Cornell University
University Assembly

AGENDA

Campus Welfare Committee
October 25, 2016
1:00pm – 2:00pm
Day Hall B12

I. Call to Order

II. Discussion of the Ithaca Plan

1. Review of Content
2. Considering a Resolution in Support

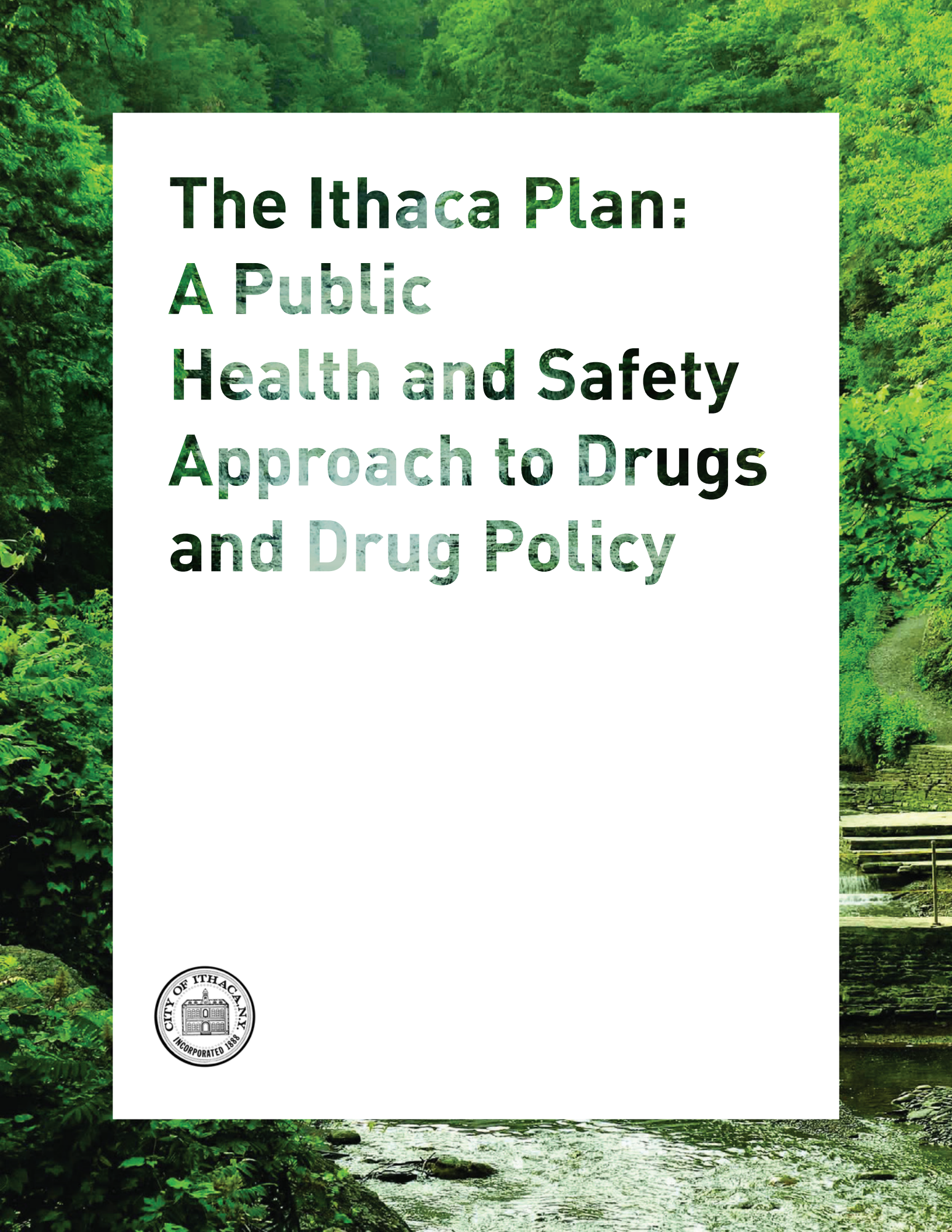
III. Tobacco-Free Campus Initiative

1. Review of Education Materials
2. Review of Insurance Coverage
3. Discussion of Options
4. DDD (Deadlines, Dates, Deliverables)

IV. Questions

V. Adjournment

We strive to make all meetings inclusive. If you are in need of accommodations for full participation, please contact the Office of the Assemblies at assembly@cornell.edu.



