) of admissions. Ninety-six percent (28,929) of individuals were not of Hispanic origin.

Marital status, educational level and living arrangements for persons seeking treatment multiple times can and did change, so our analysis of these demographics include all treatment episodes, regardless of whether the person was a repeat visit. Further research with these data may help us

determine whether those who were repeatedly referred to treatment differed substantially than those who only sought treatment once. To determine whether instability in demographic characteristics such as marital status has any relation to repeat admissions would also be helpful and ascertaining what kinds of additional social supports persons in treatment and recovery may need to prevent relapse. At the time of intake, 71% (24,347) of those treated had never been married and 11.7% (4,016) were divorced and another 5.8% (1,983) were separated from their spouse. Only 9.8% (3,389) of individuals were married at the time of intake.

Forty-nine percent (16,760) of those entering treatment had completed at least twelve years of education. A large percentage of this subset of the treatment population (44%, 15,137) completed between eight and thirteen years of school. Only two percent (655) of individuals had completed less than one year of education. While 82% (28,181) of individuals were living independently when they entered drug treatment, a significant percentage (9%, 3,102) were in dependent living arrangements, 6% (1973) were homeless, and the status of 3% was unknown.

Multiple Treatment and Drug Progression

The following analysis examines subsequent treatments of individuals to determine if those who had two or more treatment admissions did so for a different type of drug from the first treatment episode. Only the top 7 drugs were included for the percentages in subsequent treatment episodes. This means that not all treatment episodes will add to 100%. Twelve percent of individuals were admitted for more than one treatment episode between 2009 and 2013 and about 2% received 3 to 6 treatments within publicly funded facilities.

For Marijuana, Cocaine and Methamphetamine, over 70% of those who received a second treatment were for the same drugs. Eighty percent of individuals who originally received treatment for marijuana, were still seeking help for marijuana addiction by the fifth treatment episode. Approximately 11% of individuals with Methamphetamine addiction received a second treatment and one percent received a third treatment. Over 70% of people who initially started treatment for methamphetamine addiction are still seeking treatment for methamphetamine for their third treatment episode.

By comparison, with heroin and other opiates around 60% entered a second treatment for the same type of drugs. Of note, 10% of those previously treated for heroin entered a second treatment for other opiates or synthetic opiates. Four percent of those initially treated for Opiate or synthetic opiate addiction were treated for heroin in the second treatment episode.

Although Benzodiazepines are prescribed in high numbers and are associated with the most drug overdoses, they represent only 0.01% of criminal justice initiated drug treatment episodes during this period. Of persons who are treated for Benzodiazepine addiction, 6% seek treatment more than once and 52% of them still need help with Benzodiazepines addiction, 19% for marijuana, and 10% for Alcohol and Cocaine. About 5% also seek treatment for opiate addiction.

The breakdown of subsequent treatment episodes based on the primary drug of treatment are in Tables 1 to 6, which summarize primary drug of choice during multiple treatment episodes for an individual. The drugs we examine are Marijuana / hashish, cocaine / crack, methamphetamine, synthetic opiates, benzodiazepines and heroin.

Table 32. Type of Drug Treatment Following Initial Treatment for Marijuana, 2009-2013

	Treatment 1	Treatment 2	Treatment 3	Treatment 4	Treatment 5	Treatment 6
Marijuana/Hashish	100.00%	79.40%	79.45%	76.00%	80.00%	50.00%
Alcohol	-	10.00%	10.95%	10.00%	0.00%	50.00%
Cocaine/Crack	-	3.00%	1.36%	4.00%	10.00%	0.00%
Methamphetamine	-	1.80%	2.28%	4.00%	0.00%	0.00%
Other Opiates and Synthetics	-	1.20%	1.36%	2.00%	10.00%	0.00%
Benzodiazepines	-	0.40%	1.36%	0.00%	0.00%	0.00%
Heroin	-	0.10%	0.00%	0.00%	0.00%	0.00%
Total of Individuals Treated (n)	**1,360**	**1,360**	**219**	**50**	**10**	**2**
% Receiving Additional Treatment from one episode to the next	-	**15%**	**16%**	**23%**	**20%**	**20%**
% Of Total Receiving Additional Treatment	-	**14.90%**	**2.40%**	**0.55%**	**0.11%**	**0.02%**

Table 33. Type of Drug Treatment Following Initial Treatment for Cocaine / Crack, 2009-2013

	Treatment 1	Treatment 2	Treatment 3	Treatment 4	Treatment 5	Treatment 6
Cocaine/Crack	100.00%	72.94%	63.55%	60.00%	42.85%	0.00%
Marijuana/Hashish	-	14.92%	3.74%	5.00%	14.23%	0.00%
Alcohol	-	6.53%	5.61%	30.00%	42.85%	100.00%
Methamphetamine	-	0.93%	0.00%	0.00%	0.00%	0.00%
Other Opiates and Synthetics	-	1.87%	2.80%	0.00%	0.00%	0.00%
Benzodiazepines	-	0.37%	0.93%	0.00%	0.00%	0.00%
Heroin	-	0.37%	0.00%	0.00%	0.00%	0.00%
Total of Individuals Treated (n)	**3,129**	**536**	**107**	**20**	**7**	**1**
% Receiving Additional Treatment from one episode to the next	-	**17.13%**	**19.96%**	**18.69%**	**35.00%**	**14.29%**
% Of Total Receiving Addition Treatment	-	**17.13%**	**3.42%**	**0.64%**	**0.22%**	**0.03%**

Table 34. Type of Drug Treatment Following Initial Treatment for Methamphetamine, 2009-2013

	Treatment 1	Treatment 2	Treatment 3	Treatment 4	Treatment 5	Treatment 6
Methamphetamine	100.00%	74.22%	72.73%	100.00%	0.00%	0.00%

	Treatment 1	Treatment 2	Treatment 3	Treatment 4	Treatment 5	Treatment 6
Marijuana/Hashish	-	4.64%	4.55%	0.00%	0.00%	0.00%
Alcohol	-	8.24%	13.64%	0.00%	0.00%	0.00%
Cocaine/Crack	-	0.52%	4.55%	0.00%	0.00%	0.00%
Other Opiates and Synthetics	-	0.52%	0.00%	0.00%	0.00%	0.00%
Benzodiazepines	-	0.52%	0.00%	0.00%	0.00%	0.00%
Heroin	-	0.52%	0.00%	0.00%	0.00%	0.00%
Total of Individuals Treated (n)	**1,857**	**194**	**22**	**1**	**0**	**0**
% Receiving Additional Treatment from one episode to the next	**-**	**10.45%**	**11.34%**	**4.55%**	**0.00%**	**0.00%**
% Of Total Receiving Addition Treatment	**-**	**10.45%**	**1.18%**	**0.05%**	**0.00%**	**0.00%**

Table 35. Type of Drug Treatment Following Initial Treatment for Other Opiates, 2009-2013

	Treatment 1	Treatment 2	Treatment 3	Treatment 4	Treatment 5	Treatment 6
Other Opiates and Synthetics	100.00%	59.52%	50.00%	50.00%	0.00%	0.00%
Marijuana/Hashish	-	5.55%	5.55%	0.00%	0.00%	0.00%
Alcohol	-	11.11%	22.22%	0.00%	0.00%	0.00%
Cocaine/Crack	-	0.79%	0.00%	0.00%	0.00%	0.00%
Methamphetamine	-	2.38%	0.00%	0.00%	0.00%	0.00%
Benzodiazepines	-	7.14%	0.00%	0.00%	0.00%	0.00%
Heroin	-	3.97%	5.55%	0.00%	0.00%	0.00%
Total of Individuals Treated (n)	**951**	**126**	**18**	**2**	**0**	**0**
% Receiving Additional Treatment from one episode to the next	**-**	**13.25%**	**14.29%**	**11.11%**	**0.00%**	**0.00%**
% Of Total Receiving Addition Treatment	**-**	**13.25%**	**1.89%**	**0.21%**	**0.00%**	**0.00%**

Table 36. Type of Drug Treatment Following Initial Treatment for Benzodiazepines, 2009-2013

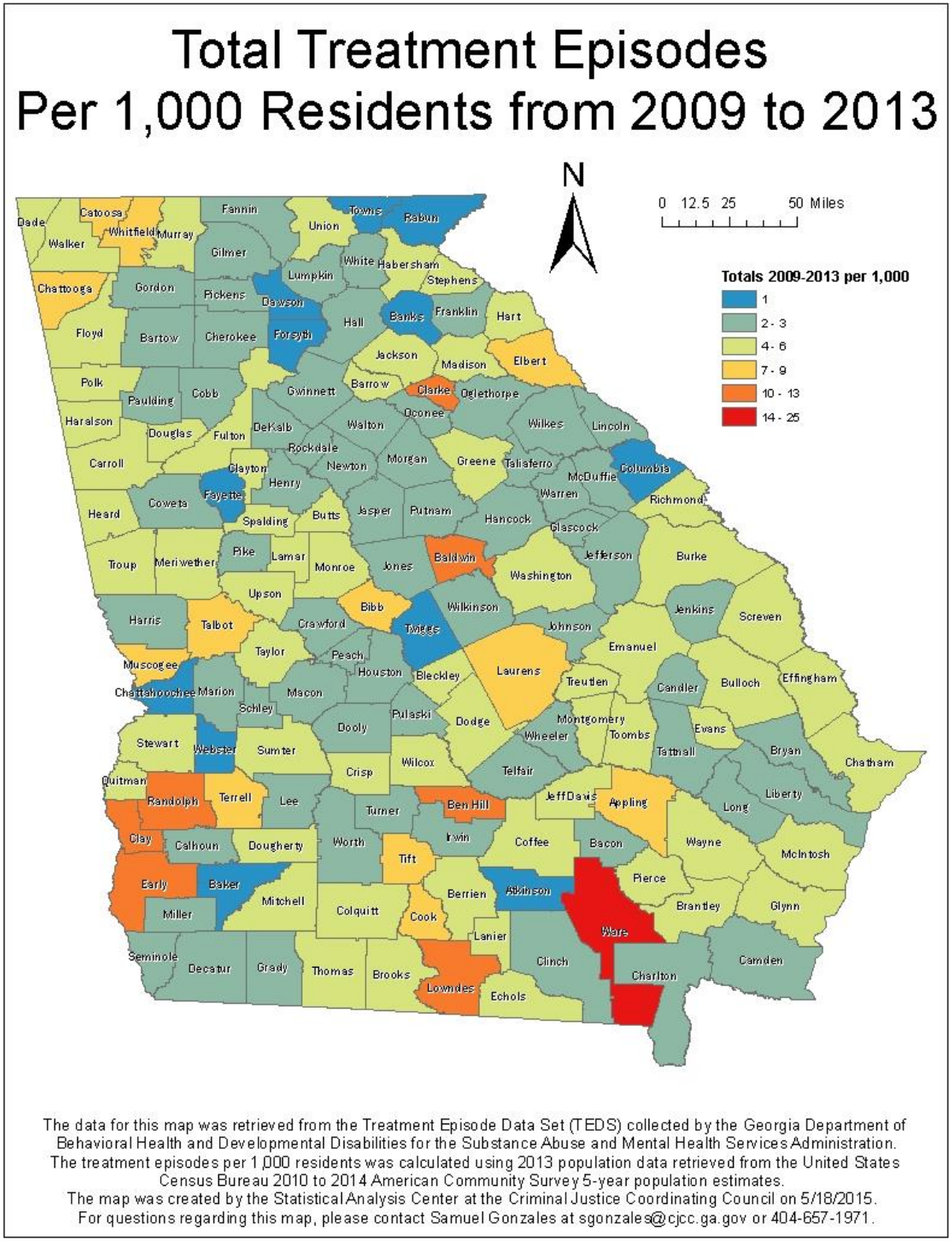
	Treatment 1	Treatment 2	Treatment 3	Treatment 4	Treatment 5	Treatment 6
Benzodiazepines	100.00%	52.38%	0.00%	0.00%	0.00%	0.00%
Marijuana/Hashish	-	19.04%	0.00%	0.00%	0.00%	0.00%
Alcohol	-	9.52%	0.00%	0.00%	0.00%	0.00%

	Treatment 1	Treatment 2	Treatment 3	Treatment 4	Treatment 5	Treatment 6
Cocaine/Crack	-	9.52%	50.00%	0.00%	0.00%	0.00%
Methamphetamine	-	0.00%	0.00%	0.00%	0.00%	0.00%
Other Opiates and Synthetics	-	4.76%	0.00%	0.00%	0.00%	0.00%
Heroin	-	0.00%	0.00%	0.00%	0.00%	0.00%
Total of Individuals Treated (n)	**322**	**21**	**2**	**0**	**0**	**0**
% Receiving Additional Treatment from one episode to the next	**-**	**6.52%**	**9.52%**	**0.00%**	**0.00%**	**0.00%**
% Of Total Receiving Addition Treatment	**-**	**6.52%**	**0.62%**	**0.00%**	**0.00%**	**0.00%**

Table 37. Type of Drug Treatment Following Initial Treatment for Heroin, 2009-2013

	Treatment 1	Treatment 2	Treatment 3	Treatment 4	Treatment 5	Treatment 6
Heroin	100.00%	63.33%	80.00%	0.00%	0.00%	0.00%
Marijuana/Hashish	-	3.33%	0.00%	0.00%	0.00%	0.00%
Alcohol	-	10.00%	20.00%	0.00%	0.00%	0.00%
Cocaine/Crack	-	3.33%	0.00%	0.00%	0.00%	0.00%
Methamphetamine	-	6.66%	0.00%	0.00%	0.00%	0.00%
Other Opiates and Synthetics	-	10.00%	0.00%	0.00%	0.00%	0.00%
Benzodiazepines	-	3.33%	0.00%	0.00%	0.00%	0.00%
Total of Individuals Treated (n)	**186**	**30**	**5**	**0**	**0**	**0**
% Receiving Additional Treatment from one episode to the next	**-**	**16.13%**	**16.67%**	**0.00%**	**0.00%**	**0.00%**
% Of Total Receiving Addition Treatment	**-**	**16.13%**	**2.69%**	**0.00%**	**0.00%**	**0.00%**

Map 8. Treatment Episodes Map by County

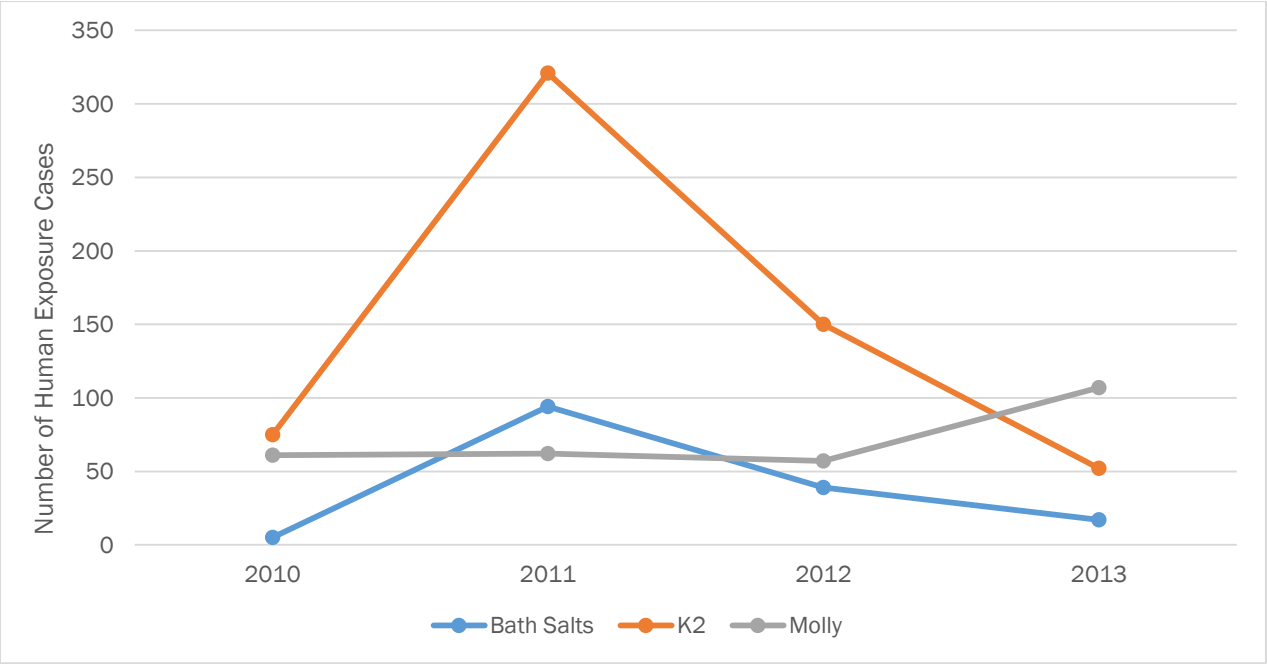


The data for this map was retrieved from the Treatment Episode Data Set (TEDS) collected by the Georgia Department of Behavioral Health and Developmental Disabilities for the Substance Abuse and Mental Health Services Administration.
The treatment episodes per 1,000 residents was calculated using 2013 population data retrieved from the United States Census Bureau 2010 to 2014 American Community Survey 5-year population estimates.
The map was created by the Statistical Analysis Center at the Criminal Justice Coordinating Council on 5/18/2015.
For questions regarding this map, please contact Samuel Gonzales at sgonzales@cjcc.ga.gov or 404-657-1971.

Human Exposure to Synthetic Marijuana, Molly and Bath Salts

The Georgia Poison Control Center received a total of 1,040 human exposure calls for bath salts, K2 and Molly during 2010 to 2013. Total encounters peaked in 2011 at 477 human exposure cases. Number of human exposure cases to bath salts and K2 both reached their peak in 2011, and have decreased more than 80% since. In contrast, human exposure to Molly was relatively consistent from 2010 to 2012 (around 60 cases per year), but the number almost doubled in 2013 and reached its peak at 107 cases.

Figure 11. Number of Human Exposure Cases to Bath Salts, K2 and Molly, 2010-2013



Age and Gender Distribution

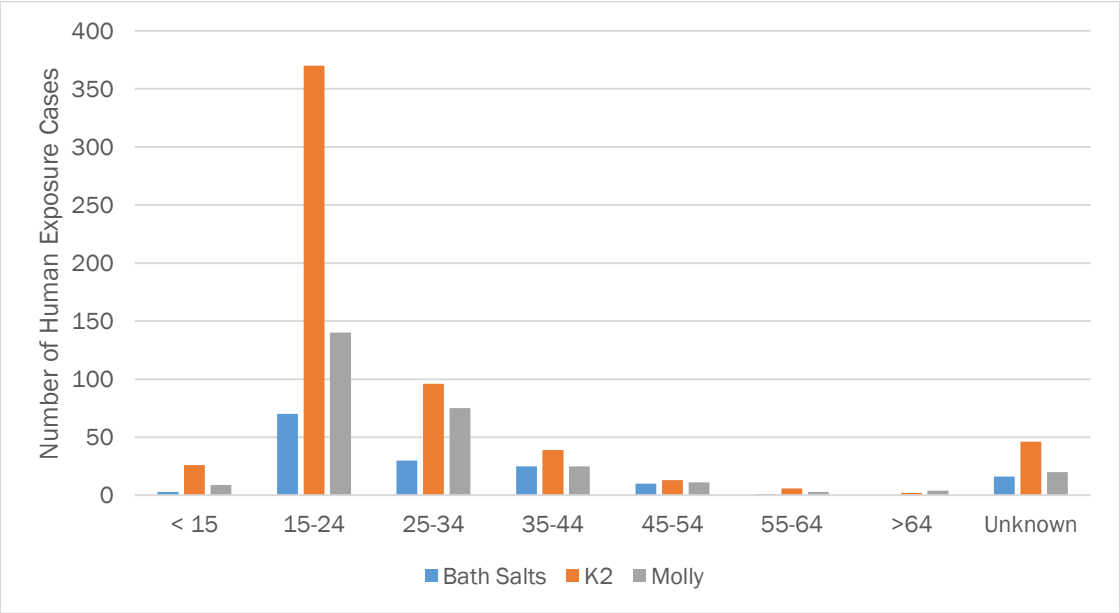
The age and gender distribution of human exposure to bath salts, K2, and Molly is outlined in the figure below. Individuals aged 15 to 24 years old accounted for more than half of all human exposures (56%). More than 70% of the human exposure cases involved males. Females were more strongly represented among cases involving persons 65 or older, but the gender distribution was reversed in any other age group, with males comprising the majority of reported exposures. For bath salts and K2, females accounted for 26% of the reported exposures, however, female exposure to Molly was much higher (37%).

Table 38. Human Exposure to Bath Salts, K2 and Molly by Age, Gender, 2010--2013

Age	Female		Male		Unknown		Total	
	N	%	N	%	N	%	N	%
< 15	13	34%	24	63%	1	3%	38	100%
15-24	170	29%	410	71%	0	0%	580	100%
25-34	56	28%	145	72%	0	0%	201	100%
35-44	29	33%	59	66%	1	1%	89	100%
45-54	9	27%	25	74%	0	0%	34	100%

Age	Female		Male		Unknown		Total	
	N	%	N	%	N	%	N	%
55-64	0	0%	10	100%	0	0%	10	100%
>64	4	67%	2	33%	0	0%	6	100%
Unknown	19	23%	56	68%	7	9%	82	100%
Total	**300**	**29%**	**731**	**70%**	**9**	**1%**	**1,040**	**100%**

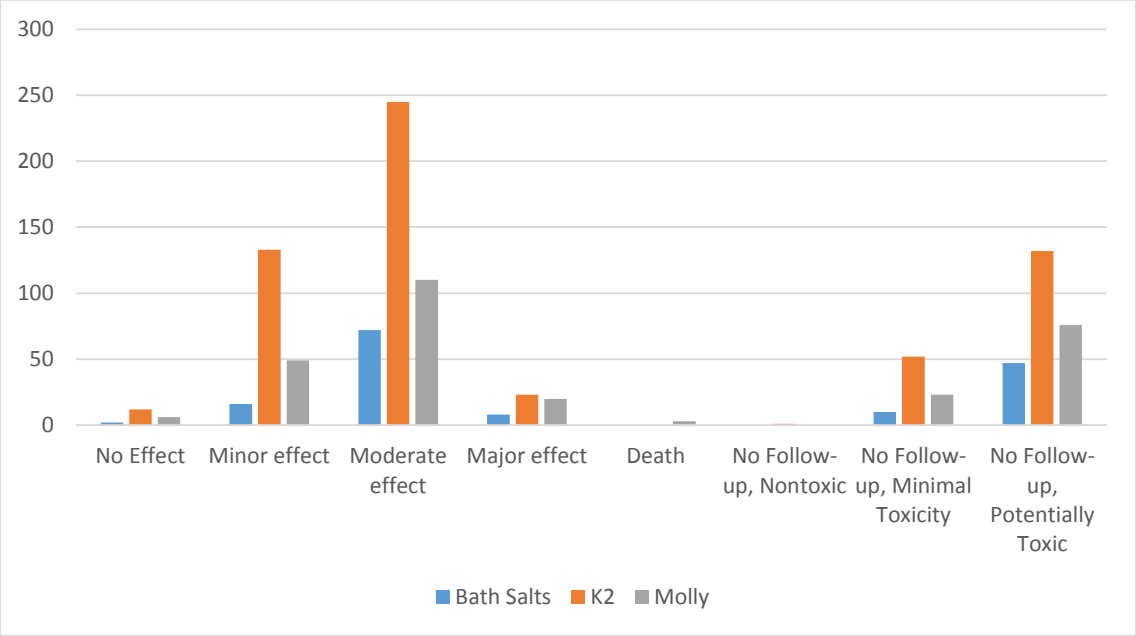
Figure 12. Human Exposure to Bath Salts, K2 and Molly by Age, 2010-2013



Medical Outcome (See Medical Definitions in Methodology section for what each category establishes)

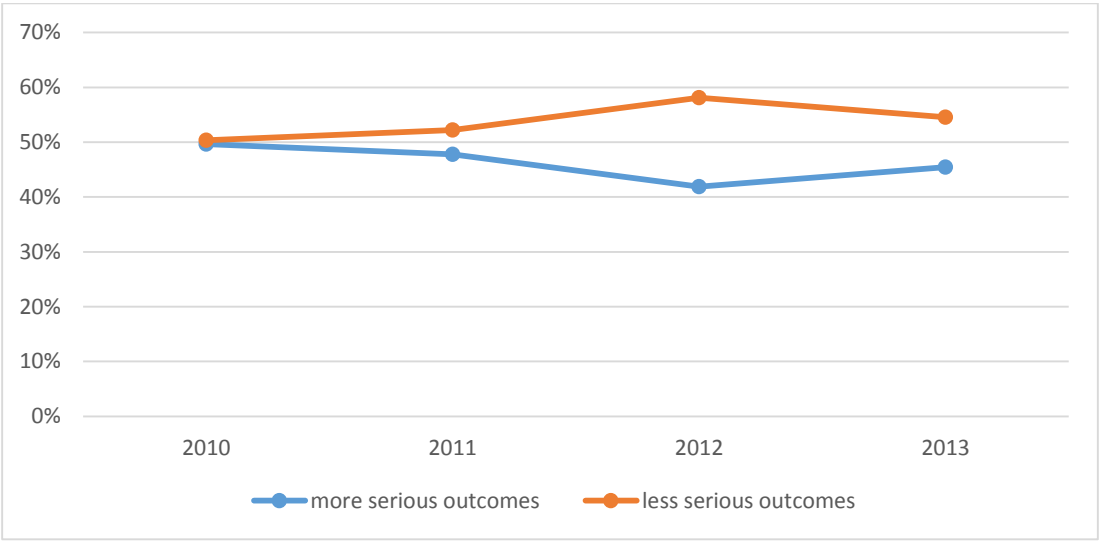
The figure below displays the medical outcome of human exposure cases to bath salts, K2 and Molly. Over 40% of the cases had moderate effect, followed by potentially toxic (25%) and minor effect (19%). Molly was the only drug that contributed 3 fatalities in this reporting period.