The Ithaca Plan: A Public Health and Safety Approach to Drugs and Drug Policy

CITY OF ITHACA N.Y. INCORPORATED 1888

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Publication Date: February 2016

The city of Ithaca has ranked on lists of America's smartest and healthiest cities.[1,2]

Yet despite Ithaca's many strengths, it has, like cities across the United States, been hit hard by problems related to drug use, drug addiction, and the broader war on drugs. As overdose deaths rise throughout the region and the nation, policymakers from across the political spectrum have joined law enforcement leaders to declare that we cannot arrest our way out of the drug problem. Simultaneously, there is a growing acknowledgement among policymakers that the war on drugs – the dominant drug policy framework for the past four and a half decades – has failed and new approaches are needed. And in the midst of these developments, communities across the nation are engaged in a powerful dialogue about race relations, a criminal justice system in need of reform, and the need to provide people with the support they need to overcome addiction.

With this backdrop, we present The Ithaca's Plan: A Public Health and Safety Approach to Drugs and Drug Policy. To develop new approaches to problems related to both drug addiction and our policy responses to it, Mayor Svante Myrick initiated a process to study the problem, gather input from the Ithaca community and issue-experts, and propose recommendations for a coordinated drug strategy, rooted in public health and safety. This report is the product of this undertaking and includes insights, findings, and recommendations that have emerged from the work of the Municipal Drug Policy Committee (MDPC), literature reviews, policy analyses, and, critically, consultations with community members and stakeholders, including elected officials, government officials, policymakers, and service providers. The co-chairs of this committee are Gwen Wilkinson, Tompkins County District Attorney and Lillian Fan, Assistant Director of Prevention Services-Harm Reduction at the Southern Tier AIDS Program. Drawing on the extensive work of the entire MDPC, the co-chairs drafted this report and then submitted it to Mayor Myrick for review and approval.

Executive Summary

This report grows out of a recognition that the city of Ithaca, despite being a national leader in many ways, could do better in its response to drug use. As in many other parts of the country, interaction of policies and available services in Ithaca needs re-imagining to respond to past approaches that have failed. This report presents insights, findings, and recommendations that have emerged from a yearlong process of consultations with community members and stakeholders, policymakers, elected officials, experts, and service providers to inform Ithaca's drug policies. Improving public health and safety are its guiding framework. As such, Ithaca stands poised to lead the nation in creating the first comprehensive municipal drug policy plan rooted in public health and harm reduction principles and grounded in the experiences and needs of the community.

The drug policies and services currently in place in the city of Ithaca reflect the broader policy dissonance of a shifting and bifurcated approach to drug use in New York state and nationally. While new practices are adopted to reduce the negative health and social consequences of drug use, older practices criminalizing drug use remain. The policy conflicts underlying these approaches are not new, but they create serious problems and inefficiencies when it comes to how drug use is addressed. Too often, our past approaches have failed to recognize that fundamentally, the community prevalence of health problems, such as problem drug use, and social problems, such as participation in the illegal drug economy, reflect deeper issues related to social and economic opportunity and racial inequality.

Over the past two decades, changes to drug policies and practices have been implemented in Ithaca with positive results. From the start of his tenure, Mayor Myrick recognized the need to build on these successes and develop an overall strategy to address the realities of drug use in our town.

In April 2014, Mayor Myrick convened a group of community experts and leaders, representing the various sectors involved with responding to drug use. This group came to be called the Municipal Drug Policy Community (MDPC). The MDPC was charged to identify and describe the drug-related problems we experience in Ithaca and to recommend policies and practices we could adopt to improve our local response to drug use and related policies. MDPC formed four teams to explore these questions: Prevention, Treatment, Harm Reduction, and Law Enforcement – four domains or "pillars" which reflect the ways our societal response to drug

use has been structured. The teams met several times to develop recommendations for new and reformed policies and practices, including reviews of the findings from community engagement activities designed to inform the process – a community convening with 200 Ithacans, eight focus groups involving nearly 100 participants, and dozens of one-on-one meetings with key stakeholders.

Summary of Findings:

Prevention

Finding 1: General programming for a substantial portion of young people is lacking and available programming is often inaccessible.

Finding 2: The drug trade is a symptom of widespread unemployment of young people and adults in Ithaca.

Finding 3: Geographic isolation, racism, and poverty contribute to hopelessness, which increases the likelihood of problematic drug use.

Finding 4: Drug education and prevention efforts should focus on both adults and young people and include information and skills about delaying the onset of use, preventing problem drug use, and reducing illness and death.

Finding 5: There is a lack of general awareness about drugs, how to navigate systems of care, and how to prevent drug-related deaths.

Treatment

Finding 1: Abstinence-based treatment programs predominate in Ithaca, and more varied treatment modalities are needed.

Finding 2: There are gaps in treatment accessibility due to limited capacity and affordability.

Finding 3: The lack of a detox center is putting an exorbitant amount of pressure on Cayuga Medical Center and costing hundreds of thousands of dollars to the tax payer.

Finding 4: Treatment programs may benefit from more cultural competency and sensitivity training.

Finding 5: Ithaca needs more medication assisted treatment options, including but not limited to, providing methadone in town and increasing the number of buprenorphine prescribers.

Finding 6: For some people, ancillary services such as mental health counseling, job training, and housing are necessary supportive services in addition to, or instead of, formal drug treatment.

Harm Reduction

Finding 1: More comprehensive training is needed on how to provide services to people at different points on the substance use continuum.

Finding 2: Harm Reduction is not widely understood, and few Ithacans know of the existing – and effective – local harm reduction programs already in operation.

Finding 3: Harm Reduction services need to be expanded.

Law Enforcement

Finding 1: Law Enforcement and community members alike do not believe that law enforcement personnel are best situated to deal with drug use.

Finding 2: Perceived experiences of racial profiling, difference in treatment, and racial disparities in arrests rates have created a perception that law enforcement targets communities of color and are less willing to connect them to services than white Ithacans.

Finding 3: Community opinion about drug courts is mixed. People like that drug courts connect those in need to resources, but most thought it would be more effective to make such resources available outside of the criminal justice system.

Finding 4: People fear calling law enforcement to help with drug-related issues because of the collateral consequences it can trigger.

Finding 5: While most community members and criminal justice system personnel recognize the good in diversion programs and treatment, more education about relapse and recovery are needed.

Recommendations were made across five categories and are summarized below.

Governance and Leadership

Goal: Create a mayoral-level office tasked to reduce the morbidity, mortality, cost, and inequities associated with illicit drugs and our current responses to them.

1. The mayor should open an Office of Drug Policy to orient the work of all city agencies towards reducing morbidity, mortality, crime and inequities stemming from drug use and our responses to it. This new approach recognizes that criminalizing people who use drugs has not been effective and anchors Ithaca's policies in principles of harm reduction, public health, and public safety. It also recognizes that city agencies often work at cross purposes and provides a structure for coordinating their work with the simple aim of improving the health and safety of communities, families and individuals across the city.

a. The mayor should appoint a director to: run the office; advise the mayor and city agencies; implement the MDPC recommendations for how the city can improve its drug policies; coordinate the activities of various city agencies and departments; be a liaison between city, county, state and federal agencies; and act as a spokesperson for the city on drug policy matters.

Education

Goal: Key stakeholders and all Ithacans should have access to evidence-based practices and education around drugs, preventing problematic use, reducing harms associated with drug use, and helping oneself or others who have a drug use problem.

1. The Office of Drug Policy would coordinate with existing Ithaca organizations that provide services to the community (like Southern Tier AIDS Program) to host a series of community education events every year around drugs, policies associated with drugs, and general health within the community. The Office would also coordinate training modules for service providers to ensure they are informed with the most up to date treatment options, strategies, and resources. Where possible, these training programs should include people who are directly impacted by drugs or drug policies, be evidence-based, and be grounded in a harm reduction approach.

Office of Drug Policy public education responsibilities include, but are not limited to:

a. General community awareness events (around drugs/drug policies).
b. Education events for parents and loved ones of those struggling with addiction (topics could include: recovery is not linear, medication assisted treatment, syringe exchanges, relapse is a part of recovery, Ithaca resources).
c. Narcan and overdose response trainings for the public.
d. Education for law enforcement, healthcare providers, service providers and users on harm reduction models. Examples include a train the trainer curriculum based on the Enough Abuse structure that can be run by STAP.
e. Cultural competency and sensitivity trainings for treatment and medical professionals working with people in treatment and medical settings.
f. Training healthcare providers around opioid prescribing and patient education, such as a standard concise information sheet distributed by all providers when opioids are prescribed that would also include treatment resources and information for the Ithaca addiction hotline.

Recovery-Oriented Treatment, Harm Reduction, and Ancillary Services

Goal: Create a recovery-oriented treatment continuum that offers access to timely, individualized, and evidence-based, effective care, through services that are people-centered and able to meet the needs of individuals no matter their current relationship to drug use or recovery.

1. Add an on demand centralized treatment resource system to the existing Ithaca 211 directory:

a. Conduct short screenings over the phone to assess appropriate service referral.
b. Provide referrals for treatment centers in Ithaca with up to date inpatient bed numbers.
c. Create a parent/loved one hotline (based on the Partnership for Drug Free.org)
d. Connect people to a treatment navigator (based on the Affordable Care Act navigator) to help persons or families in trouble navigate the treatment and referral process, including after care assistance.