Figure 13. Medical Outcome of Human Exposure to Bath Salts, K2 and Molly, 2010-2013



The figure below shows year-to-year human exposure calls broken down into cases with more serious outcomes (death, major effect and moderate effect) and less serious outcomes (minor effect, no effect, not followed (non-toxic), not followed (minimal toxicity possible), and unable to follow (potentially toxic)). In 2010, outcomes were evenly distributed between more and less serious at 50% each. Fifty-eight percent of the cases resulted in a less serious outcome in 2012, however, that number decreased to 55% in 2013. Though we see a consistent decrease in exposure calls in bath salts, K2 and Molly, the severity of exposure to these drugs has worsened since 2012.

Figure 14. More Serious Outcomes vs. Less Serious Outcomes of Human Exposure to Bath Salts, K2 and Molly, 2010-2013



County Level Analysis

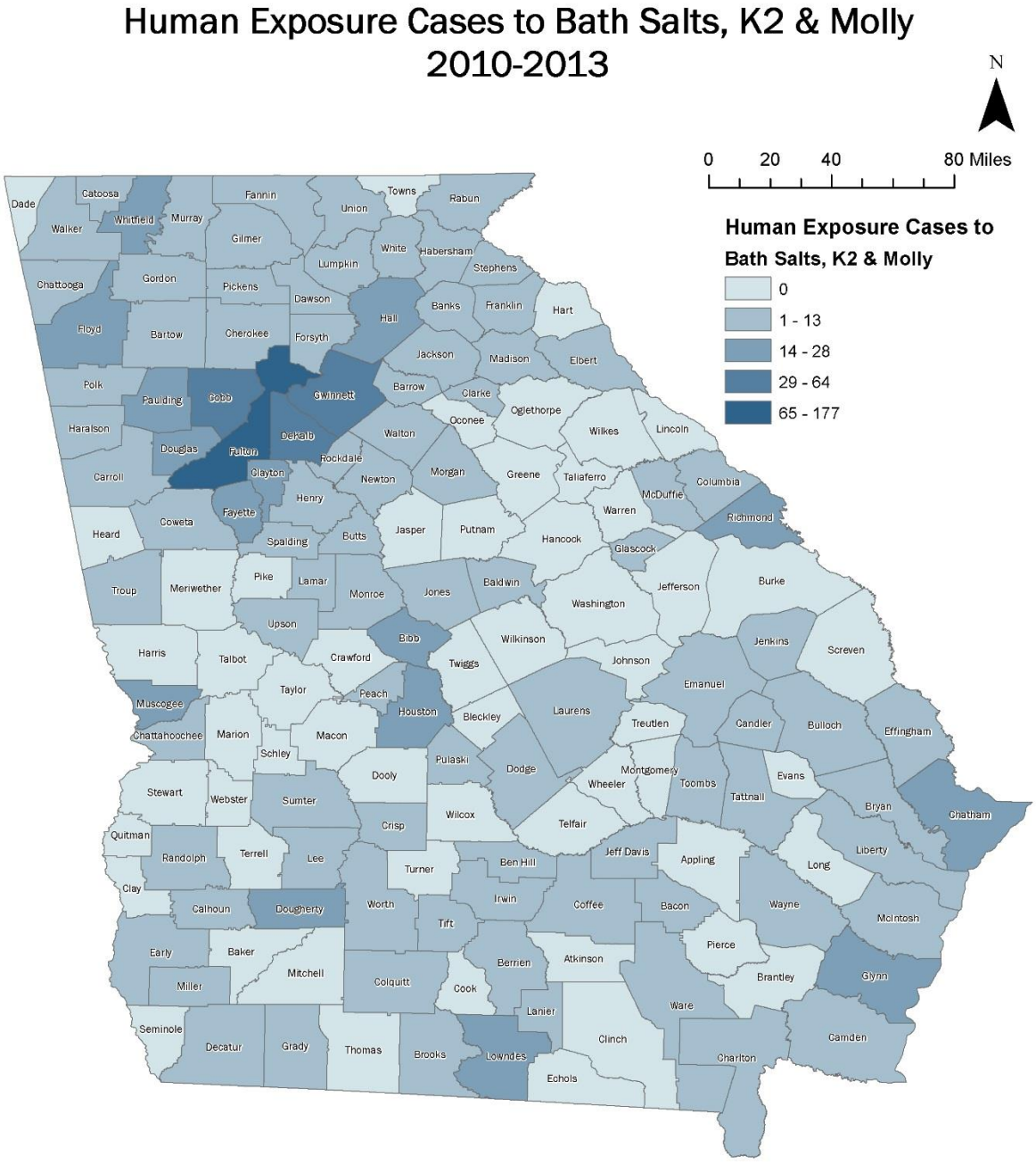
GPC received most human exposure calls to bath salts, K2 and Molly from metropolitan areas, including Atlanta, Macon, Columbus, Augusta and Savannah. Out of 159 counties, 56 counties did

not have any human exposure cases to these three types of drugs. The table below displays the top ten counties for each reported drug exposure.

Table 39. Top Ten Counties on Human Exposure to Bath Salts, K2 and Molly, 2010-2013

Bath Salts	K2	Molly
Fulton	Fulton	Fulton
Cobb	Cobb	DeKalb
Gwinnett	Gwinnett	Gwinnett
Chatham	Whitfield	Muscogee
Muscogee	Hall	Chatham
Cherokee	Paulding	Cobb
Richmond	DeKalb	Fayette
Paulding	Glynn	Baldwin
DeKalb	Muscogee	Bibb
Laurens	Richmond	Clayton

Map 11. Human Exposure Cases from Georgia Poison Center



Human Exposure data was retrieved from the Georgia Poison Center's electronic database. The data does not reflect the overall incidence of poisoning in Georgia because poisoning victims may not call the Georgia Poison Center for assistance. The map was created by Ren Hafner, Operations Analyst at the Statistical Analysis Center in Criminal Justice Coordinating Council. For questions, please contact Ren.Hafner@cjcc.ga.gov

Semi-Structured Interviews

Interview Drug Analysis

The table below indicates the top three drugs or types of drugs that interviewees identified as either a preferred drug in their area or one increasing in use. Stimulants, prescription drugs and marijuana use were mentioned so frequently that they accounted for a top three ranking in five of the six sectors. These 3 drug or drug types represented 72% interviewee responses. Only the Corrections and Treatment sectors deviated with tobacco, alcohol and narcotics ranking high as preferred drugs. Tobacco was unique in correctional facilities because it was banned in state prisons in 2010 and it garnered higher prices compared to other illicit drugs.

Stimulants were mentioned more than any other drug as preferred and in the forms of powder cocaine, crack cocaine and methamphetamine. According to the interviewees in Probation and Prosecution, stimulants were the number one preferred drug at a rate 150% to 238% higher than marijuana and prescription drugs, which were the second and third most frequently discussed drugs. As compared to all other sectors, the frequency with which Treatment sector interviewees discussed a preference for prescription drugs in their population was as much as 227% higher than Alcohol, which was ranked second within that sector.

The abuse of prescription drugs takes many forms, as observed in the GBI overdose death data and the Treatment Episodes Data. Through the interview process we identified two main groups of preferred prescription drugs, which were opiate pain relievers and benzodiazepines. Benzodiazepines are commonly used to treat insomnia or anxiety and the most common trade name we identified in the overdose data is Xanax (alprazolam). The opiate based pain relievers that interviewees identified were Oxycodone and Hydrocodone, along with combination drugs, like Narco and Lortab, which use acetaminophen to increase the effects of Hydrocodone.

Marijuana was identified in every interview and it was noted for its prevalence and widespread use. An interviewee when questioned about the drug types and use in their area said, partly in jest, "..... then there is marijuana that everyone, except myself, uses." When many interviewees were asked about drug seller characteristics, many commented that upper level sellers strictly did not use drugs with the exception of marijuana, which highlights further that marijuana is viewed differently than other types of drugs.

Table 40. Top Three Drugs by Sector

Rank	Corrections	Courts	Law Enforcement	Probation	Prosecution	Treatment
1	Stimulants	Marijuana	Prescription Drugs	Stimulants	Stimulants	Prescription Drugs
2	Tobacco	Prescription Drugs	Marijuana	Prescription Drugs	Marijuana	Alcohol
3	Marijuana	Stimulants	Stimulants	Marijuana	Prescription Drugs	Narcotics

Table 41. Drugs Identified and Coded Through the Interview Process (Total Occurrences in Interview)

Drugs Coded Through Interview	Frequency of Mention
Stimulants	**78**
Prescription Drugs	**76**

Marijuana	**68**
Synthetic Drugs	**27**
Narcotics	**18**
Alcohol	**16**
Tobacco	**14**
Hallucinogens	**11**
Depressants	**1**
Total	**309**

Corrections Interviews

By far, the major concern among interviewees affiliated with Corrections was the contraband trade. This included illicit drugs, smuggled tobacco, and cell phones. The interviewees' concerns arose due to the violence that was attributed to the trade, the degree to which contraband trade is by gangs, and the role of compromised staff.

According to interviewees, the nature of the drug market and seller characteristics played an integral role. Participants in prison drug activity are inside as well as outside the prison, which requires that corrections officers and investigators coordinate with local law enforcement. Much of the drug trade was believed to be controlled by gang members or affiliates and the sophistication of coordination with cell phones and pre-paid credit cards created challenges for enforcement. The geography surrounding prisons, particularly in rural areas, was conducive to throw overs, which added to the many ways contraband entered the prison. Finally, officers were being compromised at alarming rates. One interviewee estimated that 20 percent of the staff could be involved in the contraband trade at any given time, which the administrative data we have previously reported supports (showing approximately 17% of staff are involved in contraband trade).

What we found through our interviews was that those in corrections did have access to many law enforcement investigative resources and equipment aimed to stop contraband from entering the prisons. Interviewees employed cameras, body scanners, metal detectors, golf netting to hinder throw overs. Some used K-9 units to investigate visitor and staff vehicles, and informants had been used to target those efforts. Internal Affairs were used to investigate officers and other civilian staff and interviewees consistently employed "shakedowns" of inmate cells. Finally, Security Threat Group Coordinators were devoted to track gang members and their activities.

One factor of the contraband trade that concerned those in corrections was the lack of effective prosecution of individuals for selling drugs and or for committing violent crimes associated with the distribution of drugs in prison. If someone was prosecuted for drugs or drug-related violence in prison, we found through the interviews, that the crime must involve large quantities of drugs or an injured officer. Interviewees were also concerned that sentences often ran concurrent with the

inmate's original conviction. One interviewee expressed that without repercussions there is no deterrence, so the prosecution of drug and violent crime within prisons is their last defense.

Courts Interviews

Court-affiliated interviewees discussed the variety of substance abusing individuals they had seen cycling through their courtrooms – from of new and chronic users, sellers and user/sellers. Of note, interviewees also mentioned they had started to see younger chronic users with true addiction problems and a generational component of abuse. In addition, many individuals had co-occurring disorders, which inhibited placement within a drug or mental health court.

Within the Courts sector, an area of grave concern was the link between local socioeconomic conditions and the drug market and how that affected decisions in court. Although according to interviewees, poverty seemed to be a motivating factor, particularly in dealing drugs, wealthy neighborhoods or schools were not exempt in their use or sale. What has changed are the drugs being sold and used. An issue that court interviewees were unique in mentioning was the inability for user/offenders to pay for needed residential treatment, probation/supervision fees or home arrest fees, which left some interviewees with little options other than incarceration.

Most of the resources available to the Courts sector were associated with case investigation and there was little consistency with drug treatment options. In some areas interviewees had access to accountability courts, such as drug, mental health and family courts. Others were limited to Narcotics Anonymous and in some cases, when offenders could afford it, private therapists or treatment centers.

What we found to be the biggest need for Courts was increased access to affordable residential treatment facilities. One interviewee stated, "If money were to be allocated it would be for treatment, not diversion, not drug education or other programs, treatment." While most in the Courts sector had access to different types and levels of treatment, it was either too expensive or a bed/slot was not always available, which was the case for many drug courts. There was even a concern about the focus of treatment, with interviewees expressing the importance of family and trauma-based therapies. Finally, coupled with treatment, interviewees also stressed that follow-up care was needed along with other support services, including GED classes.

Law Enforcement Interviews

In Law Enforcement sector interviews, we identified the resources available to combat illicit drug use, the main Federal collaborators and the nature of the drug market, which included user and seller characteristics and drug sources. Law enforcement interviewees, like those from the courts, stated that drug users did not conform to a particular demographic or socioeconomic profile. On the other hand, sellers were mainly defined by racial lines depending on the type of drug sold.

We found that Atlanta is a hub for trafficking. Many Law Enforcement interviewees revealed that due to the extensive interstate system, Atlanta was strategically placed for receiving drugs from the Southwest and distribute them up the east coast to Washington D.C and down to Miami. The Mexican Cartels were smuggling large quantities of Cocaine, Methamphetamine and Marijuana from Mexico across the Texas boarder to their affiliates or other local dealers, who either distribute drugs within Georgia or place them in stash houses for distribution nationwide. Interviewees expressed that Atlanta and Northern Florida were major suppliers of prescription drugs that were distributed around the state. In Georgia's more rural areas, interviewees asserted that meth was still being manufactured, even with cheap meth from Mexico flooding the market.

To combat the drug trade, Law Enforcement used many investigative resources that ranged from specialized equipment to collaboration with federal agencies. Particularly with the highway systems surrounding Atlanta, the Georgia State Patrol, in collaboration with the DEA, plays a pivotal role intercepting drug traffickers on the State highways. Some of the tools they used were density meters, fiber optic scopes, audio and video recording equipment and they were procuring car lifts to make inspection of vehicles easier. Law enforcement interviewees also expressed access to K-9 units, money to pay for informants and access to a myriad trainings from search and seizure to drug identification.

Collaboration between state, federal and local law enforcement agencies on anti-drug enforcement in the state appears to be extensive. Those interviewed in the Law Enforcement sector mentioned working with agencies such as the DEA, FBI, ICE, the US Marshal Service, ATF, Postal Inspection Service, Homeland Security Investigations, the Department of Health and Human Services and HIDTA. Some agencies, such as the Georgia State Patrol's drug interdiction unit, even had DEA radios in their cars.

Probation Interviews

Probation sector interviewees stated that the user population in their area was comprised of both chronic and new users, and that many users were also selling drugs. Interviewees also witnessed, some of those on probation suffering from co-occurring disorders. Marijuana use at a young age was not uncommon and interviewees expressed a pattern of lacing it with other drugs as a gateway to more chronic use. In some areas Probation interviewees discussed the problem of inter-generational use.

Seller characteristics are much like user characteristics in that there are both new and chronic and there is a generational component. One interviewee gave the example of a child's parents selling. When that parent went to jail, the child eventually started to sell to survive, because, according to the interviewee, "that is what the child knows". Not all probation interviewees discussed gang involvement in drug dealing, but those who did said that was common and that gangs ranged from neighborhood crews to larger national affiliates. Interviewees talked about how younger gang members would be on probation for taking a charge for the older members, so they would be promoted within the gang.

Many resources were available to those in the Probation sector to investigate suspected drug crime. Interviewees reported access to drug testing, drug identification and mental health training and gang classification processes. They consistently used confidential informants and social media to gain information about those under their supervision. They also partner with local Law enforcement when needed.

The probation sector did have access to some outpatient treatment resources such as Day Reporting Centers, Narcotics Anonymous and programs through accountability courts. They also had access to other resources such as one-stop-shops, job training programs, mental health counselling, and GED programs that provide wraparound assistance to those under supervision. However, interviewees also alerted us that access to these resources is not universal and many programs are full. Interviewees expressed that increased access to these existing resources and assistance with transportation for those under supervision were their largest needs.

Prosecution Interviews

When dealing with the sale and the use of drugs, there were many factors that contributed to prosecutorial decision making, which lead to discussion of specific needs within this sector. Interviewees stressed that they considered criminal history and the type of crime for which the person to charged to determine whether to try a case, provide a plea deal or attempt to obtain probation. You must "earn your way into prison", said one interviewee. This prioritization strategy was heavily influenced by docket schedules and if the accused was able to bond out.

Crimes occurring within correctional settings were subjected to this prioritization, and some interviewees admitted that correctional cases were given low priority when compared to others, with the strong exception of crimes against correctional officers. Although interviewees all discussed different reasons for this classification, the assignment of low priority stemmed from the fact the crimes occurred in a prison where most witnesses were criminals and crime scenes were routinely compromised. These prove difficult for prosecutors to take a trial, particularly when the crime was against another inmate and the prosecutor was concerned with the contempt many felt juries held for prisoner victims. When it came to low level crimes and small quantities of drugs, we found those cases took low priority.

Another factor in prosecutor decision making was the Gang Statute that passed in 2010. Some prosecutors were using it successfully or as a powerful tool in plea deals. Others had a hard time with investigators providing the necessary evidence to bring enhanced charges under the gang statute and some found that the efforts to prove gang affiliation were not worth it because other charges already carry long sentences.

Prosecutorial interviewees made clear that they had a substantial fiscal need for the prosecution sector to be more effective. Interviewees expressed the need for more money to increase the pay for Assistant District Attorneys, as well as for more money to increase the staff of existing Drug Taskforces and to create new ones.[15] Interviewees also mentioned the need for more money for the Department of Corrections to ease the budgetary stress of longer sentences for more serious offenders. Fiscal resources would allow full investigations of gang activity for prosecution under the gang statute. Finally, interviewees asked for full-time prosecutors to work the drug courts.

Treatment Interviews

Treatment providers encountered individuals who had acute substance abuse disorders, a third to two-thirds of whom they estimated on average had co-occurring disorders. They saw a mix of races, more men than women and a mix of chronic and new users. The new users were more often young teenagers, who were abusing marijuana, narcotic prescription drugs and in some cases heroin. As discussed with Probation sector interviewees, providers see a generational component to substance abuse and they estimated that about 40% of the users they treat have criminal histories.

For the Treatment providers, there were numerous resources available. In some areas there were volunteer clinics that served patients who are employed but have no insurance, and private treatment facilities that had varying levels of inpatient and outpatient care. Some had access to indigent care hospitals, but this was limited across the state. Many clinics had the ability to treat co-occurring disorders and provided medication-based treatment plans to administer Suboxone or Methadone. Interviewees also used other outpatient treatment options like Narcotics Anonymous.

[15] CJCC's semi-annual Multi-Jurisdictional Drug Task Force output reports support the success of case prosecution from task force initiated cases. Since 2011, over 90% of task force initiated cases are accepted for either state or federal prosecution each year.

Some had access to drug, family and mental health courts and after care that varied in availability across the state. Transportation was available, which was directly provided by some organizations, typically in more rural counties, or they utilized public transportation. Residential treatment was also available, but the space was limited and typically full or unaffordable for some patients.

A complicated aspect of treatment that interviewees noted is that there are many barriers for individuals to be successful. According to interviewees funding for treatment or indigent care falls short of demand. We found that due to the lack of treatment resources in some areas, resources are crowded out in others. Specifically with the lack of beds for residential treatment, even if treatment services were accessible and available, there was a need for diversity in the types of treatment, so that individuals could receive the best treatment for their type of addiction. For instance, interviewees specifically discussed challenges in treating prescription drug abuse, where a medication-based treatment is needed for addiction but also for pain management. Then there are other barriers to success such as employment, transportation and housing, which are financial barriers outside the direct costs of treatment.

Providers reported that their funding streams which depended on private and public insurance and grants from the Substance Abuse and Mental Health Services Administration, the State Department of Behavioral Health and Developmental disabilities were limiting factors in their ability to treat substance abusers. What we found through the interview process was that the treatment sector needed more rehabilitation resources for low income individuals and other supportive services. This included funding for indigent care and more diverse types of treatment. Interviewees also expressed the need for additional structured housing facilities near jobs and transportations and better linkages to other resources such as GED classes and life skills programs. We also found that those in the treatment sector would like to see increased physician participation in the prescription monitoring program

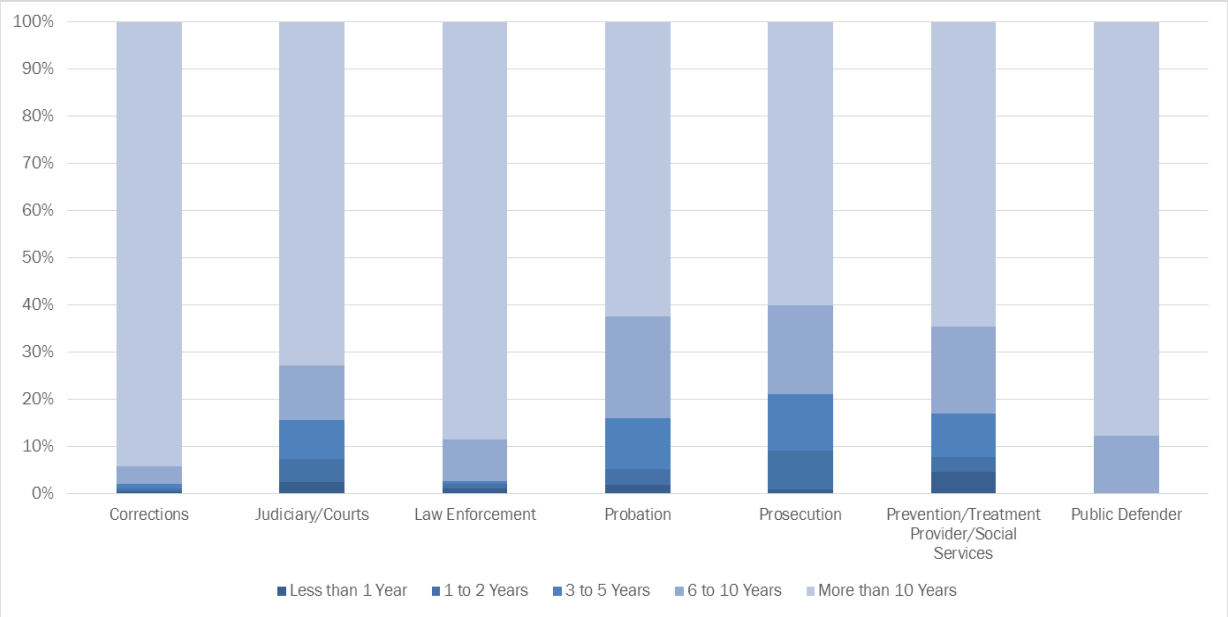
Online Survey

General Questions Findings

Survey Participants Characteristics

Over 95% of the survey participants have more than 6 years of working experience in their specific sector; of these, more than three quarters have worked in their specific is in the prevention/treatment provider/social services sector, whereas, all of public defender sector participants have been working in their field for more than 6 years. See the figure below for detailed distribution by sector.