2. Open a freestanding 24-hour crisis center in Ithaca – medication assisted and supervised outpatient detox, with case management services available on-site.

Activities:

a. Law Enforcement and laypersons can voluntarily bring an intoxicated individual for safety and respite.
b. This center will include short-term temporary beds for persons waiting for enrollment in treatment centers.
c. The center will also include a "chill out" space for people who are under the influence to help assuage the proliferation of public intoxication. This is not the same service as detox; the purpose of this space is not primarily to help someone withdraw but to even out, provide them with health education, and potentially connect them to harm reduction services.
d. The crisis center would also be appropriate for parents or loved ones to send their loved one in distress voluntarily, instead of a PINS or person in need of supervision process, which involves putting the person through the court system and often leads to intense strain on familial relationships, usually during crucial intervention windows. Services would include support groups (abstinence based and non-abstinence), on- site counseling, case management, and family support services.

3. The Tompkins County Department of Health should be encouraged to continue implementing an aggressive public education campaign about harm reduction practices to reduce risks from underage drinking, tobacco use, and other illicit substances.

4. Increasing awareness around the New York State 911 Good Samaritan laws can also help make adults and young people aware of the resources and the legal protections afforded victims and people who call for help.

5. The city should partner with the Tompkins County Health Department and local medical providers to offer low cost or free Hepatitis A & B vaccinations and Hepatitis C treatment to people who actively inject drugs.

6. Implement a Housing First, basic, non-contingent needs model for Ithaca to increase access to housing, nutrition and health care services without requiring abstinence or participation in treatment.

Activities:

a. Maintaining the safety of themselves and those around them should be the criteria to receive services, which should not be dictated by whether or not a person is using a substance.
b. This model should include but not be limited to sober living facilities, low threshold housing, and housing options for people with families.

7. The city should work with relevant agencies to integrate mental health care options into substance use services, with an emphasis on providing more robust service options for people with dual diagnoses.

8. Increase the availability of medication assisted treatment in Ithaca, including opening a methadone clinic and increasing the number of office-based buprenorphine (i.e., Suboxone) prescribers.

9. Continue and expand proven harm reduction programs, including but not limited to, syringe exchange services, opioid overdose education/ trainings, syringe disposal kiosks, and naloxone distribution.

10. Explore the operation of a supervised injection site staffed with medical personnel as a means to: prevent fatal and non-fatal overdose, infectious disease, and bacterial infections; reduce public drug use and discarded needles; and provide primary care and referrals to basic services, housing, and substance use services and treatment, including the integration a basic health care provider at harm reduction sites.[1,2]

11. The city of Ithaca should request the New York Academy of Medicine or another objective research institute to study the efficacy and feasibility of heroin maintenance therapy for people who do not respond effectively to other forms of opioid replacement therapies.[3]

Community and Economic Development

Goal: Support and expand existing efforts to improve youth and family development, economic opportunity, and public health of communities, targeting vulnerable communities as immediate beneficiaries and ensuring that all Ithacans have the same access to resources and investments.

1. Partner with alternative to incarceration programs that connect low level users and sellers to jobs programs (see LEAD recommendation); integrate a jobs training program as an ancillary service in treatment centers; and create an apprenticeship program in conjunction with the Downtown Ithaca Alliance and Tompkins County Chamber of Commerce and community outreach worker to encourage youth employment.

2. Pass Ban the Box legislation for private and public sector jobs and encourage Tompkins County to do the same in order to expand job opportunities for people returning from incarceration.

3. Develop a citywide training/education program on basic work skills that would be offered before the start of any potential job training course.

4. Lobby Tompkins County to create a dedicated case management program for the re-entry population.

5. Seek to reform zero tolerance programs in the school district to incorporate restorative justice systems in order to curb the rise of suspensions, expulsions, and dropout rates all of which contribute to a young person's general community disengagement and raise the likelihood of unhealthy risk behaviors.

6. Integrate comprehensive services to reduce the risks associated with drug use or alcohol poisoning at local establishments frequented by residential college students such as, safe settings where patrons can sit and rest

away from loud, crowded spaces; setting up syringe disposal containers in restrooms; and providing free and accessible water during school year weekends.

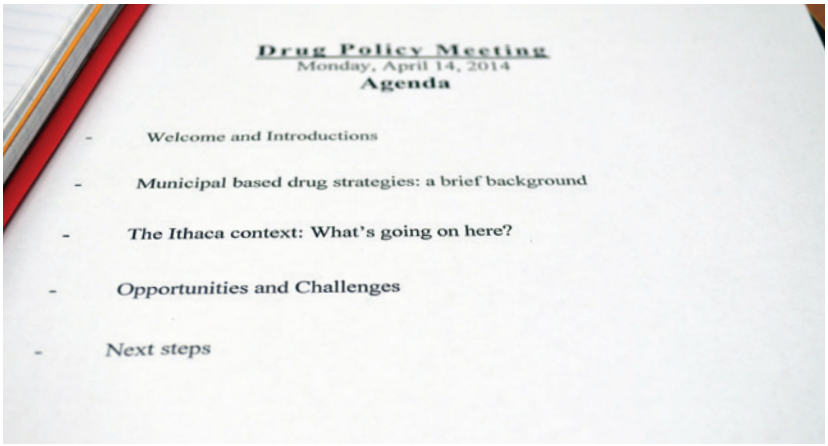
7. Establish a process through the Ithaca Office of Drug Policy to monitor, investigate, and address racial, gender, age, and geographic disparities in health and socio-economic outcomes across administrative and criminal systems. These efforts should include surveillance, research, and analysis of the different data systems (including desk appearance tickets, Unlawful Possession of Marijuana violation, treatment admissions/ graduations, drug court enrollment, etc.). ODP should issue a findings report and make recommendations to reduce unwarranted disparities.

Public Safety

Goal: Redirect law enforcement and community resources from criminalization to increasing access to services. Encourage a shared responsibility for community health and safety that extends beyond the Ithaca Police Department.

1. Pilot a Law Enforcement Assisted Diversion program, modeled on the successful Seattle LEAD program (see alternatives to incarceration program).

2. Train Ithaca Police Department on the syringe exchange program annually. The trainings, conducted by Southern Tier AIDS Program, should include how to make sure officers are safe when interacting with people who inject drugs and collaboratively identifying public spaces to place syringe and medication disposal kiosks.



Left: Agenda from Mayor Myrick's initial municipal drug strategy convening – April 2014

[1] Wood, E., Kerr, T., Spittal, P. M., Li, K., Small, W., Tyndall, M. W., & Schechter, M. T. (2003). The potential public health and community impacts of safer injecting facilities: evidence from a cohort of injection drug users. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 32(1), 2-8.

[2] Ministry of Health, Canada. (2008). *Vancouver's INSITE Service and Other Supervised Injection Sites: What Has Been Learned from Research?*. Vancouver, BC, Canada.

[3] March, J. C., Oviedo-Joekes, E., Perea-Milla, E., & Carrasco, F. (2006). Controlled trial of prescribed heroin in the treatment of opioid addiction. *Journal of substance abuse treatment*, 31(2), 203-211.

1. Developing this Report: Background

In May 2013, Mayor Myrick was a featured speaker at a major conference about drug policy at the University of Buffalo.3 One theme of the conference was city-based drug strategies in different parts of the world. Conference participants noted that there were few, if any, municipal drug policy strategies in the U.S. that were guided by a public health and safety approach; local drug strategies, to the extent they exist at all in the U.S., are too often rooted in some way or another in the war on drugs. Mayor Myrick began reaching out to drug policy experts to talk about ways to reimagine Ithaca's response to drug use and the illicit drug trade, and develop a more effective approach for achieving better outcomes.

In April 2014, Mayor Myrick convened a stakeholder meeting at City Hall to discuss the potential for developing a municipal drug strategy. Attendees at this initial meeting included:

- Gwen Wilkinson, Tompkins County District Attorney
- Chief John Barber, Ithaca Police Dept.
- Chief Tom Parsons, Ithaca Fire Dept.
- Judy Rossiter, Judge, Ithaca City Court
- Kevin Sutherland, Chief of Staff, City Of Ithaca
- Ari Lavine, City Attorney, City of Ithaca
- Gary Ferguson, Downtown Ithaca Alliance
- Marcia Fort, Greater Ithaca Activities Center (GIAC)
- Leslyn McBean-Clairborne, GIAC
- Liz Vance, Ithaca Youth Bureau
- Ami Hendrix, Tompkins County (TC) Youth Services
- Kathy Schlather, Human Services Coalition
- John Barry, Southern Tier AIDS Program
- Frank Kruppa, Tompkins County Department of Health
- Laura Santacrose, Cornell Health Education
- Angela Sullivan, Alcohol & Drug Council
- Seth Peacock, Attorney
- Judy Hoffman, Ithaca City School District
- Travis Brooks, GIAC
- Lillian Fan, Southern Tier AIDS Program
- gabriel sayegh, Drug Policy Alliance
- Julie Netherland, Drug Policy Alliance
- Kassandra Frederique, Drug Policy Alliance

At this initial meeting, participants agreed that there was room for improvement in Ithaca's drug policies and response to drug use, and expressed interest in a process to develop a new approach.