Figure 15. Survey Participants' Years of Experience by Sector

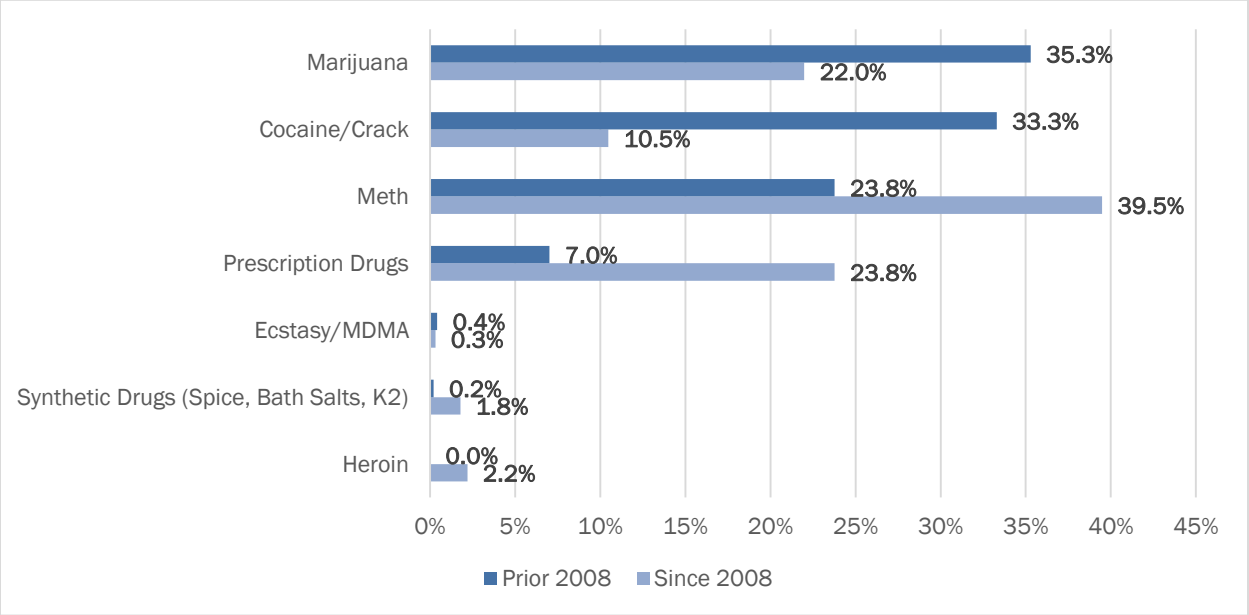


Drug Market Characteristics

Survey participants were asked to select the most prevalently abused drugs in their jurisdiction or treatment service area prior to the 2008 recession and since the 2008 recession. More than 35% of participants chose Marijuana, followed by Cocaine/Crack (33%), and Methamphetamine (24%) for the pre-recession period. Interestingly, none of the participants thought heroin was the most prevalent drug in their areas before 2008. Since 2008, Methamphetamine is identified the most prevalent drug in close to 40% of the participants' jurisdiction or service area, followed by Prescription Drugs (24%), and Marijuana (22%). We also see more cases involving Synthetic drugs and Heroin abuse since 2008. Ecstasy/MDMA is the only drug type that remained the same during this period.

When we look at the data from the perspective of the various respondents' occupation, participants in the judiciary/courts, prosecution, prevention/treatment providers/social services, and public defenders offices chose Cocaine/Crack as the number one drug. Persons working in corrections, probations and law enforcement agencies chose Marijuana as the most prevalent drug prior to 2008. Since the 2008 recession, methamphetamine is the drug identified as most prevalent across all sectors except for prevention/treatment providers/social services. Over 30% of respondents working in the treatment sector stated prescription drugs are their clients' primary drug choice.

Figure 16. Most prevalently abused Drugs in Respondent Jurisdiction or Treatment Service Area



Drug Consumer Characteristics

Respondents were asked to express their opinions on any changes in the age and gender of users in their local drug market. The majority agreed that the age and gender of the average substance abuse consumer in their jurisdiction or service area stayed the same. Meanwhile, a substantial number (31% and 22% respectively) of respondents agreed that drug consumers are younger than before and that there is an increasing number of female drug consumers in their area.

Table 42. The Change in Gender

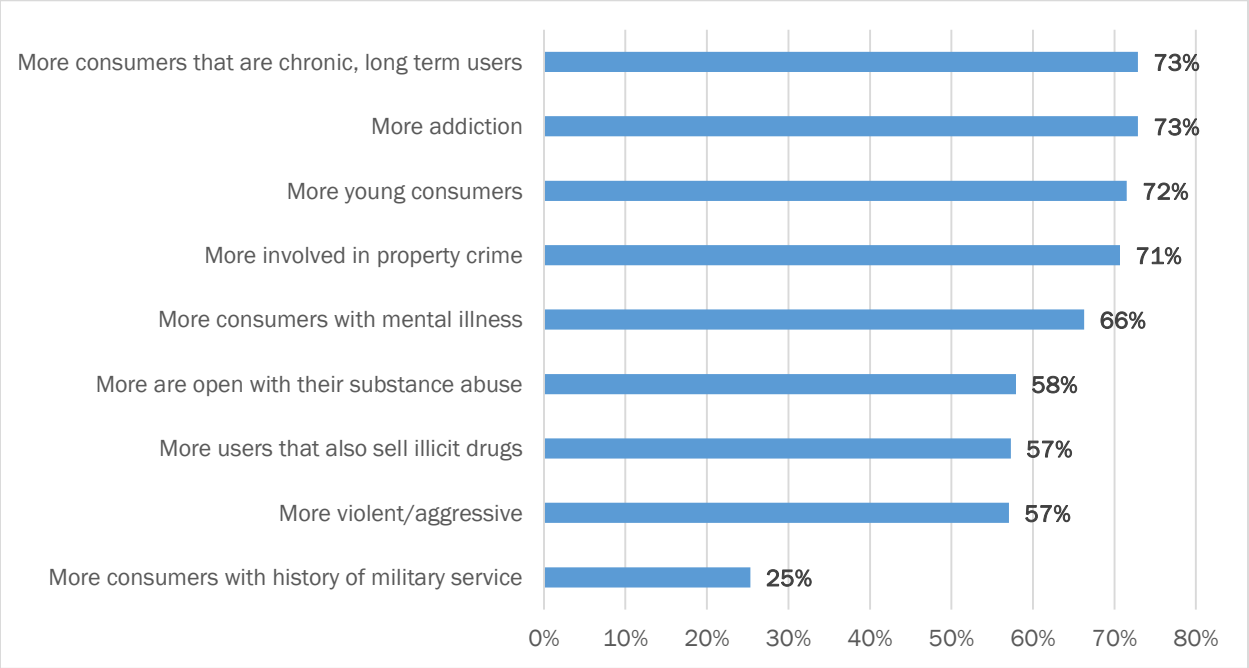
Gender Change	No. Participants	Percentage
More Males Doing Drugs	80	8%
The Same	413	43%
More Females Doing Drugs	213	22%
Don't Know	233	24%
No Answer	16	2%
Total	955	100%

Table 43. The Change in Age

Age Change	No. Participants	Percentage
Younger	295	31%
The Same	353	37%
Older	72	8%
Don't Know	219	23%
No Answer	16	2%
Total	955	100%

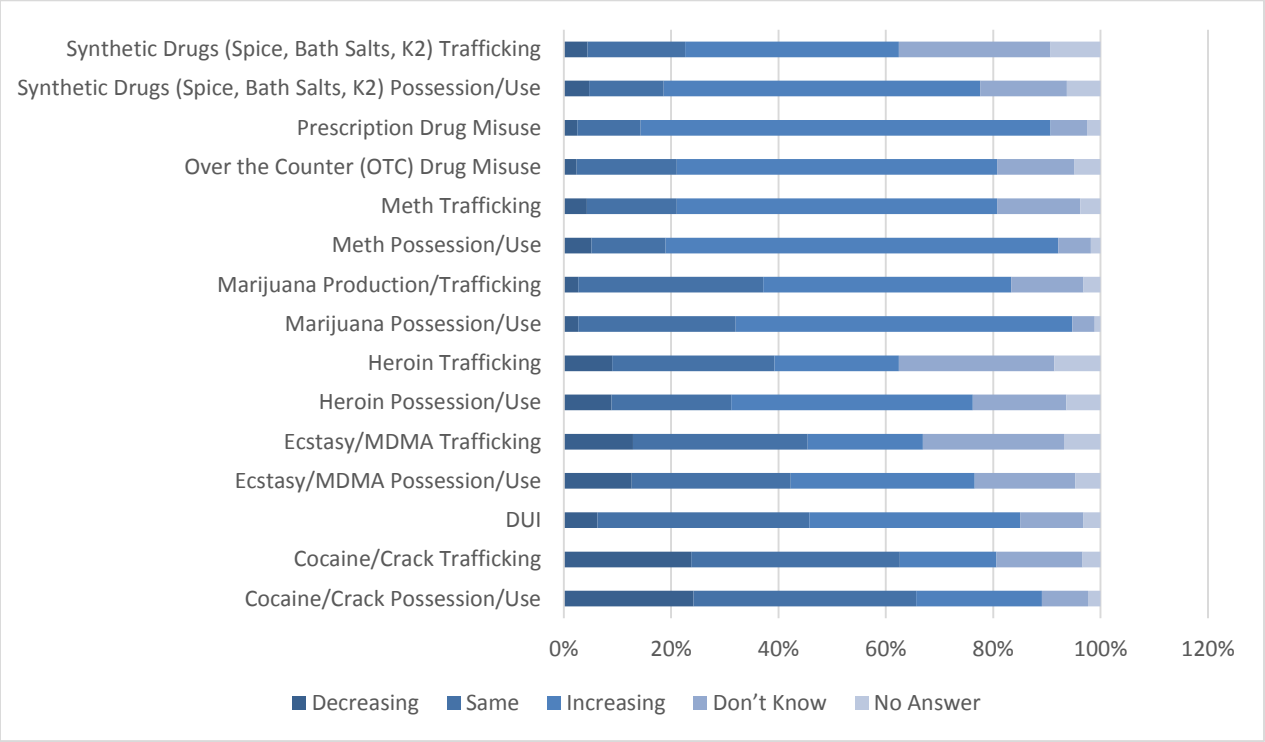
Survey respondents were asked whether they had observed any of the changes listed in the chart below in drug consumer characteristics in their service area. More than 70% of respondents indicated that they are seeing more chronic consumers (73%), more addiction (73%), more young consumers (72%) and more persons involved in property crime (71%). Almost two-thirds of respondents are seeing more consumers with mental illness. Close to 60% of respondents thought more consumers are open with their substance abuse (58%), more users also sell illicit drugs (57%), and more users are violent or aggressive (57%). About a quarter of the participants also stated that there are more consumers with history of military service.

Figure 17. Drug Consumer Characteristics



The majority of respondents stated that only 4 out of the 15 substance abuse issues remained the same since the 2008 recession: Cocaine/Crack Possession/Use (41%), Cocaine/Crack Trafficking (39%), DUI (39%), and Heroin Trafficking (30%). In comparison, more than 70% of respondents indicated that they noticed increasing Prescription Drug Misuse (76%) and Meth Possession/Use (73%). Approximately 60% of respondents reported an increase in Marijuana Possession/Use (63%), Meth Trafficking (60%), Over the Counter (OTC) Drug Misuse (60%), and Synthetic Drugs (Spice, Bath Salts, K2) Possession/Use (59%). The figure below illustrates respondent opinions about drug abuse trends in their area since 2008.

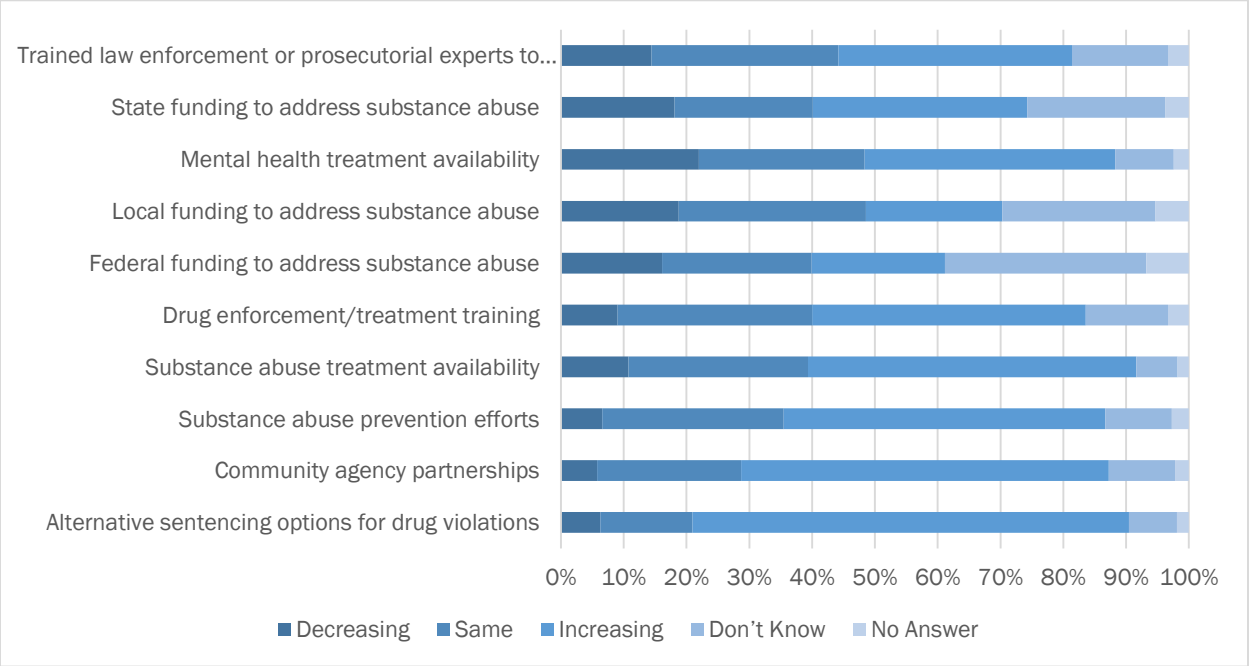
Figure 18. Changes in Substance Abuse Issues Since 2008



Resources Available for Combating Substance Abuse Issues

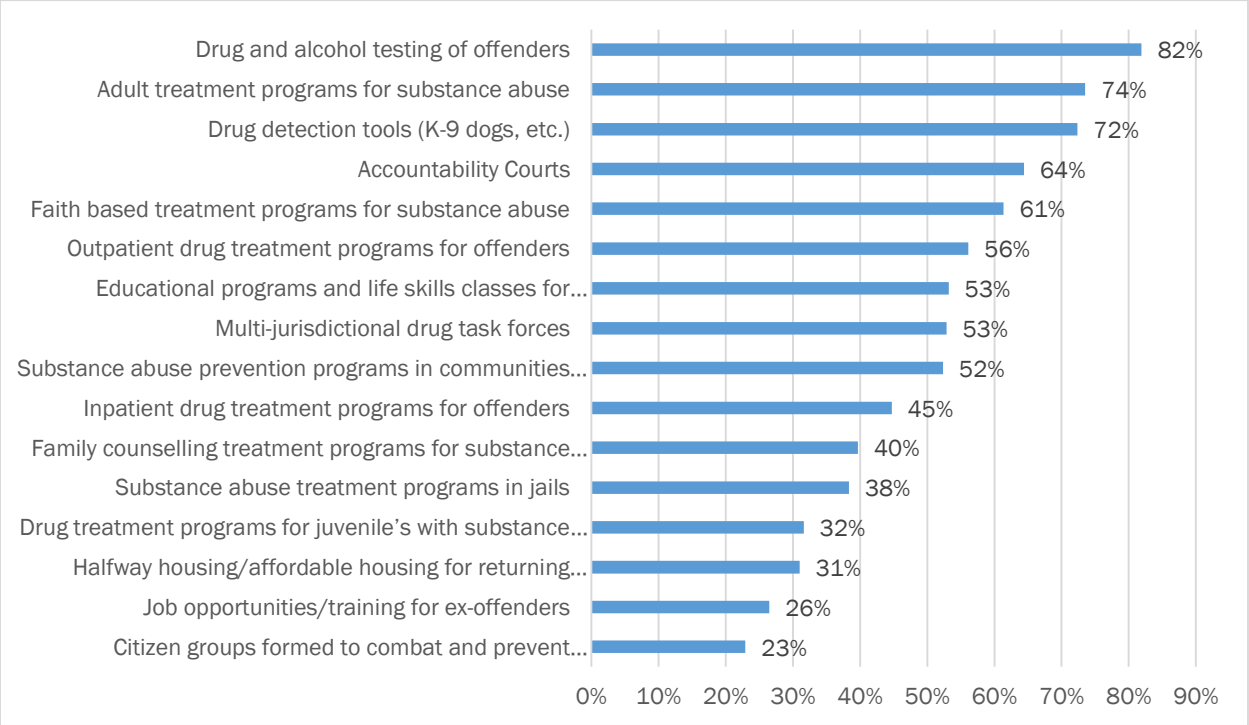
We are all aware of the difficulties on tackling substance abuse issues, especially with very limited resources. More than a third of survey respondents expressed that they have seen an increase in most of the resources available to combat drug abuse and crime except for funding to address substance abuse from the federal level (21%) or the local level (22%). The biggest change in trying to solve substance abuse issues came from alternative sentencing options for drug violations (70%), community agency partnerships (59%), substance abuse treatment availability (52%) and substance abuse prevention efforts (51%).

Figure 19. Changes in Resources Available for Treating Substance Abuse



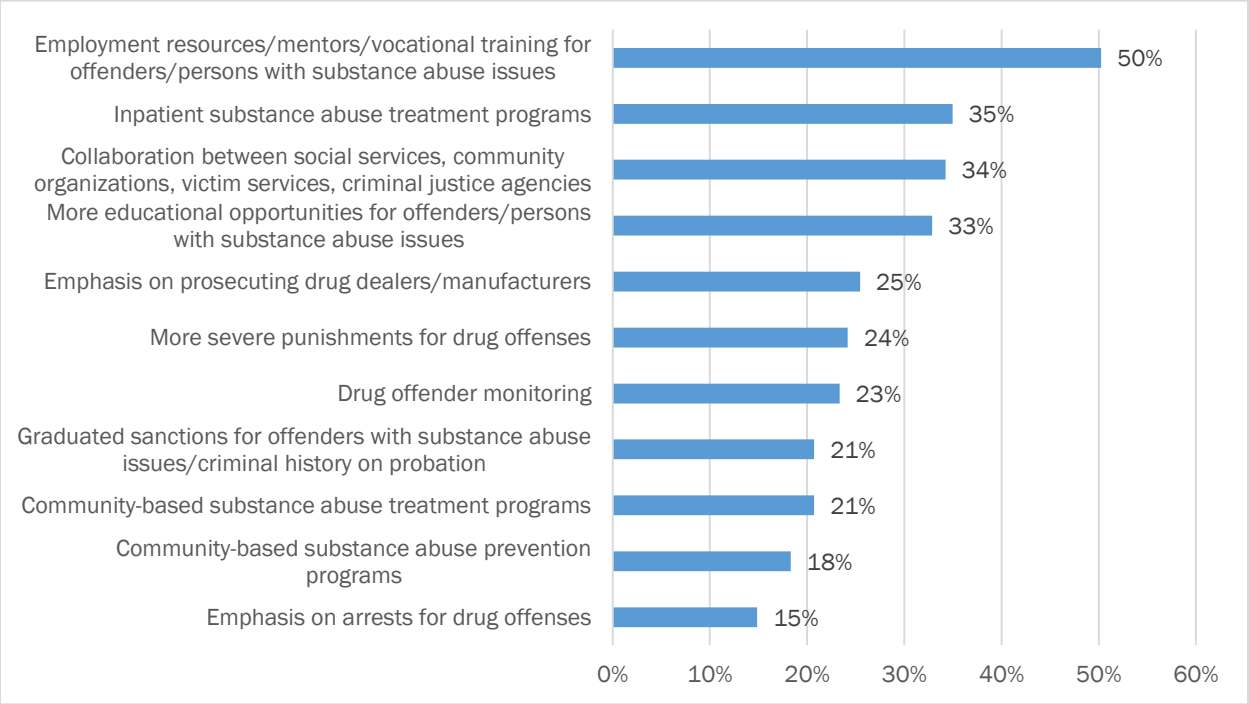
A variety of substance abuse programs have been introduced and implemented, which are aimed at reducing substance abuse. Widely used and available resources for combatting drug abuse and crime including: random drug and alcohol testing for offenders (82% of respondents reported access); availability of adult treatment programs for substance abuse (74%); using K-9 units as a drug detection tool (72%); access to an accountability court (64%); and, and access to faith-based treatment programs for substance abuse (61%). The programs that respondents reported as lacking in their service area are: drug treatment programs for juveniles, halfway housing/affordable housing for returning citizens, job opportunities/training for ex-offenders, and citizen groups to combat and prevent substance abuse.

Figure 20. Substance Abuse Programs in Place



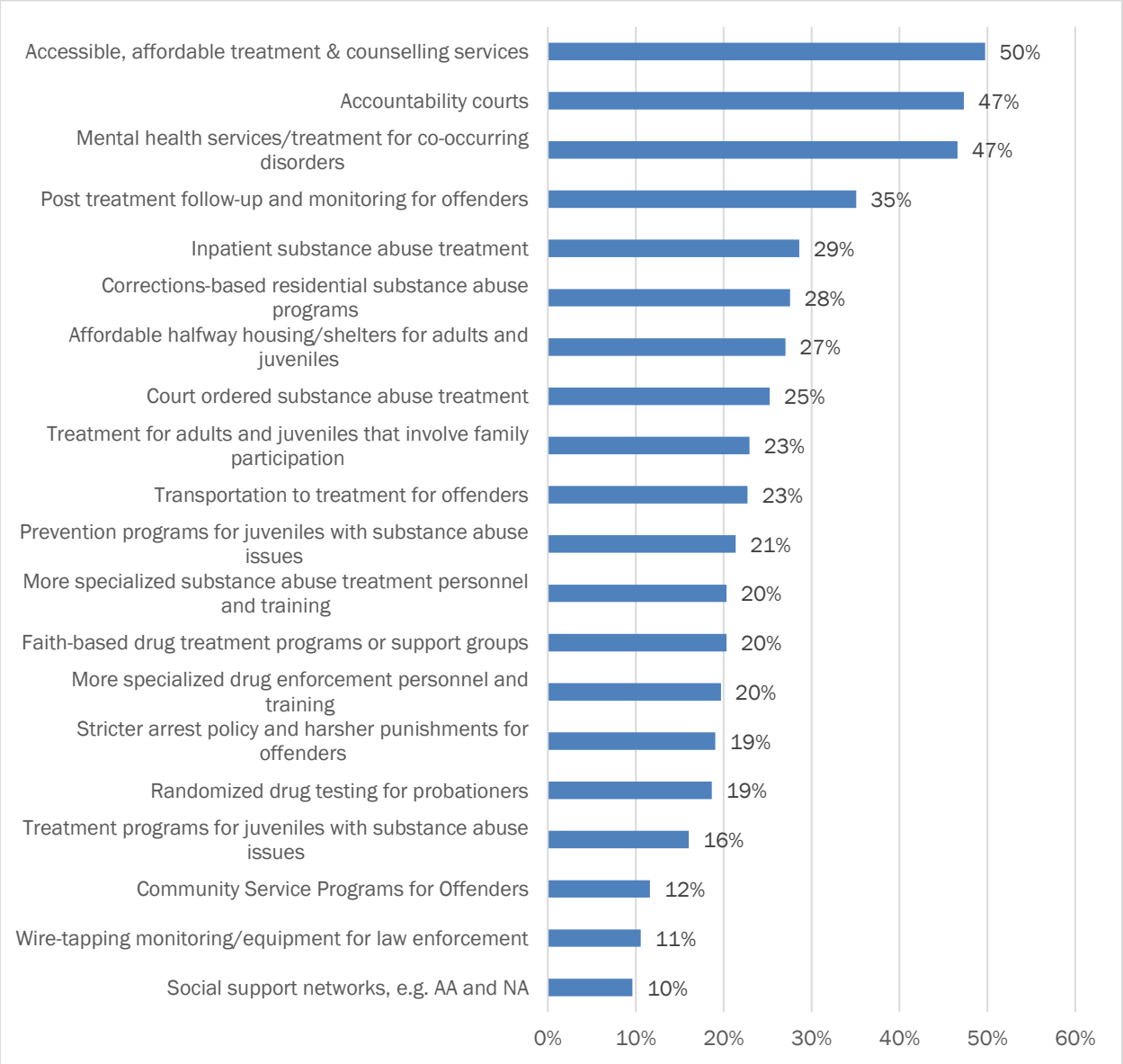
Survey respondents were asked to select the top 3 resources that their jurisdiction or treatment service area does not currently have, which would be most beneficial to reducing drug crime. Approximately half of the participants chose employment resources/mentors/vocational training for offenders/persons with substance abuse issues, followed by inpatient substance abuse treatment programs (35%) and collaboration between social services, community organizations, victim services, criminal justice agencies (34%).

Figure 21. Substance Abuse Programs That Would be Beneficial (Yes / No Question)



Respondents were also asked to choose the top 5 recommendations that they think would be the most beneficial for handling offenders with substance abuse issues. The top 5 recommendations selected were accessible, affordable treatment and counselling services (50%), followed by accountability courts (47%), mental health services/treatment for co-occurring disorders (47%), post-treatment follow-up and monitoring for offenders (35%) and inpatient substance abuse treatment (29%).

Figure 22. Top 5 Recommendations that are Most Beneficial for Handling Offenders with Substance Abuse Issues



Solving substance abuse issues requires collaboration from all kinds of community partners from social services, community organizations, victim services, to criminal justice agencies. Participants rated the quality of their working relationship with their partners in their jurisdiction or service area. Of note, the majority of respondents rated their relationships with almost all community partners as good or excellent. Community partners with a larger percentage of respondents reporting weak (Fair

to Very Poor) relationships included DFCS, workforce development agencies, prevention program providers, and life skills program providers. Of note, these were also listed as some of the most lacking resources for combating drug abuse and drug crime.

Table 44. Community Partner Working Relationship

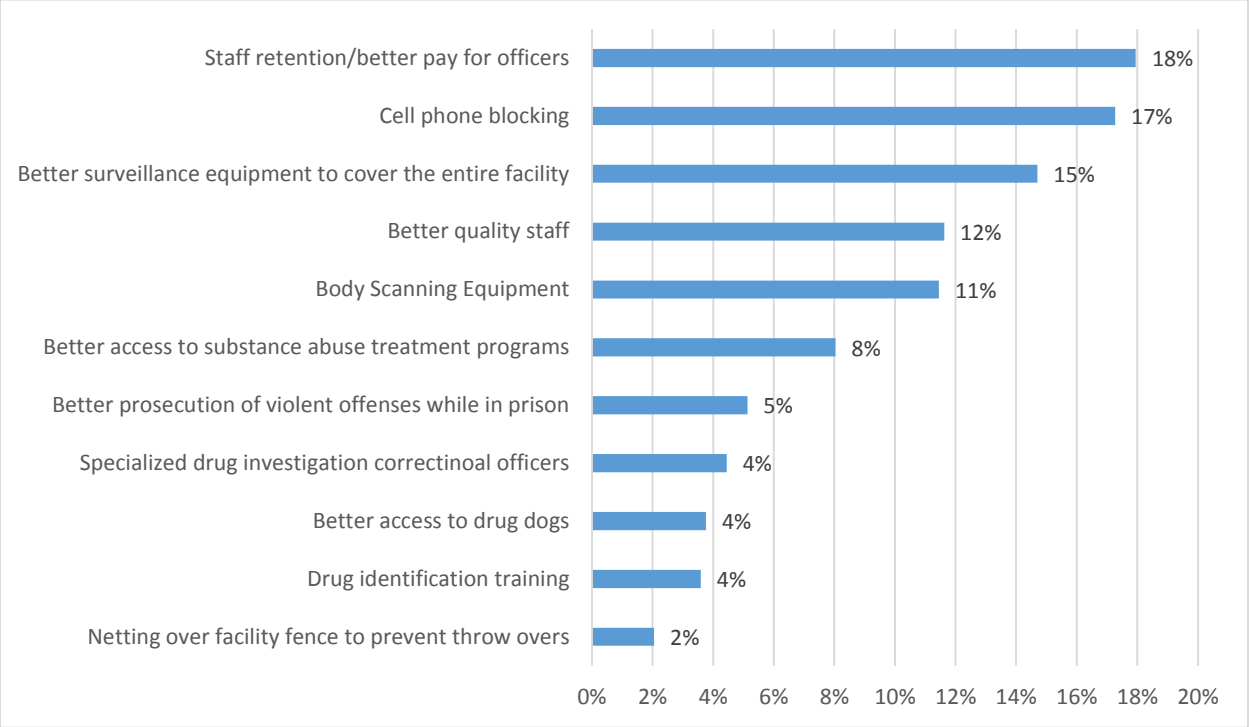
Community Partner Working Relationship	Very Poor	Poor	Fair	Good	Excellent	N/A	No Answer
Corrections	3%	4%	11%	35%	37%	7%	3%
Department of Family and Children Services	5%	11%	27%	35%	9%	8%	5%
Judges	1%	3%	9%	36%	44%	4%	3%
Life skills program provider	3%	6%	14%	31%	8%	24%	14%
Parole Officers	3%	7%	14%	39%	24%	8%	5%
Prevention program providers	5%	6%	17%	33%	8%	19%	12%
Probation Officers	1%	3%	9%	36%	43%	5%	2%
Prosecutors	2%	4%	11%	35%	40%	4%	4%
Treatment Providers	3%	7%	15%	43%	16%	9%	8%
Workforce development agencies	6%	10%	18%	25%	6%	20%	15%

Sector-Specific Needs and Resources

Corrections Sector Results

There were 195 individuals surveyed from the corrections sector. Eighty-one percent of those respondents were Wardens or Deputy Wardens and 19% (37) were correctional administrative staff or management. No respondents were correctional officers. Corrections survey respondents were asked about the top 3 resources that their correctional facility needs to combat drug-related crime. The top three responses included staff retention/better pay for officers (18%, 105), cell phone blocking (17%, 101) and better surveillance equipment to cover the entire facility (15%, 86). These resources encompassed 50% of the responses.

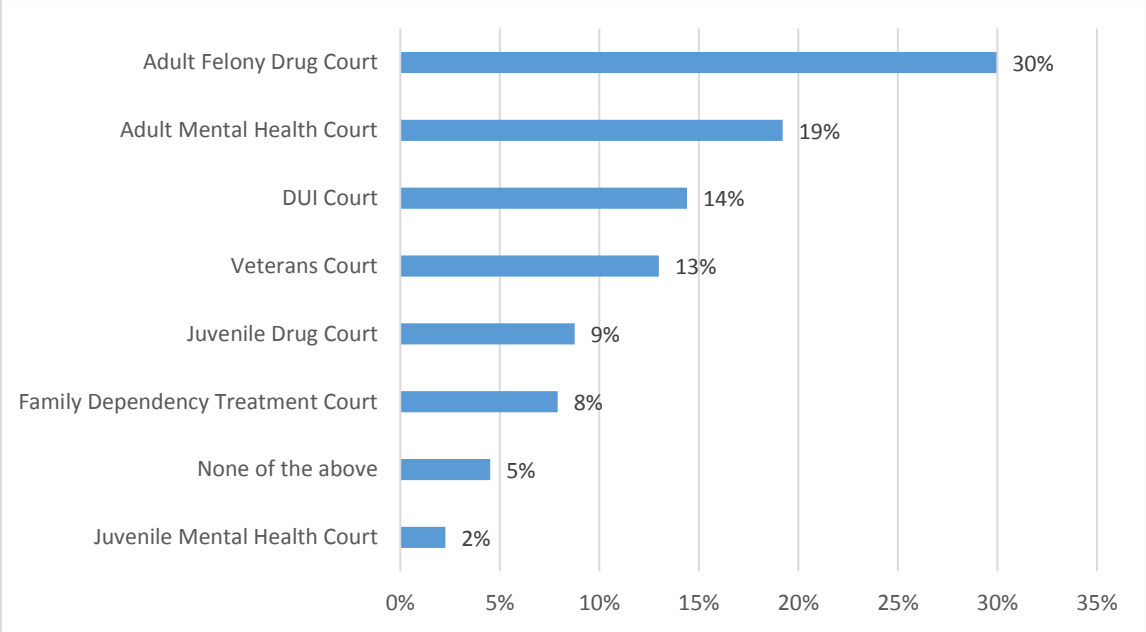
Figure 23. Top 3 Resources That Your Correctional Facility Needs to Combat Drug-related Crime



Judicial Sector Results

Survey respondents from the judicial sector represented a variety of accountability courts throughout the state. The largest response rates came from the Adult Felony Drug Count (30%, 106), Adult Mental Health Court (19%, 68) and DUI Court (14%, 51). These three courts represented 63% of the survey responses. Fifty-five percent (67) of the survey participants were court support staff, but 45% (55) presided over the court at the time of the survey. When asked about their case load, 69% (38) of respondents indicated they had sufficient contact with program participants and 31% (17) disagreed. Although, 55% of the respondents did not answer this question.

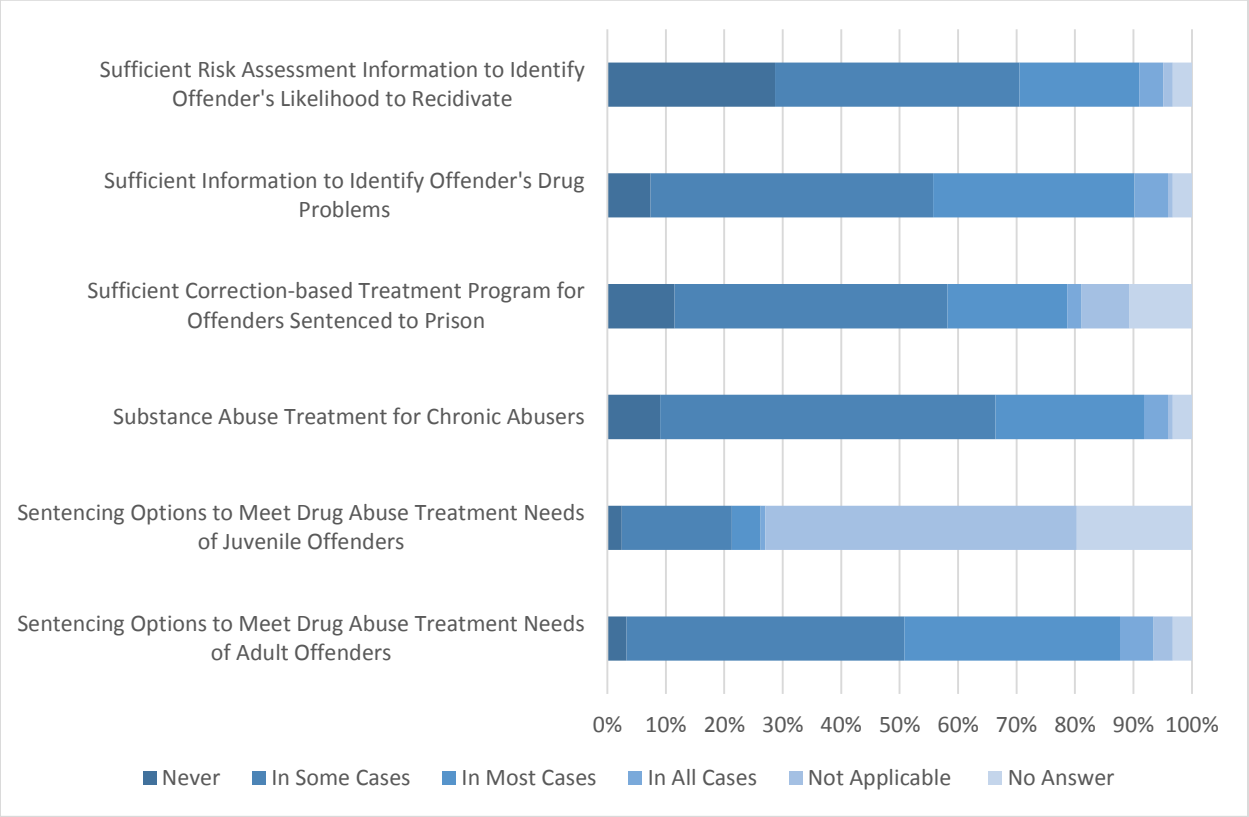
Figure 24. Accountability Court Type



Survey respondents were asked a series of questions about whether they had sufficient sentencing options for drug-related cases. For each question between 55% and 71% of the respondents, excluding those Juvenile Drug Court respondents, indicated that they either never had or rarely had sufficient resources or sentencing options for drug offenders (list of questions in Chart). The greatest need identified was for risk assessment information to identify an offender's likelihood to recidivate; 29% (35) of the respondents indicated they never had this resource.

Thirty-seven percent of respondents (45) indicated that in most cases they had the resources to meet the drug abuse treatment needs of adult offenders, but this dramatically decreased to 11% for juvenile offenders. One quarter of respondents felt that in most cases there are substance abuse treatment options for chronic users and 20% felt in most cases there were sufficient corrections-based treatment programs for offenders.

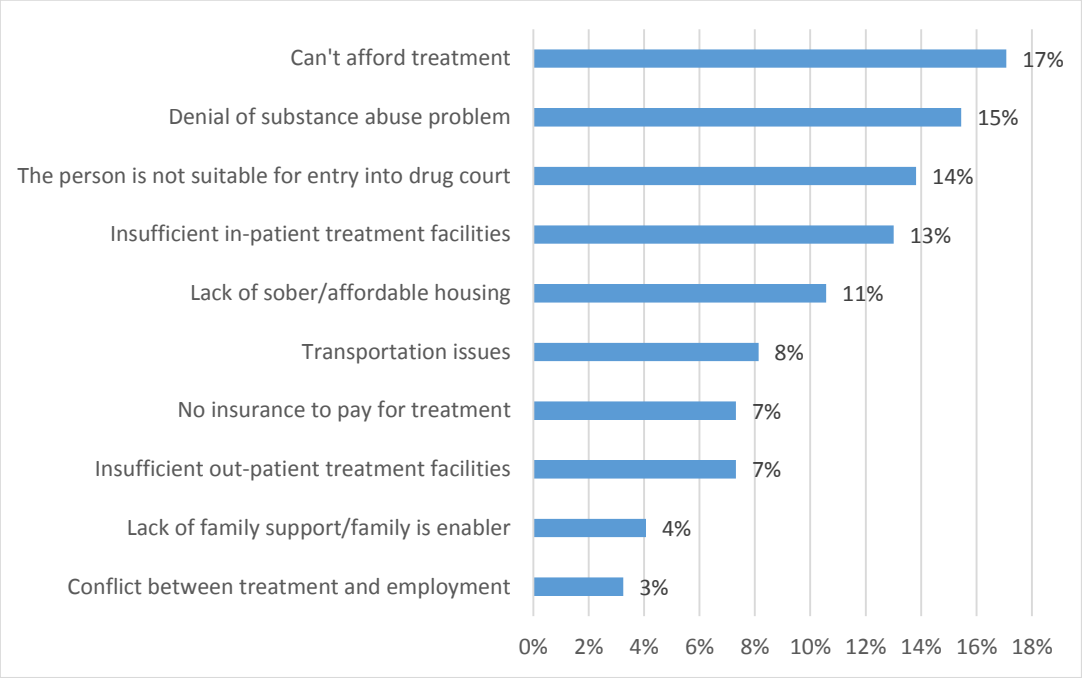
Figure 25. Availability of Resources to Make Decisions about Sentencing Options for Drug Offenders



On average, survey respondents indicated that they presided over 500 drug cases during CY 2013. Of these cases, 52% were for drug possession, 30% for drug-related property crime, 12% for drug-related violent crime and 6% were for drug trafficking. There is also a sense that jurors are not educated about drug crime with 56% of the respondents reporting this in the survey.

The three largest barriers preventing offenders from receiving treatment are they cannot afford treatment (17%, 21), they are in denial about their substance abuse problem (15%, 19) and the person is not suitable for entry into drug court (14%, 17). These three barriers represent 46% of the responses, but respondents chose the fourth and fifth largest barriers at similar rates. These were insufficient in-patient treatment facilities (13%, 16) and lack of sober / affordable housing (11%, 13).

Figure 26. Top Three Barriers Preventing Offenders from Receiving Treatment

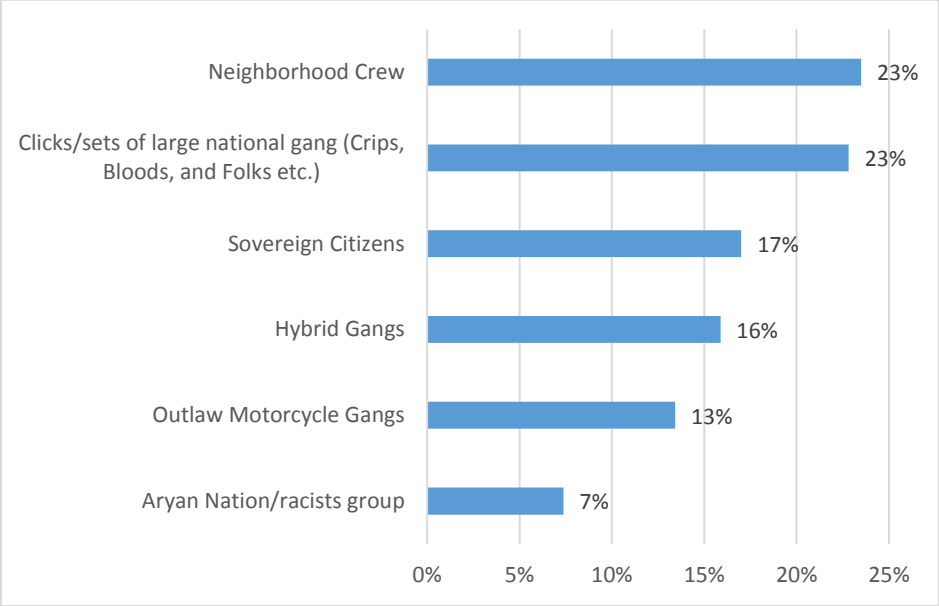


Law Enforcement Sector Results

One hundred ninety four law enforcement personnel responded to this section of the survey. Almost three quarters (137, 70%) of them were Chiefs/ Command Staff, management/administration or Sheriffs/Deputy Sheriffs. Thirty percent were either Narcotics Officers (18%, 34) or Patrol Officers/Troopers (23, 12%).

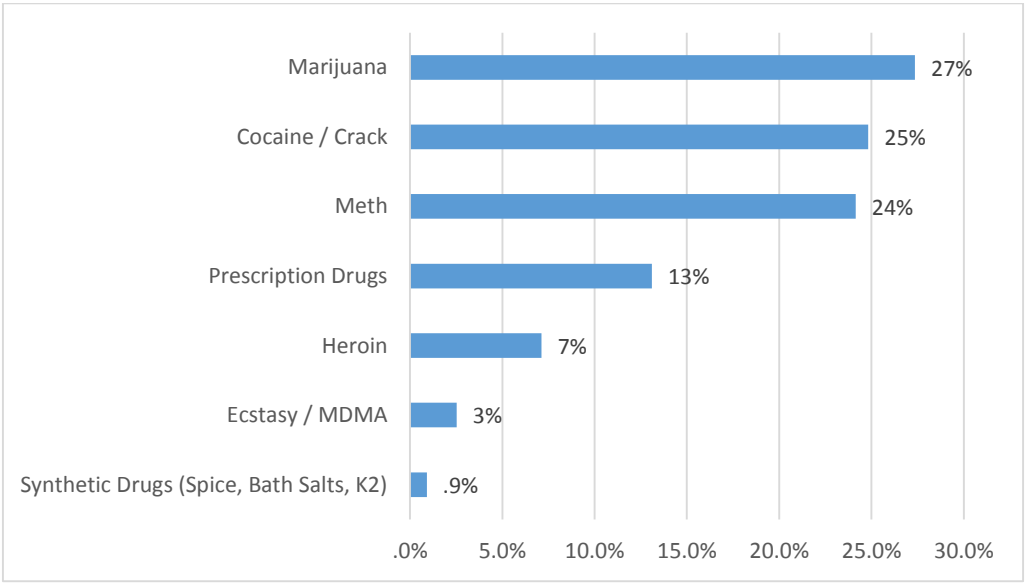
Eighty-four percent (163) of respondents indicated that they had active gangs in their jurisdiction and 89% (145) of those also indicated that these gangs were involved in the drug market. The most common gangs identified were neighborhood crews (23%, 105) and affiliates of larger national gangs (23%, 102), such as the Bloods and the Crips. They also identified Hybrid Gangs, in which members of multiple gangs worked together in a criminal enterprise and they represented 16% (71) of the identified gangs. Outlaw Motorcycle gangs (13%, 60) and Racist Groups (7%, 33), such as the Aryan Nation comprised 20% (93) of the identified gangs. Of note – particularly because of the threat they pose to responding office safety – 17% of respondents indicated that sovereign citizens were a gang threat in their jurisdiction.