In July 2014, Mayor Myrick appointed Bill Rusen, Chief Executive Officer of the Cayuga Addiction Recovery Services, as chair of the MDPC.

Under Rusen's leadership, the MDPC held its first meeting in September 2014. Mayor Myrick instructed the MDPC to identify and describe the drug-related problems in Ithaca and to recommend policies and practices the city could adopt to improve responses to drug use. During the meeting, the MDPC formed four working groups to explore these issues: Prevention, Treatment, Harm Reduction, and Law Enforcement. The working groups began meeting to develop and articulate recommendations for new and reformed policies and practices.

In February 2015, Rusen stepped down as chair of the MDPC, and Mayor Myrick appointed two new co-Chairs – a representative from law enforcement, Gwen Wilkinson, District Attorney for Tompkins County – and a representative from harm reduction, Lillian Fan, Assistant Director of Prevention Services – Harm Reduction of the Southern Tier AIDS Program (STAP). The co-chairs were tasked with managing the workgroups and the production of this report.

Community Engagement: Film Panel and Community Focus Groups

To ensure that Ithaca's drug strategy was guided by community input, the MDPC held several public events. In February 2015, the Mayor hosted a community screening of The House I Live In, an award-winning documentary about the war on drugs. The event was attended by more than 180 people from the Ithaca community, and the conversation and discussion that followed the screening provided valuable insight into the concerns and ideas of community members. From this event and other dialogue around the work of MDPC, those expressing a desire for further sharing their ideas, opinions, and experiences were engaged for individual meetings throughout 2015 with the MDPC co-chairs.

In addition to the informative community input from the film screening event, members of the MDPC worked with representatives from The New York Academy of Medicine and the Drug Policy Alliance to convene a series of eight focus groups around the city. The goal of these community focus groups was to learn how drug use – and current responses to drug use – affected communities, families, and individuals, and to ask community members how our drug policies can be improved.

Nearly 100 people participated in the focus groups, with an average of 12 people per group. Each focus group represented a specific constituency. The eight groups were: law enforcement personnel; physicians, nurses and pharmacists; people who use drugs; young people; people of color; parents; business owners; and people in recovery. These efforts generated substantial input and data from hundreds of Ithacans.

The Ithaca plan was a comprehensive process commissioned by Mayor Myrick in 2014. He created a Municipal Drug Policy Committee made up of "Pillars" whose members were stakeholders from [various] county and city agencies. The Pillars were tasked with brainstorming recommendations for drug policy reform in the city of Ithaca. To further increase community input, the MDPC chair and the mayor convened focus groups made up of a broad spectrum of community members who discussed the issues and offered their own set of recommendations to the committee. The focus groups' recommendations were then offered to the MDPC for review. The MDPC adopted many of the recommendations from the focus groups, and submitted their final recommendations to the co-chairs who researched and curated all the recommendations. In addition to reviewing the submitted recommendations, the co-chairs held individual interviews with providers, impacted people, and services providers. After their review, the co-chairs conducted a literature review to determine

Guiding Principles

The work of the MDPC, and this final report, were guided by a set of core principles, outlined by Mayor Myrick early in the process at an MDPC meeting.

1 Policy proposals should be developed in consultation with those who will be most directly affected by the proposed changes – in this case, people who previously used or currently use drugs as well as the people living and working in communities hardest hit by drug use, the illicit drug trade, and our policy responses to it.

2 Policy proposals should be based on the best available evidence about need and effectiveness.

3 Complex social problems, like drug use, will only be solved by addressing both upstream and proximate causes and employing both structural and short-term solutions. To succeed, we must engage multiple sectors of society, including government, business, academia, health, social services, treatment, and religious institutions, as well as community members.

4 Different communities and groups of people have different needs and priorities. Therefore, policies must be able to take into account different local and cultural contexts.

5 Existing service systems too often operate in silos, and strategies that work across and integrate these isolated entities are desperately needed.

whether the recommendations were aligned with the guiding principles outlined by the Mayor at the Dec. 8, 2014 meeting. The document was then presented to Mayor Myrick for his review. While not all the recommendations were accepted, most were, reflecting a broad sweep of insight and local knowledge among Ithacans from different areas of the city.

Important Note: Drugs/Substances

Large numbers of substances can be categorized as drugs, and this document cannot include the breadth of consequences associated with the use of every substance considered a drug in Ithaca. We focused our assessments and recommendations on the drugs that community members and stakeholders reported as substances presenting the most immediate and intractable problems in the area. Ithaca's struggle with the nationwide opioid overdose epidemic most significantly informs the context and content of this document. It is important to note that marijuana is not taken up in great detail, though it is referenced in terms of the collateral consequences and criminalization it causes residents – particularly Black, Latino, and Native residentsa. Additionally, alcohol is not often named explicitly in this report; however the problems it causes are discussed in some detail and overlap some with those of problem opioid use.

[a] Because we relied on secondary data in some places, we were not able to use the same racial and ethnic classifications throughout. Some researchers compare Black and white populations; others group all people of color together; while still others distinguish between Black, white, Latino, and other racial groups. While these classifications and comparisons are all problematic in some way, we felt it important to include information about the racial disparities related to drug use and drug policies to the degree they were available.

Left: Discarded used syringes found in front of abandoned home on State Street in Ithaca – January 2016

2. The Scope of the Problem in Ithaca

Ithaca is a small city in central New York. Our population of 30,000 includes both lifelong residents and young people who live in Ithaca to attend one of its colleges and universities. Like many cities across New York, drug use, addiction, and our policy responses to these issues are complicated – and widespread – problems. Indeed, one in thirteen people in New York State suffers from a substance use disorder,[4] yet many New Yorkers lack access to treatment.[5]

One of the challenges to devising solutions in Ithaca is that stakeholders don't share a common orientation to the problem. The drug policies and services currently in place in the city of Ithaca reflect the bifurcated approach to drug use in New York State and nationally: while new practices have been adopted to reduce the negative health and social consequences of drug use, older practices criminalizing drug use remain in effect. Historically, drug use has been perceived alternately as a criminal problem, a behavioral problem, and a health problem, and laws and practices have been developed from all three perspectives. The MDPC's work uncovered this dissonance in Ithaca.

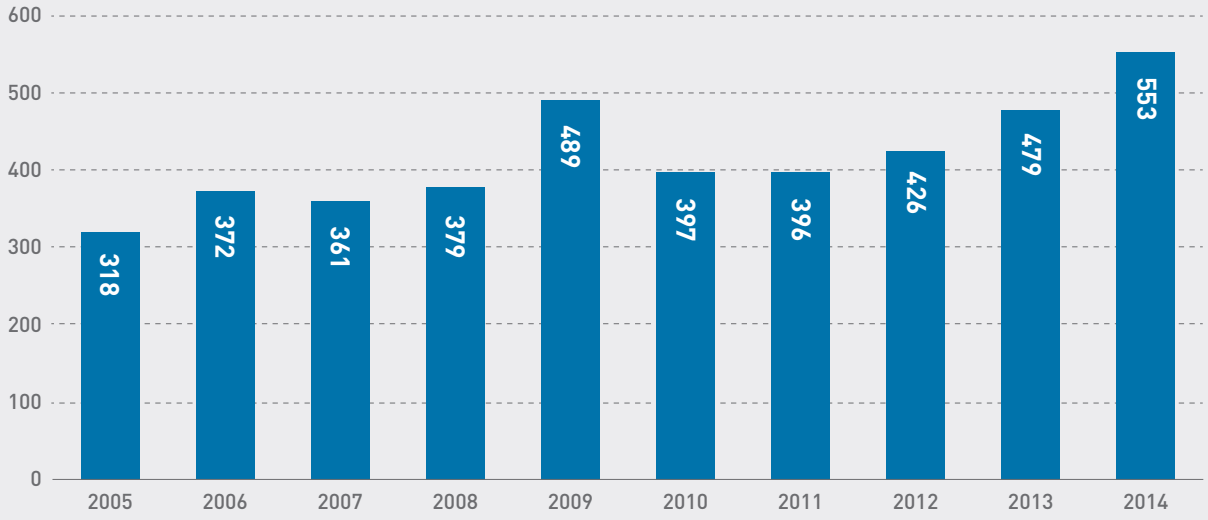
"It's hard for probation officers to wrap their head around this syringe exchange program when we have conditions of probation about being abstinent. These are not optional conditions about not using drugs. Conditions of probation are often 'don't use drugs' – and syringe exchange programs seem like hypocrisy."