Figure 27. Type of Gangs Identified



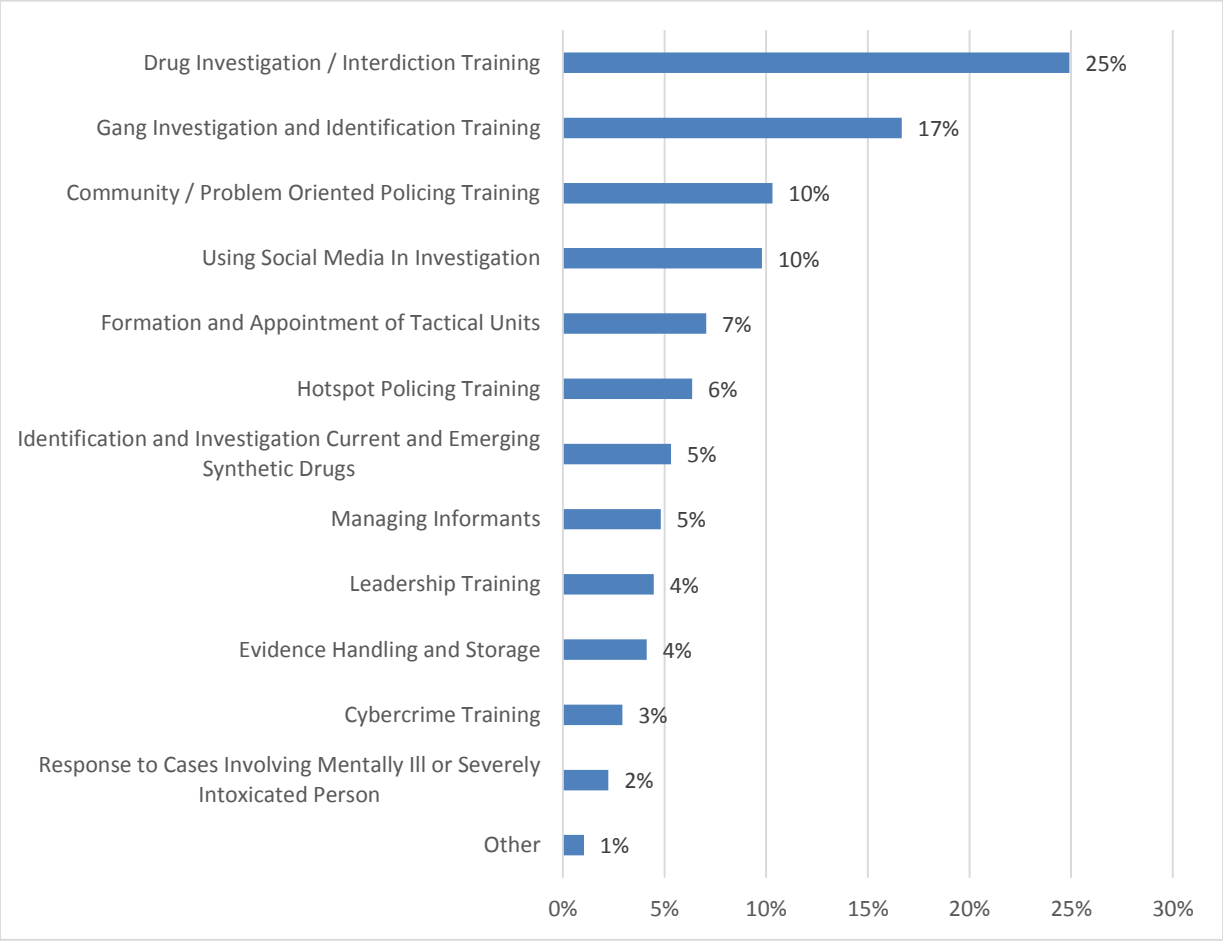
Almost two-thirds of the respondents considered gangs to be active in the drug market as low level street dealers (31%, 105) or as mid-level distributors (31%, 104). Nineteen percent (64) of respondents felt that gangs were active as users and another 19% (66) indicated that the gangs in their jurisdiction were connected to cartels. The three drugs with which gang are most involved are marijuana (27%, 119), cocaine / crack (25%, 108) and methamphetamine (24%, 105). Only 20% of law enforcement respondents indicated that gangs are involved with Prescription drugs (13%, 57) and heroin (7%, 31).

Figure 28. Top 3 Drugs with which Gangs are Involved in the Drug Market



The three types of training that respondents most requested were drug investigation/interdiction training (25%, 145), gang investigation and identification training (17%, 97) and Community/Problem Oriented Police training (10%, 60. Using social media in investigations was the fourth most frequently requested training (10% of respondents).

Figure 29. Top 3 Training Topics



Resources are needed to improve law enforcement's response to drug related crime. The three most necessary resources that respondents identified were: drug investigation unit officers (18%, 106), more patrol officers (15%, 90) and increased intelligence sharing with other law enforcement (13%, 78). A quarter of respondents (117) that indicated a priority for increased funding should be for hiring more drug investigators. Updating equipment to investigate drug cases (23%, 109) and additional training (23%, 109) ranked a close second. Funding an Assistant District Attorney specifically assigned to a Drug Task Force ranked third at 20% (95). Money for to purchase evidence and information ranked last at 10% with 46 responses.

Figure 30. Top 3 Responses for Resources Combat Drug-related Crime

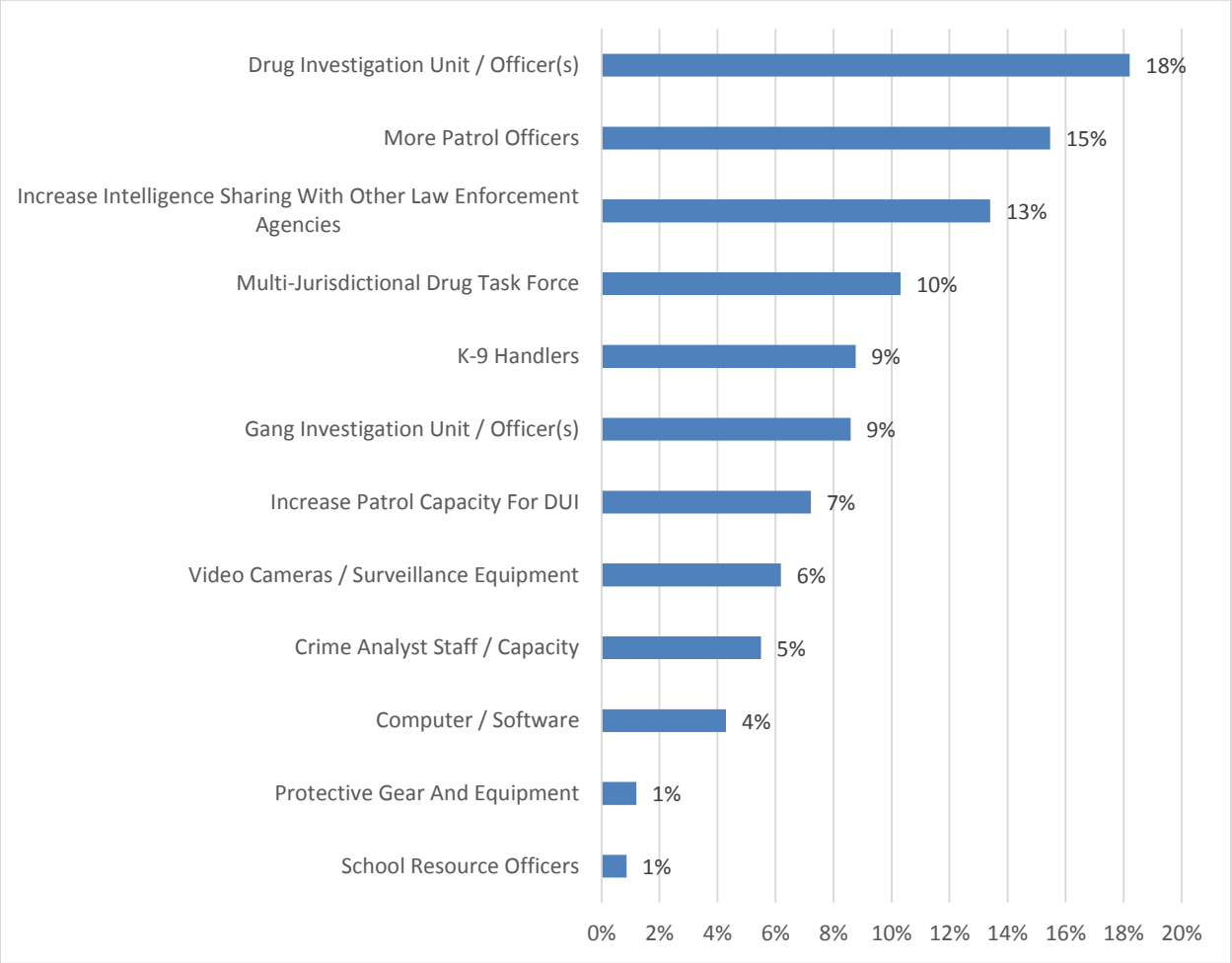
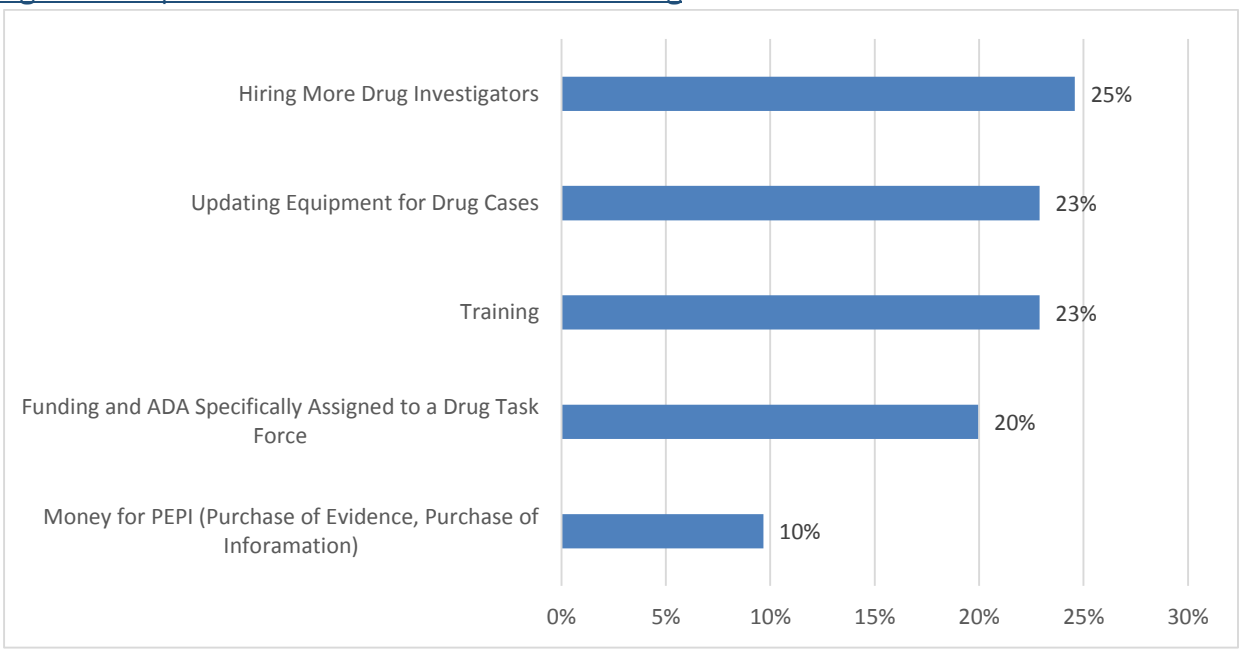


Figure 31. Top 3 Areas Identified for Enhanced Funding

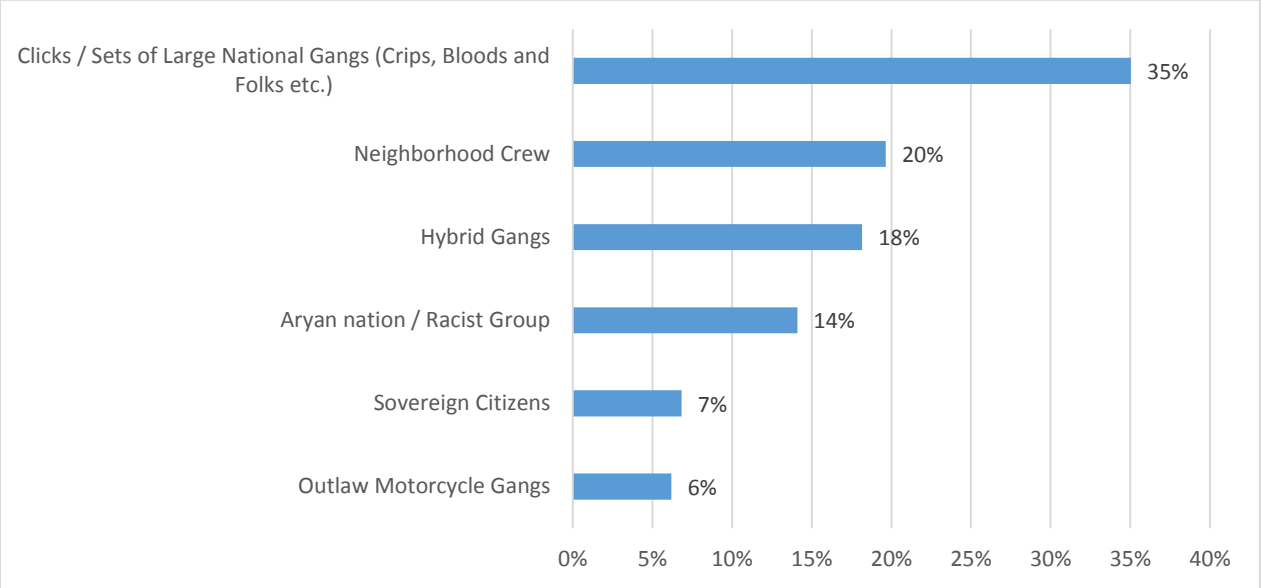


Probation Sector Results

Of the Probation survey respondents, 53% (113) were Probation Officer IIIs, 21% (44 and 45) were Probation Officer Specialists (POSS) Officers and Chief Probation Officers and 5% (11) were Day Reporting Center Administrators. Ninety-two percent (196) of these respondents reported gangs in their jurisdiction, while 6% (12) didn't know and 2% (5) indicated there was no gang involvement in their jurisdiction. Over half of those (100) who did have gangs indicated that up to 15% of persons on their case loads are gang-affiliated. Over one third of respondents (36%, 71) indicated 16% to 30% of their case load was gang-affiliated. Few respondents (5%) indicated over half of their case load was gang related.

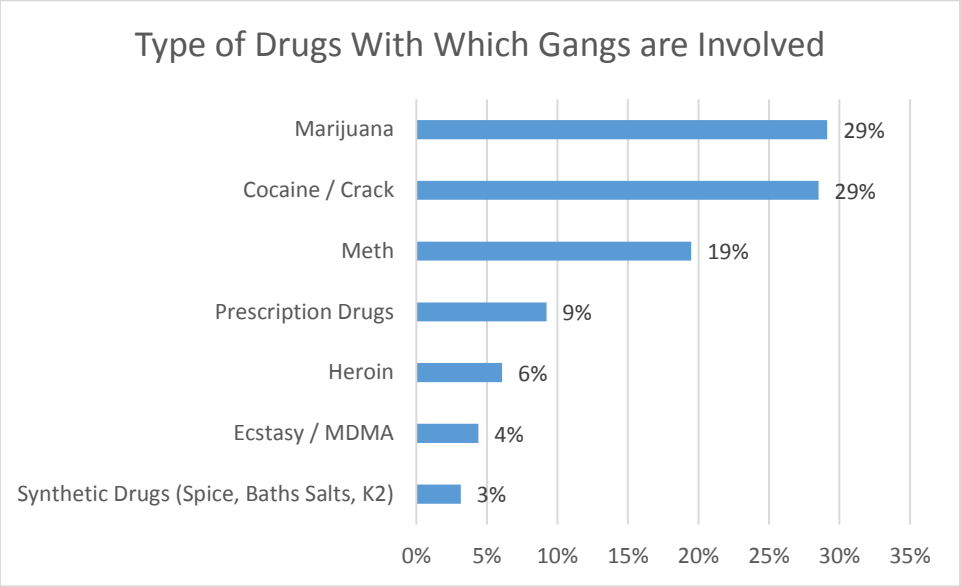
Probation officers most frequently cited (35% of respondents) that the most prevalent types of gangs they see on their caseloads are Clicks or Sets of Large National Gangs. Approximately one-fifth also reported large involvement with Neighborhood Crews and Hybrid gangs on their caseloads. Eighty-five percent of respondents reported that gangs in their jurisdiction were involved in the drug market. Not a single respondent stated that gangs were not a factor in their drug markets, though some did not how gangs were involved.

Figure 32. Type of Gangs Identified



Similar to law enforcement, Probation respondents reported that gang involvement in the drug market was primarily as low level street dealers (37%, 126) or mid-level distributors (29%, 99). Just 11% (38) of respondents indicated that the gangs in their area were connected to cartels and trafficking. Many reported that gang involvement in the drug market was not only on the supply side, but also the demand side as users (24%, 81). Roughly two thirds of respondents stated that gangs were most frequently involved with either the marijuana or cocaine/crack markets. Almost one-fifth of respondents stated gangs were involved with meth.

Figure 33. Top 3 Drugs with Gang involvement in the Drug Market

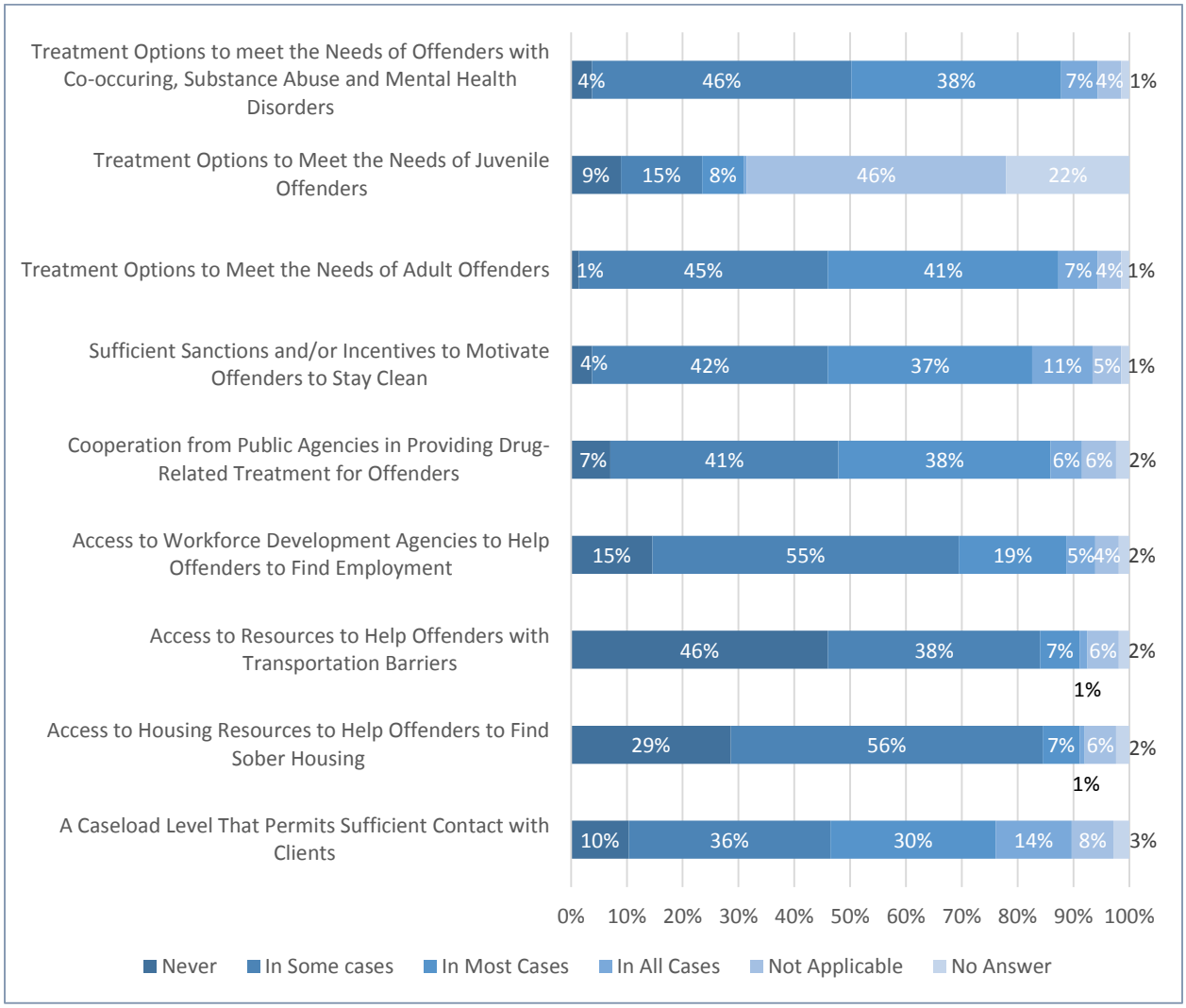


Those surveyed were asked questions about access to resources to effectively supervise drug-related cases and those results are in Table 34 below. Access to transportation and sober housing were the two areas of greatest need. Forty-six percent of respondents (98) indicated that they never had access to transportation resources for those under their supervision and 38% (81) responded that they rarely did. Twenty-nine percent (61) responded that they never had access to sober housing options for those under their supervision and 56% (119) said that sober housing was a scarce resource. The third area to which probation officers reported least access was workforce development. Fifty-five percent of probation respondents indicated that they rarely had access to resources to help probationers find employment and 15% (31) said they never had access.

With respect to treatment options for adult offenders, a substantial proportion of respondents (48%) indicated these were available in all or most cases, but 45% expressed that treatment options were only available in some cases. With respect to treatment options to meet the needs of juvenile offenders, 68% of the respondents did not answer the question or the question was not applicable to their work. Fifteen percent of the respondents indicated that in some cases drug treatment options are available for juvenile offenders; while 17% indicated treatment options are rarely or never available. There seemed to be less access to treatment options for co-occurring disorders. Fifty percent of the respondents indicated that there are never or rarely treatment options for these cases.

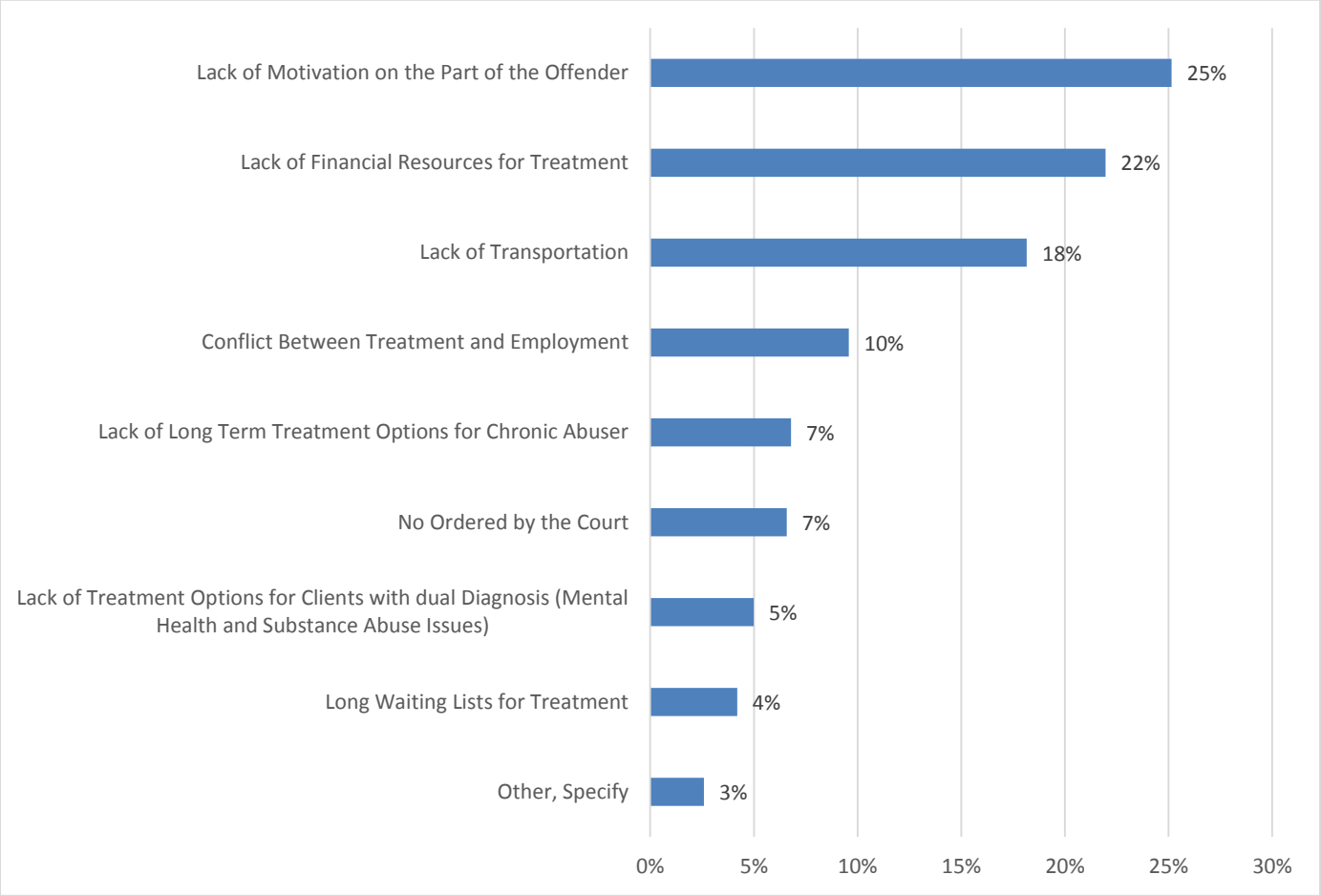
The disparity between the number of probationers who need treatment and those who actually receive it supports survey respondents' perceptions about resource availability. Respondents were asked approximately how many probationers on their caseload needed substance abuse treatment and then how many failed to receive it. Because the number of offenders under a respondents' supervision varied, we took the average number of offenders under supervision and the average number receiving treatment. Respondents indicated that 42% of those under their supervision did not get the drug treatment they need.

Figure 34. Access to Resource for Drug-related Cases



When asked the top 3 reasons why probationers fail, respondents pointed to a lack of motivation on the part of the offender (25%, 126), lack of financial resources for treatment (22%, 110) and lack of transportation (18%, 91). These reasons represent 65% of the responses. When we asked respondents about what they needed to better manage substance abusing probationers, more access to employment opportunities (20%, 128), additional case management staff to help probationers connect to resources (18%, 113) and additional in-patient treatment for probationers (14%, 91) were the top three needs.

Figure 35. Top 3 Reasons Probationers Fail

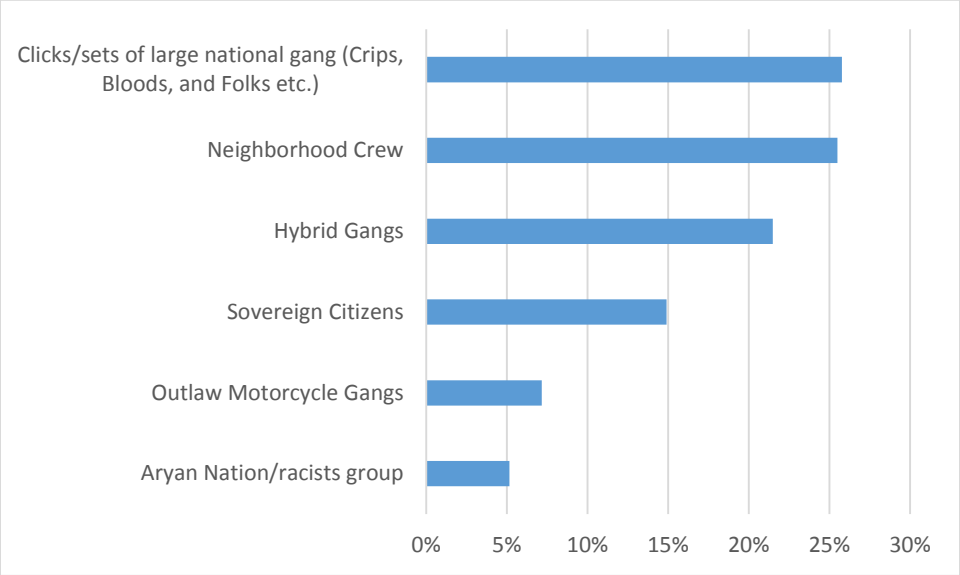


Prosecution Sector Results

The prosecution section of the survey had 133 respondents. Sixty-eight percent (91) were Assistant District Attorneys, fifteen percent (20) were Assistant Solicitors-Generals, fourteen percent (18) were District Attorneys, and only three percent (4) were Solicitors-General. The vast majority of prosecutors indicated that they had gangs in their jurisdiction (118, 89%). Only six percent did not know (8, 6%) and five percent indicated that they did not have gangs in their jurisdiction (7, 5%).

When prosecutors were asked which types of gangs they believed existed in their jurisdiction, various gangs/groups were identified and multiple responses were given (349 responses). Clicks and sets of large national gangs such as the Crips, Bloods and Folks were twenty-six percent (90, 26%) of the responses along with Neighborhood Crews (89, 26%). Other gangs identified were Hybrid Gangs, (75, 21%), Sovereign Citizens (52, 15%), Outlaw Motorcycle Gangs (25, 7%), and the Aryan Nation and other racist groups (18, 5%).

Figure 36. Type of Gangs Identified

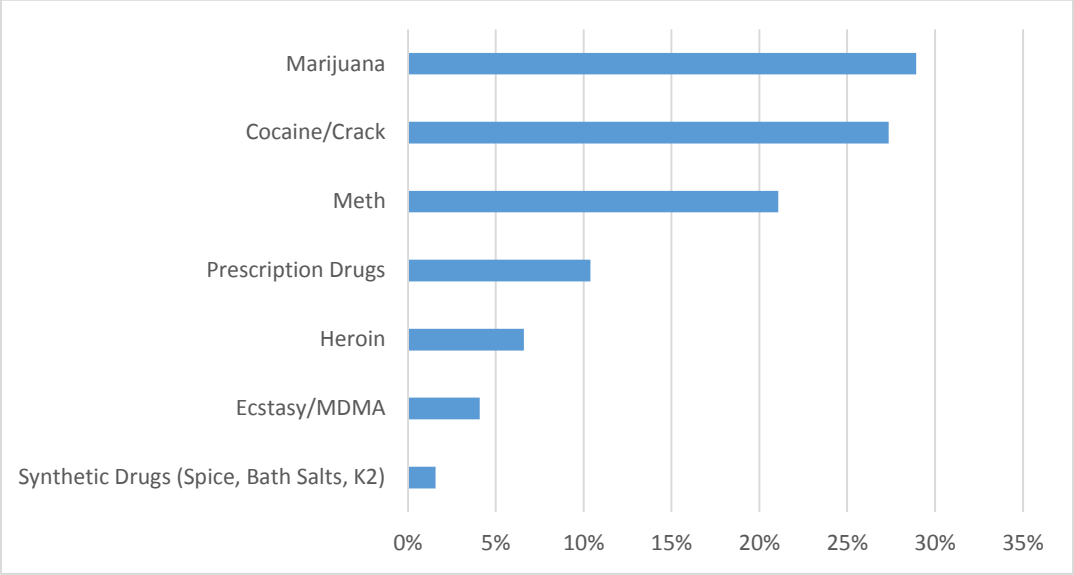


Ninety percent of prosecutors believed that gangs in their jurisdiction were involved in the drug market (106, 90%). Only three percent indicated that they were not involved in the drug market (3, 3%), and eight percent did not know (9, 8%).

When prosecutors were asked more specifically about the type of involvement gangs had in the drug market, about a third of respondents (94) identified them as low level street dealers and over a quarter (81) responded they were mid-level distributors. Only 14% (40) of prosecutors indicated that gangs in their jurisdiction had connections to drug trafficking or cartels. A quarter of prosecutors also stated that gang members also abused drugs.

Prosecutors were asked what the top three drugs were that gangs in their jurisdiction were involved in. Twenty-nine percent responded with marijuana (92, 29%), twenty-seven percent cited cocaine and crack (87, 27%) and twenty-one percent cited Meth (67, 21%). Other drugs indicated were prescription drugs (33, 10%), heroin (21, 7%), ecstasy/MDMA (13, 4%) and synthetic drugs (2%, 5).

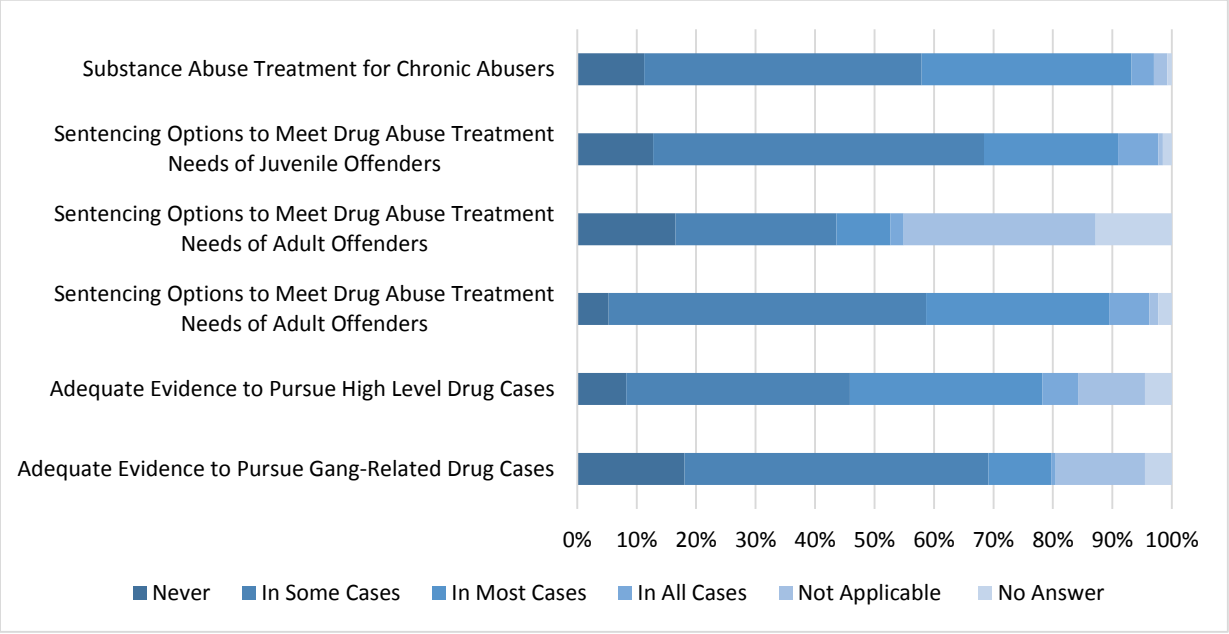
Figure 37. Top 3 Drugs with which Gangs are involved in the Drug Market



Of prosecutors who responded, 43% had attempted to use the gang statute in conjunction with the Georgia Substance Abuse Control Act to pursue penalties against the gangs in their jurisdiction (51, 43%). A majority of prosecutors did not know if they had attempted to use the gang statute (67, 57%). Eleven percent of prosecutors surveyed did not answer (15, 11%).

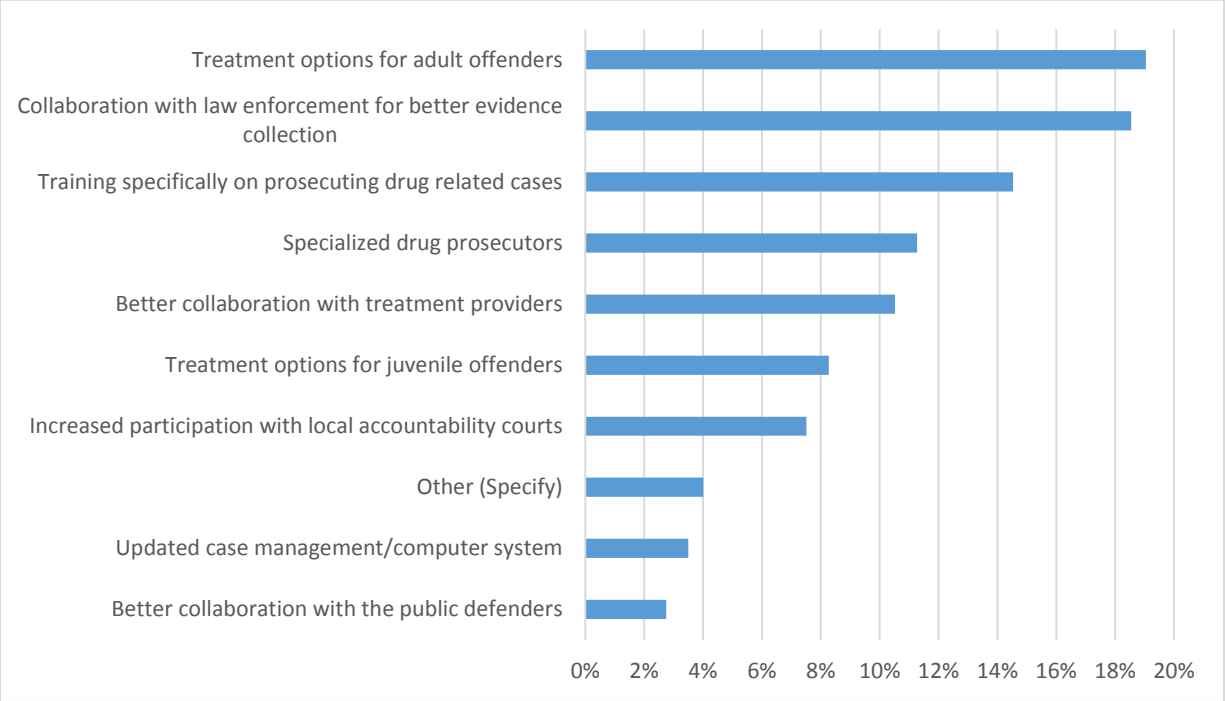
Fifty-four prosecutors identified barriers to using the gang statute in their jurisdiction. Many described the difficulty in proving gang activity or an individuals' connection to a gang when relating to the sale or possession of drugs. Prosecutors cited a lack of clear definition in what constitutes a gang for prosecution and a lack of investigation or adequate evidence to successfully prosecute is also a barrier. Some prosecutors cited a reluctance to pursue gang statute cases because they do not have sufficient training, or they the resources necessary to prove the case. Four respondents had never had the opportunity to use the gang statute, and five respondents cited no barriers to using it. Seventy-nine prosecutors did not respond to these questions.

Figure 38. Adequate Access to the following Resources Over the Last Year



Of prosecutors who responded, approximately half said they rarely had sentencing options to meet the drug abuse treatment needs of juvenile offenders (36, 56%), adult offenders (71, 53%) and chronic abusers (74, 47%). Sixty-nine percent felt they never or rarely had adequate evidence to pursue gang-related drug cases (92, 69%). Fewer than 10% of prosecutors felt like they always had sentencing options or evidence to pursue the case. This lack was most notable in gang-related drug cases (1, 1%) and sentencing options to meet drug abuse treatment needs of adult offenders (9, 2%).

Figure 39. Top 3 Specialized Resources to Help Prosecute Drug-Related Cases



The top three specialized resources that would help prosecutors better pursue drug-related cases were treatment options for adult offenders (76, 19%), collaboration with law enforcement for better evidence collection (74, 19%), and training specifically on prosecuting drug-related cases (58, 15%).

Thirty-two respondents submitted information about their caseloads. These prosecutors indicated that an average of 517 of their cases in CY2013 were drug-related. In 4.2% of the cases, the individual was convicted as charged. The majority of cases (62%), according to the survey respondents, resulted in guilty pleas to the original charges and 23% pleas to lesser charges. Only 7% were placed in an alternative sentencing, 2% were convicted of lesser charges and 2% percent were acquitted.

Public Defender Sector Results

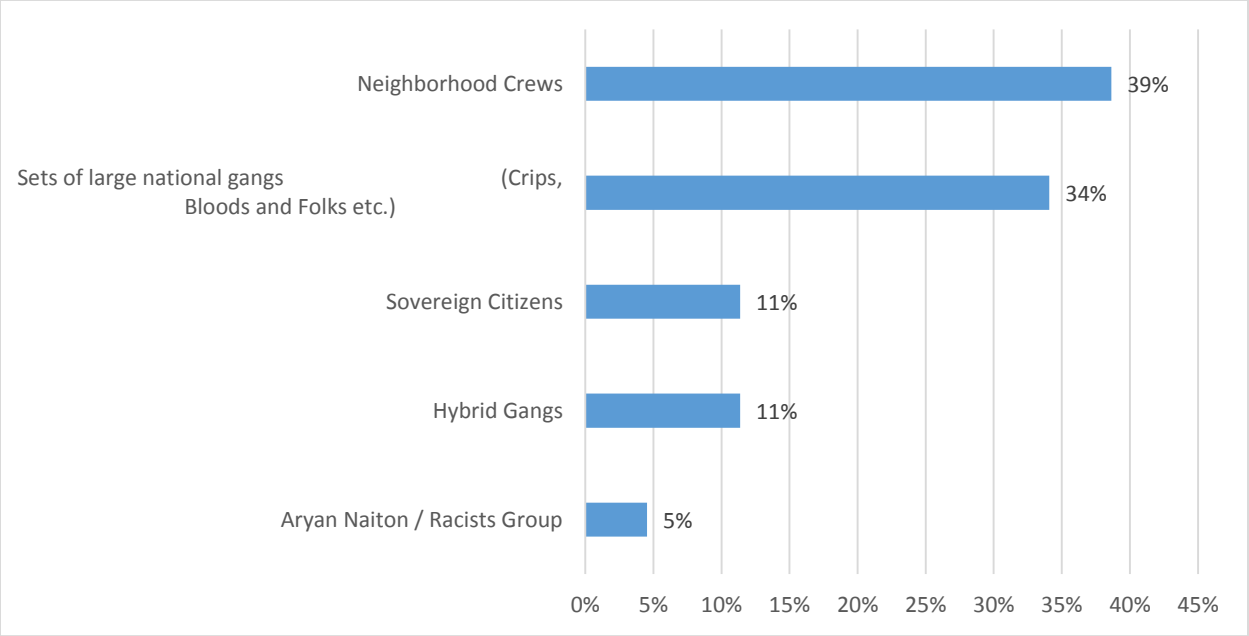
Thirty-three public defenders responded to our survey. Of the respondents 85% (28) were Circuit Public Defenders, 9% (3) were Capital Defenders, one was an Assistant Public Defender and one was a Mental Health Advocate.

Of these respondents 79% (26) reported that they had active gangs in their jurisdiction, 12% (4) did not and 9% didn't know. Of the 26 Public Defender respondents who expressed active gangs in their jurisdictions, 73% felt that up to 15% of their caseloads were gang affiliated. Twenty percent of the respondents expressed that between 16 to 30 percent of their cases were gang affiliated and 6% felt that between 31% up to 50% of their cases were gang related. Well over two-thirds (69%) of respondents expressed that gangs in their area are involved in drugs and just one person said gangs were not involved in the drug market. Twenty-seven percent (7) expressed that they didn't know.

Almost three quarters of the active gangs that respondents identified were either neighborhood crews (39%) or chapters of large national gangs, such as the Crips or Bloods (34%). Thirty-three

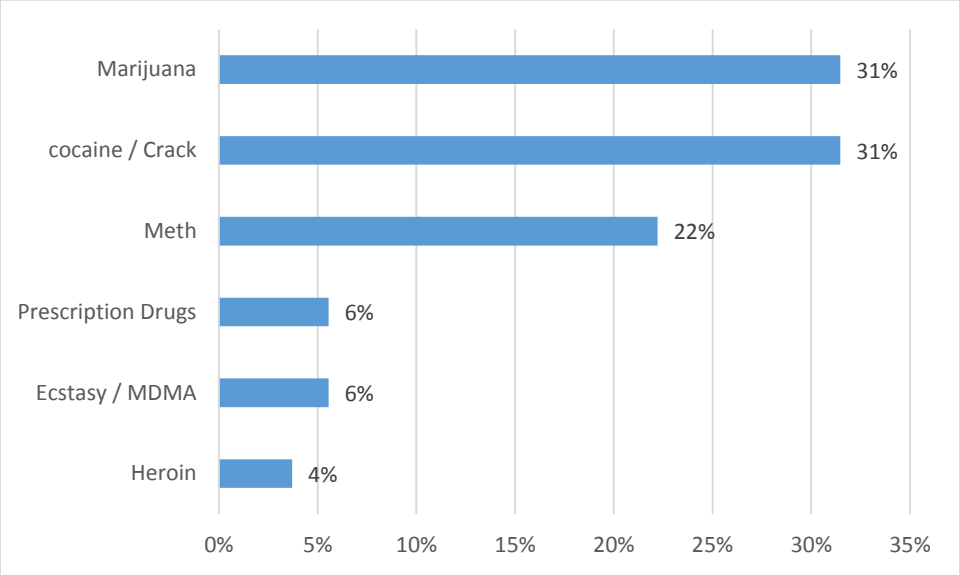
percent of respondents reported more than one type of gang in their area with six percent reporting three different types of gangs.

Figure 40. Type of Gangs Identified



The survey asked about the level at which gangs were involved with the drug market and 43% responded that gangs were mostly low level street dealers. Twice as many public defenders reported this level of gang involvement as did involvement as abusers or mid-level distributors. Only 8% of the respondents indicated that gangs were involved in trafficking. The drugs of choice that those in Public Defense identified were Marijuana (31%, 17), Cocaine/Crack (31%, 17) and Methamphetamine (22%, 12). Prescription drugs and Ecstasy both accounted for just 6% of responses (3) and heroin for 4% (2).

Figure 41. Top 3 Drugs with which Gangs are involved in the Drug Market



The survey asked Public defenders how they felt about access to resources for defending drug-related cases. Eighty-two percent responded that there were no resources (18%, 6) or that resources were only available for some cases (64%, 21) for substance abuse treatment for chronic abusers. Just 18% (6) responded that in most cases treatment options were available for chronic abusers. The responses were similar for sentencing options to meet adult offender treatment needs. Only18% of respondents expressed there was a sentencing option for all cases. Seventy-three percent responded that sentencing options for adult treatment needs are never (12%, 4) or rarely (61%, 20) available.

As compared to respondents from other sectors, a greater proportion of public defenders indicated they had resources for juvenile offenders with 27% (9) expressing that there were sentencing options to meet juvenile offenders treatment needs for most or all cases. However, under half (42%) indicated that they had sufficient information to identify an offender's drug issues.

When it came to defending high level drug cases, over a quarter of respondents (27%, 9) never or rarely had adequate evidence to defend their clients. This need was more pronounced for defending gang-related drug cases with a third (33%, 11) of the respondents indicating that they never or rarely had adequate evidence for defense.

When asked the top three specialized resources that Public Defenders needed to better defend clients accused of drug-related crimes, 55% of the 99 responses indicted better treatment options for adult and juvenile offenders. The third resource most requested (15%, 15) was better collaboration with treatment providers. Only 4% (4) of respondents indicated increased participation with local accountability courts as a necessary resource.

Figure 42. Survey Response to Adequate Access to Resources

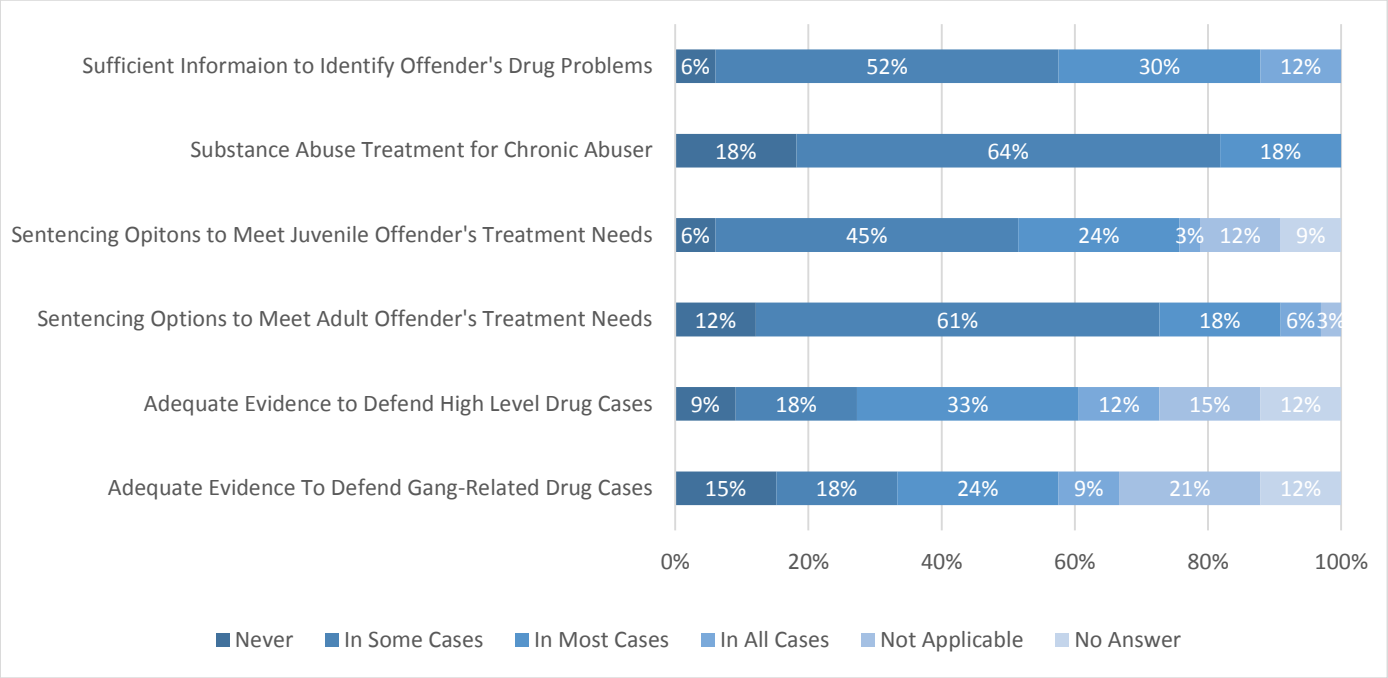
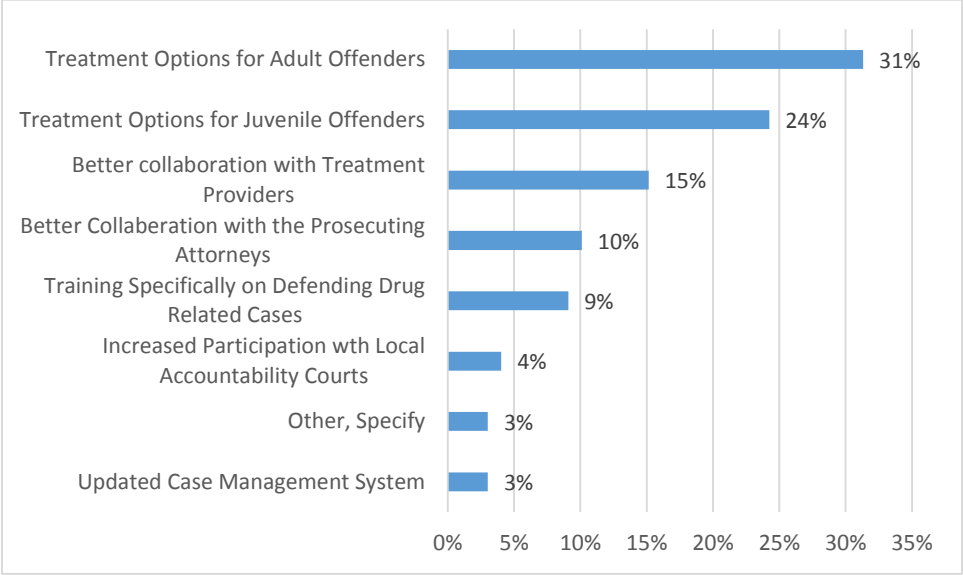


Figure 43. Specialized Resources to Better Defend Clients Accused of Drug-Related Crimes



Treatment Sector Results

The treatment section of the survey had sixty-five respondents. Fifty percent (33, 50%) were Management/Clinical Directors. Eleven percent were Administrative Staff (7, 11%), three percent were Therapists /Psychologists (2, 3%), just over one percent were Case Workers/Managers (1, 1%), and 33% identified as other. This included Health Educators and Prevention/Program Coordinators (22, 33%).

Only 55% of treatment providers answered the question regarding the number of persons that they treated who were referred by the criminal justice system and one respondent provided what we assume is inaccurate information of nearly 1 million referrals for CY 2013. After removing this outlier, respondents on average, were referred 60 individuals from the criminal justice system for treatment in CY2013.

Even fewer survey respondents (30%, 15) answered the question about whether they denied treatment to any person referred by the criminal justice system. Of those who answered, 67% (10) of the respondents indicated that they did not deny treatment. Two respondents did deny treatment, and three did not know whether they did. Of the two respondents who indicated they denied persons only one provided a numeric answer when asked, which indicated they denied 5 individuals.

Of the reasons for denial, one was because of a child molestation charge (1, 33%), one offender was deemed not stable enough to receive treatment (1, 33%), and one offender had a history of violence that potentially put the provider and other patients at risk (1, 33%).

Forty-two respondents indicated the referral sources for their patients. The top three referral sources for treatment were Probation Officers (11, 26%), Accountability Courts (7, 17%), and the Division of Family and Children Services (6, 14%). Other referral sources, not specified below, were from Judges (1, 3%), Juvenile Court (1, 3%) and self-referral (1, 3%).

Figure 44. Top 3 Treatment Referral Sources

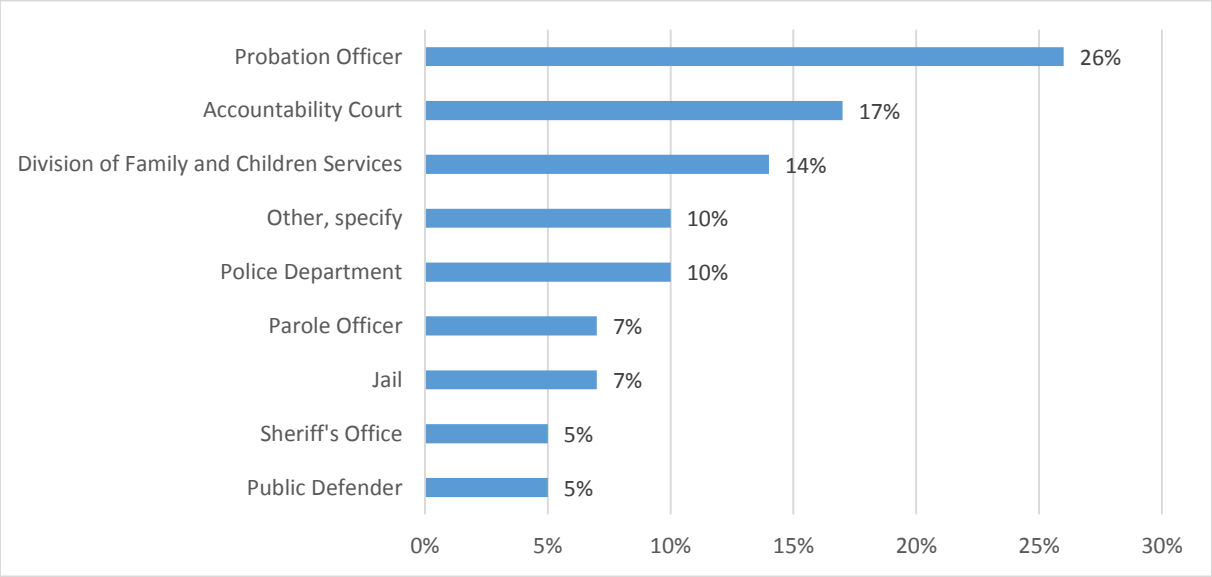
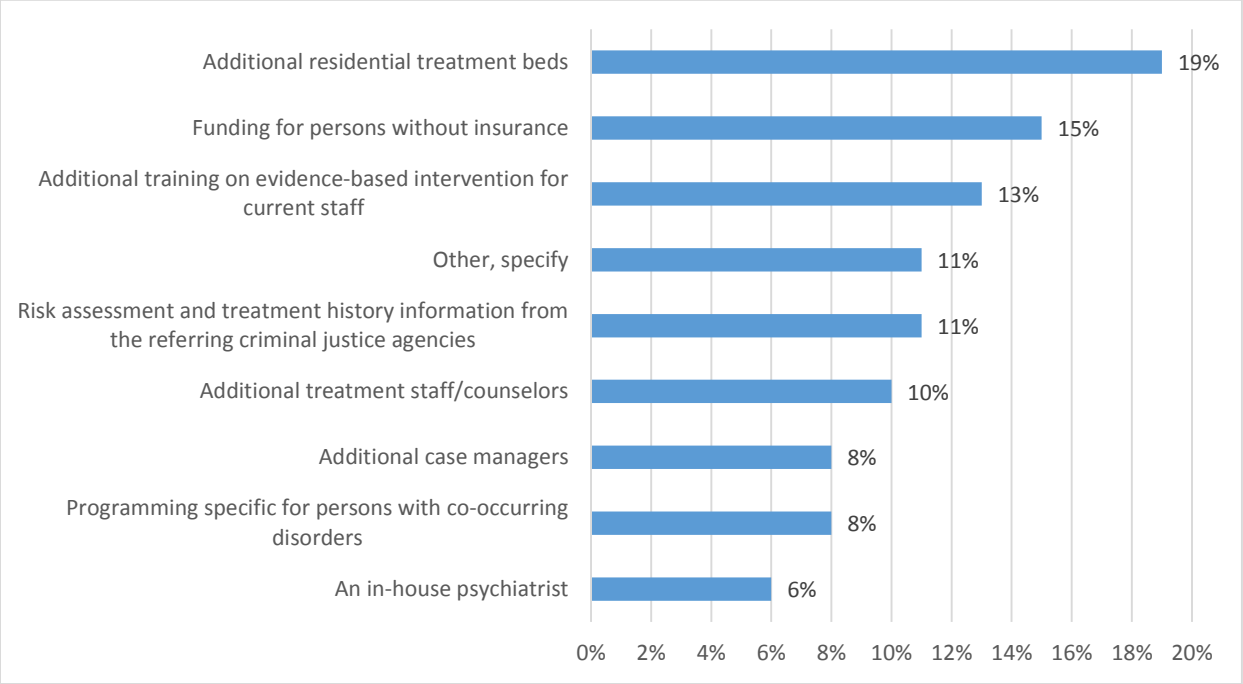


Figure 45. Top 3 Additional Resources Needed to Provide More Successful Treatment



Additional residential treatment beds (36, 19%) were the top resource needed to provide more successful treatment, which was followed by funding for persons without insurance (29, 15%) and additional evidence-based intervention training for staff (26, 13%), (See Figure 45). Several respondents chose “other” for necessary resources. Of these, multiple respondents indicated the need for additional resources for drug prevention, funding for more types of treatment and housing options.

Policy Implications, Recommendations, and Future Research

Statewide Drug Enforcement and Treatment Advisory Group

The CJCC received a tremendous amount of guidance, assistance and suggestion for this needs assessment. A continuation of discussion, resource sharing and experience learning would be beneficial to all stakeholders in combating substance abuse issues in the State of Georgia. This effort will not only bring all concerned parties on the table, but also will provide a platform for information to be shared across the board. Such an advisory group would meet to share data regarding trends, arrive at policy and practice proposals, and potentially apply for federal funding in partnership to tackle some of the burning needs identified in this assessment.

Continuous Drug Enforcement and Treatment Data Surveillance

To stay ahead of current drug trends, data surveillance is necessary. The combination of drug enforcement with drug treatment data in this report provides a particularly robust picture of the drug market in Georgia that is necessary for continued monitoring. With a comprehensive collection of data sources a larger picture of the drug markets, both supply and demand, can be analyzed. This will aid in targeted enforcement and treatment strategies to better allocate resources. Maintaining a pulse on growing drug abuse trends by age group, geography, and sector will also help us target prevention and education initiatives.

Additionally, the Georgia SAC obtained an extract of the state's National Forensic Laboratory Information System data from 2002-2014, which included over 400,000 drug submissions for forensic analysis. As of the completion of this report, staff were still in the midst of compiling the codebook for the myriad entries identified in the analysis so that we may examine drug use and trafficking trends based on law enforcement evidence submissions – in addition to the seizure data from our multi-jurisdictional task forces and HIDTA.

Better Usage of the Prescription Drug Monitoring Program

The Georgia Prescription Drug Monitoring System (PDMP) is a database established by the Georgia Drug and Narcotics Agency in accordance of Georgia Code, Title 16, Chapter 13. The database was developed and is maintained by Health Information Designs, LLC (HID) for the state. The drugs that are monitored are Schedule II, III, IV and V controlled substances. Although, Pharmacists could elect to participate in the PDMP as early as September 1, 2012, as of May 15, 2013 all Georgia pharmacies were required to report the total number of these drugs dispensed on a weekly basis. Prescribers did not gain access until July 2013.

The goal of the PDMP is to monitor duplicative prescribing or overprescribing of these types of medications in an effort to curb any abuse and to help healthcare providers increase the quality of care to their patients. Another important way that the PDMP can contribute further, is through the identification of trends in prescription drug use. To better identify these trends, the ability to analyze the number and type of controlled substances prescribed by county is necessary. Over time these data could provide valuable information to target enforcement efforts and public health campaigns.

Better Determine the Magnitude of Need for Residential Treatment Beds for Chronic Drug Abusers and Those with Co-Occurring Disorder. Once determined, fund sufficient beds to reduce or eliminate wait times to receive treatment.

Access to residential treatment beds for chronic drug abusers was a need expressed across all sectors. There are many ways that an individual can currently receive treatment, including in local jail or state correctional residential substance abuse treatment programs, and via community services boards while on probation or parole. Survey respondents, and stakeholders at our findings discussion meeting, were in agreement that we need more residential treatment beds, but we need further study to determine how many additional beds would meet chronic abuser needs. A question remains regarding the current wait times that persons who need residential treatment experience and where those waits are occurring. Moreover, treatment for persons with co-occurring disorders was also an identified gap. Such treatment may involve in-patient crisis stabilization, in addition to residential substance abuse treatment. The number of persons who need these specialized resources could not be determined in the present assessment.

The CJCC recommends a needs assessment be conducted to examine the extent to which chronic abusers are denied residential treatment at various points of contact within Georgia (Criminal Justice and/or Public Heath). Once there is a clear understanding of the scope of need and where that need exists, we are then able to effectively identify funding resources for increasing the stock of residential treatment beds and are able know to the extent to which funding would affect the target population.

Fund Programs that Combine Drug Treatment and Job Skills Training

In Hall County Georgia, the SAC is working with the Hall County Correctional Institute to document and evaluate its REACT program, which is being funded through the Edward Byrne Memorial Justice Grant Program (JAG). The REACT program is an offender reentry program that combines drug treatment with education and job placement to enable an offender to receive a GED and a certificate of vocational training from a local technical college. The offender is then allowed to work in that vocation with pay prior to their release. When someone finishes the REACT program they have successfully completed a substance abuse program, increased their education level, gained marketable skills and job training, and obtained some savings to help them get established upon release.

The Hall County program is just one example of how the largest identified needs in combating drug use and abuse (access to treatment and employment resources) through contact with the criminal justice system can be implemented, but it is not the only avenue. It may be a consideration to also prioritize these type of resources with the expansion of drug courts, through probation or parole or other drug treatment programs.

Appendix A: Semi-structured Interview Questions

All sectors

1. Talk to me about the geographic, demographic, economic and social conditions that contribute to drug distribution, drug abuse and criminal activity in your area.
2. What kinds of drug and drug-related crime are you seeing in your area?
3. What resources are readily available to combat drug crime and abuse in your area?
4. What resources are necessary and/or lacking to successfully combat drug crime and abuse in your served areas?
5. Does your agency collaborate with other agencies to combat drug crime and assist drug users? If so, what is the nature of that collaboration?
6. Are you seeing many new users become addicted to drugs, or would you say that the persons caught buying/selling drugs tend to be chronic users? What does the typical drug user/abuser in your area look like? What about the typical seller/distributor?
7. What is the main funding source for your drug enforcement/treatment services? If there is additional funding available, where would you allocate the money to?
8. What training have personnel in your agency received to respond to drug abuse, or drug crime? What additional training would be beneficial to your work?
9. Does your agency have a drug screening policy for your own employees? If so, what are the policy and procedures?
10. Are you seeing a notable increase in any type(s) of substance abuse?

Corrections

11. What substance abuse treatment programs are available to inmates?
12. How do you handle treatment for inmates who may need prescription drugs for pain management, anti-anxiety management, etc. to ensure those medications do not end up in the wrong hands?
13. How often do you have a drug-induced death happen to inmates in your custody?
14. Are you seeing illicit drugs moving in or out of your facility? If so, how do you monitor the potential movement of illegal drugs in and out of correctional facilities?
15. Do you have gangs in your correctional facility? Are they involved in any drug activity within or moving out of the facility? How do you investigate and track this activity?

Courts

16. What are the referral sources for your substance abuse programs?
17. What screening instruments do you use to determine what offenders in your court may need in terms of treatment and services?
18. How do you monitor offenders in your court? Talk to me about the sanctions and incentives in place to keep offenders on track toward meeting their goals.
19. What kinds of aftercare resources are available in your community to help offenders who successfully complete treatment to stay clean and sober? Does your court offer any aftercare programming/mentoring? Do you work with probation, for those offenders who may still have a probation term to serve after completing your court

program?

Prosecution

20. Do you have a seasoned prosecutor in your office who typically handles drug-related cases?
    a. Is there a drug court in your jurisdiction? If not, what you see as the reason(s) that there is not one. Does your office have a relationship with the local drug court (if there is one)?
    b. How do you determine to whom to offer drug court/plea deals and whom to prosecute and request prison time?
21. What kinds of drug enforcement are occurring in your circuit?
    a. Who primarily conducts drug enforcement in this area? Do different agencies work together?
    b. What kinds of drug crime does drug enforcement in this area primarily target – e.g. distribution, sales, drug abuse/possession, etc.?
22. Do you have gangs in this area? If so, what kinds of gangs are they (e.g. Outlaw Motorcycle Gangs, Bloods/Crips, Neighborhood crews etc.)?
    a. Is there a relationship between drug crime and gang activity in your area? How does your agency prosecute gang-related drug crime?
    b. Do you pursue charges under the 16-15-8 or 16-15-10 – the gang law, in addition to under the controlled substances act?
23. Where are the illegal drugs popular among abusers in your area coming from? How does the area's transportation infrastructure (highways, ports, borders, airports) affect the movement of drugs through and into the area?

Law Enforcement

24. What kinds of drug enforcement are occurring in your area? Who primarily conducts drug enforcement in this area? Do different agencies work together? What kinds of drug crime does law enforcement in this area primarily target – e.g. distribution, sales, drug abuse/possession, etc.?
25. What is your information source for drug-related crimes in your area? Informants? Citizens? Undercover law enforcement officers?
26. Does your agency offer a drug take-back program? If so, how does it work?
27. [ONLY FOR METRO] Is your agency part of the High Intensity Drug Trafficking Area (HIDTA)?
28. What is your strategy/ initiative to reduce or eliminate the production, manufacture, transportation, distribution, and use of illegal drugs and money laundering? Do you work with other law enforcement agencies to address these crimes?
29. Does your agency host any community outreach sessions? If so, who is your target population? Schools? Civic groups? Non-profits? etc.
30. Do you have gangs in this area? If so, what kinds of gangs are they (e.g. Outlaw Motorcycle Gangs, Bloods/Crips, Neighborhood crews etc.)? Is there a relationship between drug crime and gang activity in your area?

31. Where are the illegal drugs popular among abusers in your area coming from? How does the area's transportation infrastructure (highways, ports, borders, airports) affect the movement of drugs through and into the area?

Probation

32. What screening instrument do you use to determine whether an offender you are monitoring has a substance abuse problem?
33. Do you develop a case plan with the offenders you monitor? If so, what do those case plans typically entail?
34. Do you conduct random drug screens on *all offenders* under your supervision, or only those with a drug-related offense, or only those found to have a substance abuse issue?
35. Do you monitor offender compliance with substance abuse or other treatment? If so, how?
36. How frequently do you interact with the offenders under your supervision? Do you conduct any interventions or meetings with the offender's family?
37. What resources are available in your community to assist offenders with substance abuse issues? Do you feel those resources are adequate? What kinds of resources do you feel would help offenders under your supervision successfully complete their probation terms? What are the reasons, in your experience, that offenders most frequently violate their probation terms?

Treatment Provider

38. What is your primary substance abuse treatment referral source?
39. Does your agency host any community outreach sessions? If so, who is your target population? Schools? Civic groups? Non-profits? etc.
40. What are the barriers that your consumers face to successfully completing treatment? Employment, housing? Etc.
41. Do you offer aftercare treatment for consumers who successfully complete your program? If you do not, do you refer these consumers to other providers to help them with aftercare/support groups to stay clean and sober?3
42. What is the most common drug of choice among your treatment population?
43. How many of the consumers that you treat are criminally involved, or have a criminal history? Do you have a relationship with law enforcement or the courts?
44. How many of the consumers that you treat have a co-occurring mental illness? What kinds of services do you offer these consumers?

Appendix B: Online Survey Questions

Thank you for taking time to complete the State Drug Enforcement Strategy Online Survey. The CJCC Statistical Analysis Center (SAC) received the 2013 State Justice Statistics Formula Grant to conduct a needs assessment. The goal is to determine the best strategy for Georgia's future drug enforcement activities based on current issues and trends. Please respond to the survey questions based upon your experience with substance abuse and drug crime in your jurisdiction and/or treatment service area.

The survey starts with a series of general questions about substance abuse and drug crime. Drug crime, means violations of the Georgia Controlled Substances Act (O.C.G.A. §16-13-1); which includes possession, sale, or trafficking of illicit drugs. It also refers to property or violent crimes, such as burglaries, theft, assault, etc., committed as part of the possession, sale, or trafficking of illicit drugs.

This survey should take less than 20 minutes to complete. Your feedback and responses are

General Questions:

Please indicate the county(ies) in which you a. have some jurisdiction or b. provide treatment services. We have a choice for "All counties" if you provide service statewide. (If you are part of a police department or drug task force that serves only certain cities, please indicate the counties in which your cities are located.)

Appling
Atkinson
Bacon
Baker
Baldwin
Banks
Barrow
Bartow
Ben Hill
Berrien
Bibb
Bleckley
Brantley
Brooks
Bryan
Bulloch
Burke
Butts
Calhoun
Camden
Candler
Carroll
Catoosa
Charlton
Chatham
Chattahoochee
Chattooga
Cherokee
Clarke
Clay
Clayton
Clinch
Cobb
Coffee
Colquitt
Columbia
Cook
Coweta
Crawford
Crisp
Dade
Dawson
Decatur
DeKalb
Dodge
Dooly
Dougherty
Douglas
Early
Echols
Effingham
Elbert
Emanuel
Evans
Fannin
Fayette
Floyd
Forsyth
Franklin
Fulton
Gilmer
Glascock
Glynn
Gordon
Grady
Greene
Gwinnett
Habersham
Hall
Hancock
Haralson
Harris
Hart
Heard
Henry
Houston
Irwin
Jackson
Jasper
Jeff Davis
Jefferson
Jenkins
Johnson
Jones
Lamar
Lanier
Laurens
Lee
Liberty
Lincoln
Long
Lowndes
Lumpkin
Macon
Madison
Marion
McDuffie
McIntosh
Meriwether
Miller
Mitchell
Monroe
Montgomery
Morgan
Murray
Muscogee
Newton
Oconee
Oglethorpe
Paulding
Peach
Pickens
Pierce
Pike
Polk
Pulaski
Putnam
Quitman
Rabun
Randolph
Richmond
Rockdale
Schley
Screven
Seminole
Spalding
Stephens
Stewart
Sumter
Talbot
Taliaferro
Tattnall
Taylor
Telfair
Terrell
Thomas
Tift
Toombs
Towns
Treutlen
Troup
Turner
Twiggs
Union
Upson
Walker
Walton
Ware
Warren
Washington
Wayne
Webster
Wheeler
White
Whitfield
Wilcox
Wilkes
Wilkinson
Worth
All Counties

How long have you been working in your field?

Less than 1 year
1 to 2 years
3 to 5 years
6 to 10 years
More than 10 years

In your opinion, what was the most prevalently abused drug in your jurisdiction or treatment service area prior to the 2008 recession?

Cocaine/Crack
Ecstasy/MDMA
Heroin
Marijuana
Meth
Prescription Drugs
Synthetic drugs (spice, bath salts, K2)

In your opinion, what is the most prevalently abused drug in your jurisdiction or treatment service area since the 2008 recession?

Cocaine/Crack
Ecstasy/MDMA
Heroin
Marijuana
Meth
Prescription Drugs
Synthetic drugs (spice, bath salts, K2)

Has the age of the average substance abuse consumer in your jurisdiction or treatment service area changed since the 2008 recession?

Younger
The Same
Older
Don't know
No answer

Has the gender of the average substance abuse consumer in your jurisdiction or treatment service area changed since the recession?

More males doing drugs
The same
More females doing drugs
Don't know
No answer

Have you noticed any change to consumer characteristics in your jurisdiction or treatment service area?

	Yes	No
More addiction		
More are open with their substance abuse		
More consumers that are chronic, long term users		
More consumers with history of military service		
More consumers with mental illness		
More involved in property crime		
More users that also sell illicit drugs		
More violent/aggressive		
More young consumers		

In your opinion, have the following substance abuse issues been increasing or decreasing in your jurisdiction or treatment service area since the recession?

	Greatly Decreasing	Decreasing Somewhat	Staying the same	Increasing Somewhat	Greatly increasing	Don't know	No Answer
Cocaine/Crack Possession/Use							
Cocaine/Crack Trafficking							
DUI							
Ecstasy/ MDMA Possession/Use							
Ecstasy/ MDMA Trafficking							
Heroin possession/use							
Heroin Trafficking							
Marijuana Possession/Use							
Marijuana Production/Trafficking							
Meth possession/Use							
Meth trafficking							
Over the counter (OTC) drug misuse							
Prescription drug misuse							
Synthetic drugs (spice, bath salts, K2) possession/use							
Synthetic drugs (spice, bath salts, K2) trafficking							

Please indicate the extent to which the following resources have increased or decreased?

	Greatly Decreasing	Decreasing Somewhat	Staying the same	Increasing Somewhat	Greatly increasing	Don't know	No Answer
Alternative sentencing options for drug violations							
Community agency partnerships							
Substance abuse prevention efforts							
Substance abuse treatment availability							
Drug enforcement/treatment training							

Federal funding to address substance abuse							
Local funding to address substance abuse							
Mental health treatment availability							
State funding to address substance abuse							
Trained law enforcement or prosecutorial experts to assist in drug enforcement							

The following is a list of programs that may lead to a reduction in issues related to substance abuse. Please select the ones that are already in place in your jurisdiction or treatment service area. (Select all that apply.)

Accountability Courts
Adult treatment programs for substance abuse
Citizen groups formed to combat and prevent substance abuse
Substance abuse prevention programs in communities and schools
Substance abuse treatment programs in jails
Drug and alcohol testing of offenders
Drug detection tools (K-9 dogs, etc.)
Drug treatment programs for juvenile's with substance abuse issues
Educational programs and life skills classes for offenders
Faith based treatment programs for substance abuse
Family counselling treatment programs for substance abuse
Halfway housing/affordable housing for returning citizens
Inpatient drug treatment programs for offenders
Job opportunities/training for ex-offenders
Multi-jurisdictional drug task forces
Outpatient drug treatment programs for offenders

The following is a list of items that may help reduce illicit drug use. Please select the top 3 items that your jurisdiction or treatment service area does not currently have, but would be most beneficial to reduce drug crime.

Collaboration between social services, community organizations, victim services, criminal justice agencies
Community-based substance abuse prevention programs
Community-based substance abuse treatment programs
Drug offender monitoring
Emphasis on arrests for drug offenses
Emphasis on prosecuting drug dealers/manufacturers
Employment resources/mentors/vocational training for offenders/persons with substance abuse issues

Graduated sanctions for offenders with substance abuse issues/criminal history on probation
Inpatient substance abuse treatment programs
More educational opportunities for offenders/persons with substance abuse issues
More severe punishments for drug offenses

Please select the top 5 recommendations that you believe would be most beneficial for handling offenders with substance abuse issues?

Accessible, affordable treatment & counselling services
Accountability courts
Affordable halfway housing/shelters for adults and juveniles
Community Service Programs for Offenders
Corrections-based residential substance abuse programs
Court ordered substance abuse treatment
Faith-based drug treatment programs or support groups
Inpatient substance abuse treatment
Mental health services/treatment for co-occurring disorders
More specialized drug enforcement personnel and training
More specialized substance abuse treatment personnel and training
Post treatment follow-up and monitoring for offenders
Prevention programs for juveniles with substance abuse issues
Randomized drug testing for probationers
Social support networks, e.g. AA and NA
Stricter arrest policy and harsher punishments for offenders
Transportation to treatment for offenders
Treatment for adults and juveniles that involve family participation
Treatment programs for juveniles with substance abuse issues
Wire-tapping monitoring/equipment for law enforcement

Please rate your working relationship with other community partners.

	Very Poor	Poor	Fair	Good	Excellent	N/A	No Answer
Corrections							
Department of Family and Children Services							
Judges							
Life skills program provider							
Parole Officers							
Prevention program providers							
Probation Officers							
Prosecutors							
Treatment Providers							
Workforce development agencies							

If you could make a policy recommendation to successfully address drug abuse and/or trafficking in the state of Georgia, what would it be? (Less than 500 characters)

_____
_____
_____

In which sector do you work?
Corrections
Judiciary/Courts
Law Enforcement
Probation
Prosecution
Prevention/Treatment Provider/Social Services
Public Defender

Law Enforcement

What is your position in your organization?

Chief/Command staff
Management/Admin
Narcotics Officers/Investigators
Patrol Officer
Sheriff/Deputy Sheriff
Other, Please Specify: _____

Gang Involvement in Drug Crime

The following questions ask about the connection – if any – between gang activity and drug crime in your area. O. C. G. A. § 16-15-3 defines a Criminal Street Gang as: (A) Any organization, association, or group of three or more persons associated in fact, whether formal or informal, which engages in criminal gang activity. The existence of such organization, association, or group of individuals associated in fact may be established by evidence of a common name or common identifying signs, symbols, tattoos, graffiti, or attire or other distinguishing characteristics, including, but not limited to, common activities, customs, or behaviors. Such term shall not include three or more persons, associated in fact, whether formal or informal, who are not engaged in criminal gang activity.

Please respond to the questions below with this definition in mind.

Based on the definition above, do you have active gangs in your jurisdiction?

Yes
No
Don't Know

If yes, how would you describe the gangs in your jurisdiction?

Aryan Nation/racists group
Clicks/sets of large national gang (Crips, Bloods, and Folks etc.)
Hybrid gangs
Neighborhood crew
Outlaw Motorcycle Gangs
Sovereign Citizens

Are these gangs involved with the drug market in your jurisdiction?

Yes
No
Don't Know

If yes, at what level are the gangs involved in the drug market? (Select all that apply.)

Low level street dealer
Mid-level distributors
Traffickers/connection to Cartels
Abusers

Please select the top 3 types of drugs in which gangs in your jurisdiction are primarily involved?

Cocaine/Crack
Ecstasy/MDMA
Heroin
Marijuana
Meth
Prescription Drugs
Synthetic Drugs (Spice, Bath Salts, K2)

Drug-Related Crime Questions

The last few questions ask about drug-related crime in your area. Drug-related crime means:

- Cases involving violations of the Georgia Controlled Substances Act (O.C.G.A. §16-13-1);
- Property and/or violent crimes that have a connection to the sale, trafficking, or distribution of illicit drugs;
- Property and/or violent crimes involving a person with substance abuse issues who commits crime to support their habit.

Please select the top 3 training topics that would improve your agency's response to drug-related crime.

Community/problem oriented policing training

Cybercrime training
Drug investigation/interdiction training
Evidence handling and storage
Formation and appointment of tactical units
Gang Investigation and identification training
Hotspot policing training
Identification and investigation current and emerging synthetic drugs
Leadership training
Managing informants
Response to cases involving mentally ill or severely intoxicated person
Using social media in investigation
Other, specify: _____

Please select the top 3 resources that would improve your organization's response to drug-related crime in your jurisdiction.

Computer/software
Crime analyst staff/capacity
Drug investigation unit/officer(s)
Gang investigation unit/officer(s)
Increase intelligence sharing with other law enforcement agencies
Increase patrol capacity for DUI
K-9 handlers
More patrol officers
Multi-jurisdictional drug task force
Protective gear and equipment
School resource officers
Video cameras/surveillance equipment

In which specific areas would enhanced funding provide the greatest benefit for enforcing the drug laws? (Please select the top 3)

Funding an ADA specifically assigned to a Drug Task Force
Hiring more drug investigators
Money for PEPI (Purchase of Evidence, Purchase of Information)
Training
Updating equipment for drug cases. I.e. Computers, cars, wiretapping equipment, etc.

<u>Prosecution</u>

What is your position in your organization?
District Attorney
Assistant District Attorney
Solicitors-General

Assistant Solicitors-General

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Please respond to the questions below with this definition in mind.

Based on the definition above, do you have active gangs in your jurisdiction?
Yes
No
Don't Know

If yes, how would you describe the gangs in your jurisdiction?

Aryan Nation/racists group
Clicks/sets of large national gang (Crips, Bloods, and Folks etc.)
Hybrid gangs
Neighborhood crew
Outlaw Motorcycle Gangs
Sovereign Citizens

Are these gangs involved with the drug market in your jurisdiction?

Yes
No
Don't Know

If yes, at what level are the gangs involved in the drug market? (Select all that apply.)

Low level street dealer
Mid-level distributors
Traffickers/connection to Cartels
Abusers

Please select the top 3 types of drugs in which gangs in your jurisdiction are primarily involved?

Cocaine/Crack
Ecstasy/MDMA
Heroin
Marijuana
Meth
Prescription Drugs
Synthetic Drugs (Spice, Bath Salts, K2)

Have you ever attempted to use the gang statute in conjunction with the Georgia Substance Abuse Control Act to pursue penalties against the gangs in your jurisdiction?

Yes
No
Don't Know

If no, what barriers have you experienced in connection with utilizing the gang statue against the gang(s) in your jurisdiction?

Drug-Related Crime Questions

The last few questions ask about drug-related crime in your area. Drug-related crime means:

- Cases involving violations of the Georgia Controlled Substances Act (O.C.G.A. §16-13-1);
- Property and/or violent crimes that have a connection to the sale, trafficking, or distribution of illicit drugs;
- Property and/or violent crimes involving a person with substance abuse issues who commits crime to support their habit.

With regard to the drug-related cases that your office prosecuted in the last year, do you feel you that have adequate access to the following resources?

	Never	In Some Cases	In Most Cases	In All Cases	N/A	No Answer
Adequate evidence to pursue gang-related drug cases						
Adequate evidence to pursue high level drug cases						
Sentencing options to meet drug abuse treatment needs of adult offenders						

Sentencing options to meet drug abuse treatment needs of juvenile offenders						
Substance abuse treatment for chronic abusers						
Sufficient information to identify offender's drug problems						

Please choose the top 3 specialized resources that would better help you to prosecute drug-related cases.

Better collaboration with the public defenders
Better collaboration with treatment providers
Collaboration with law enforcement for better evidence collection
Increased participation with local accountability courts
Specialized drug prosecutors
Training specifically on prosecuting drug-related cases
Treatment options for adult offenders
Treatment options for juvenile offenders
Updated case management/computer system
Other, Specify: _____

With the definition of "drug-related case" in mind, how many of your cases in CY2013 were drug-related?

Of the drug-related cases you prosecuted in CY2013, what are the sentencing outcomes?

Convicted guilty as charged	
Plead guilty to charges	
Plead to lesser charges	
Convicted of Lesser Charges	
Placed in Alternative Sentencing	
Acquitted	

Judicial/Courts

Which of the following types of accountability courts are available in your judicial circuit? (Select all that apply.)

Adult Felony Drug Court
Adult Mental Health Court
DUI Court
Family Dependency Treatment Court
Juvenile Drug Court
Juvenile Mental Health Court
Veterans Court
None of the above

Do you preside over an accountability court?
Yes
No

If yes, do you feel your caseload allows you to have sufficient contact with program participants?

Yes
No

Drug-Related Crime Questions

The last few questions ask about drug-related crime in your area. Drug-related crime means:

- Cases involving violations of the Georgia Controlled Substances Act (O.C.G.A. §16-13-1);
- Property and/or violent crimes that have a connection to the sale, trafficking, or distribution of illicit drugs;
- Property and/or violent crimes involving a person with substance abuse issues who commits crime to support their habit.

With regard to the drug-related cases that you have tried in the last year, do you feel that you had sufficient resources based on the list below to provide sentencing options?

	Never	In Some Cases	In Most Cases	In All Cases	N/A	No Answer
Sentencing options to meet drug abuse treatment needs of adult offenders						
Sentencing options to meet drug abuse treatment needs of juvenile offenders						

Substance abuse treatment for chronic abusers						
Sufficient correction-based treatment program for offenders sentenced to prison						
Sufficient information to identify offender's drug problems						
Sufficient risk assessment information to identify offender's likelihood to recidivate						

Based upon the definition of "drug-related case", how many drug cases did you preside over in CY2013?

Of the drug cases that you presided over in CY 2013, how many cases were:

Drug possession cases	
Drug trafficking cases	
Property cases involve a substance abusing offender	
Violent crime cases where the offender was under the influence when committing the crime	

In your opinion, are the jurors in your jurisdiction educated about the drug crime in your area?
Yes
No

Thinking of the drug-related cases that you presided over in 2013, what were the top 3 barriers that prevented offenders from participating in a drug court or receiving substance abuse treatment?

Can't afford treatment
Conflict between treatment and employment
Denial of substance abuse problem

Insufficient in-patient treatment facilities
Insufficient out-patient treatment facilities
Lack of family support/family is enabler
Lack of sober/affordable housing
No insurance to pay for treatment
The person is not suitable for entry into drug court (e.g. not addicted, a dealer, mental health problems, other health issues, sexual predator, etc.)
Transportation issues

Probation

What is your position in your organization?

Chief Probation Officer
Day Reporting Center Administrator
Probation Office III
POSS Officer

Gang Involvement in Drug Crime

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Please respond to the questions below with this definition in mind.

Based on the definition above, do you have active gangs in your jurisdiction?
Yes
No
Don't Know

If yes, thinking of your current caseload, approximately what percentage of the probationers under your supervision are gang-affiliated?

0-15%
16-30%
31-50%
51-75%
76-100%

How would you describe the gangs in your jurisdiction?

Aryan Nation/racists group
Clicks/sets of large national gang (Crips, Bloods, and Folks etc.)
Hybrid gangs
Neighborhood crew
Outlaw Motorcycle Gangs
Sovereign Citizens

Are these gangs involved with the drug market in your jurisdiction?

Yes
No
Don't Know

If yes, at what level are the gangs involved in the drug market? (Select all that apply.)

Low level street dealer
Mid-level distributors
Traffickers/connection to Cartels
Abusers

Please select the top 3 types of drugs in which gangs in your jurisdiction are primarily involved?

Cocaine/Crack
Ecstasy/MDMA
Heroin
Marijuana
Meth
Prescription Drugs
Synthetic Drugs (Spice, Bath Salts, K2)

Drug-Related Crime Questions

The last few questions ask about drug-related crime in your area. Drug-related crime means:

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- Property and/or violent crimes that have a connection to the sale, trafficking, or distribution of illicit drugs;
- Property and/or violent crimes involving a person with substance abuse issues who commits crime to support their habit.

With regard to the drug-related cases that you supervised in CY 2013, do you feel that you have adequate access to the following resources?

	Never	In Some Cases	In Most Cases	In All Cases	N/A	No Answer

A caseload level that permits sufficient contact with clients						
Access to housing resources to help offenders to find sober housing						
Access to resources to help offenders with transportation barriers						
Access to workforce development agencies to help offenders to find employment						
Cooperation from public agencies in providing drug-related treatment for offenders						
Sufficient sanctions and/or incentives to motivate offenders to stay clean						
Treatment options to meet the needs of adult offenders						
Treatment options to meet the needs of juvenile offenders						
Treatment options to meet the needs of offenders with co-occurring, substance abuse and mental health disorders						

Thinking of your caseload in CY2013, approximately how many of your probationers needed substance abuse treatment?

Of those needing substance abuse treatment, how many failed to receive it?

What are the top 3 reasons why probationers failed to receive substance abuse treatment?

Conflict between treatment and employment
Lack of financial resources for treatment
Lack of long term treatment options for chronic abusers
Lack of motivation on the part of the offender
Lack of transportation options
Lack of treatment options for clients with dual diagnosis (mental health and substance abuse issues)
Long waiting lists for treatment
Not ordered by the court
Other, specify: _____

Please select your agency's top 3 needs to better manage substance abusing probationers under your supervision.

Additional case management staff to help probationers connect to resources
Additional in-patient treatment for probationers
Additional out-patient treatment for probationers
Better risk assessment
Collaboration with law enforcement
Graduated sanctions for probationers
More access to education and life skills programming for probationers
More access to employment opportunities for probationers
More access to randomized drug testing for offenders
Specialized probation officers

Correction

What is your position in the correctional system?

Administration/Management
Correctional Officer
Treatment Staff
Warden/Deputy Warden

In your opinion, what are the top 3 resources that your correctional facility needs better to combat drug-related crime?

Better access to drug dogs
Better access to substance abuse treatment programs
Better prosecution of violent offenses while in prison
Better quality staff
Better surveillance equipment to cover the entire facility
Body Scanning Equipment
Cell phone blocking
Drug identification training
Netting over facility fence to prevent throw overs
Specialized drug investigation correctional officers
Staff retention/better pay for officers

Prevention & Treatment Provider

What is your position in the treatment organization?

Administrative staff
Case worker/manager
Intake staff
Management/clinical director
Psychiatrist
Therapist/Psychologist
Other, specify:_____

In CY 2013, how many of the persons that you treated were referred by the criminal justice system (law enforcement, prosecutor, public defender, judges, etc.)?

Don't Know

Did you deny treatment to any persons who were referred by the criminal justice system?

Yes
No
Don't Know

If yes, how many persons did you deny treatment?

In thinking about the persons to whom you denied treatment, what were the top 3 reasons for denial?

Insufficient treatment slots
Lack of motivation on the part of the offender
Lack of offender financial resources / insurance for treatment
Lack of transportation options for offender to consistently come to treatment
Offender history of violence potentially put provider and other patients at risk
Offenders were not stable enough to receive treatment
Treatment options available in your organization more suitable for individuals with a severe substance use disorder
Treatment options in your organization are not suitable for clients with co-occurring disorders
Other, specify:_____

Which of the following agencies in the criminal justice system are your top 3 treatment referral sources?

Division of Family and Children Services
Accountability Court
Jail
Parole Officer
Police Department
Probation Officer
Prosecutor's Office
Public Defender
Sheriff's Office
Other, specify:_____

For the persons you treated in CY 2013, what are the top 3 additional resources that your organization needed to provide or more successful treatment?

Additional case managers
Additional residential treatment beds
Additional training on evidence-based intervention for current staff (Cognitive behavioral training, moral recognition training, etc.)
Additional treatment staff/counselors
An in-house psychiatrist
Funding for persons without insurance
Programming specific for persons with co-occurring disorders
Risk assessment and treatment history information from the referring criminal justice agencies
Other, specify:_____

Public Defender

What is your position in your organization?

Circuit Public Defender
Assistant Public Defender
Capital Defender

Mental Health Advocate

Gang Involvement in Drug Crime

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Please respond to the questions below with this definition in mind.

Based on the definition above, do you have active gangs in your jurisdiction?
Yes
No
Don't Know

If yes, thinking of your caseload in CY 2013, approximately what percentage of your clients do you think were gang-affiliated?

0-15%
16-30%
31-50%
51-75%
76-100%

What kinds of gangs were your clients primarily affiliated with?

Aryan Nation/racists group
Clicks/sets of large national gang (Crips, Bloods, and Folks etc.)
Hybrid gangs
Neighborhood crew
Outlaw Motorcycle Gangs
Sovereign Citizens

Were some of these gang-affiliated clients also involved with the drug market in your jurisdiction?

Yes
No
Don't Know

If yes, at what level are the gangs involved in the drug market? (Select all that apply.)

Low level street dealer
Mid-level distributors
Traffickers/connection to Cartels
Abusers

Please select the top 3 types of drugs in which gangs in your jurisdiction are primarily involved?

Cocaine/Crack
Ecstasy/MDMA
Heroin
Marijuana
Meth
Prescription Drugs
Synthetic Drugs (Spice, Bath Salts, K2)

Drug-Related Crime Questions

The last few questions ask about drug-related crime in your area. Drug-related crime means:

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- Property and/or violent crimes that have a connection to the sale, trafficking, or distribution of illicit drugs;
- Property and/or violent crimes involving a person with substance abuse issues who commits crime to support their habit.

With regard to the drug-related cases that your office defended in the last year, do you feel you that have adequate access to the following resources?

	Never	In Some Cases	In Most Cases	In All Cases	N/A	No Answer
A caseload level that permits sufficient contact with clients						
Adequate evidence to defend gang-related drug cases						
Adequate evidence to defend high level drug cases						
Sentencing options to meet						

drug abuse treatment needs of adult offenders						
Sentencing options to meet drug abuse treatment needs of juvenile offenders						
Substance abuse treatment for chronic abusers						
Sufficient information to identify offender's drug problems						

Please choose the top 3 specialized resources that would better help you to defend clients accused in drug-related cases.

Better collaboration with the prosecuting attorneys
Better collaboration with treatment providers
Increased participation with local accountability courts
Training specifically on defending drug-related cases
Treatment options for adult offenders
Treatment options for juvenile offenders
Updated case management/computer system
Other, specify:_____

With the definition of "drug-related case" in mind, how many of your cases in CY2013 were drug-related?

Of the drug-related cases you defended in CY2013, what are the sentencing outcomes?

Convicted guilty as charged	
Plead guilty to charges	
Plead to lesser charges	
Convicted of Lesser Charges	
Placed in Alternative Sentencing	
Acquitted	