– Participant in Law Enforcement Focus Group

The Criminal Justice System

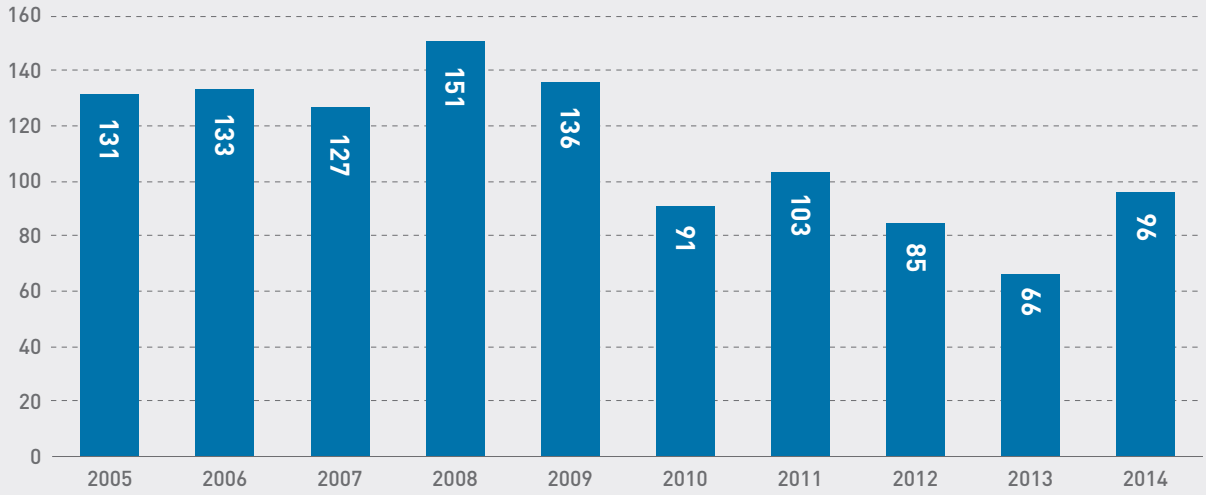
A basic problem occurs at the front end, with how a person who uses drugs is treated by the different systems. Under existing criminal law, a person who uses illicit drugs is a criminal involved in illegal transactions. The tools at law enforcement's disposal are limited: appearance ticket, or arrest. Arrests for property crimes have grown by 74% in less than a decade in Ithaca. Arrest data from Ithaca Police Department shows that arrests for drug law violations have gone down, likely attributed to the Mayor Myrick's order to make marijuana arrests a low priority. While these figures reflect the criminalization of drug use, they also indicate an increase in criminal justice costs.

Fig. 1 Misdemeanor Property Crime Arrests in City of Ithaca, 2005-2014



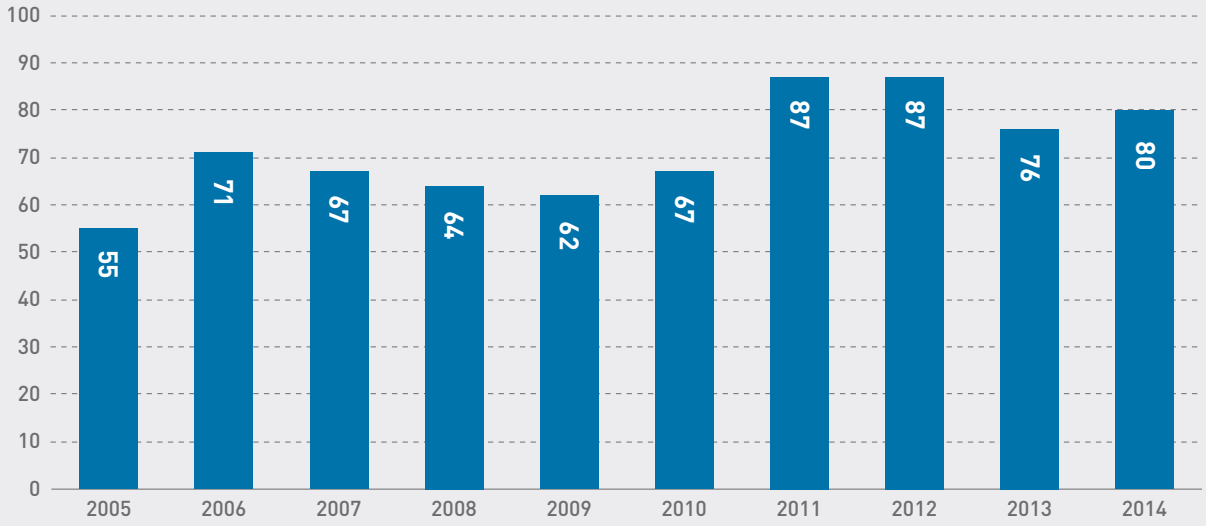
Source: Ithaca Police Department
Property Crime Arrests as reported by National Incident-Based Reporting System. See Appendix C for full list of crimes reported.

Fig. 2 Misdemeanor Drug Law Violation Arrests in City of Ithaca, 2005-2014



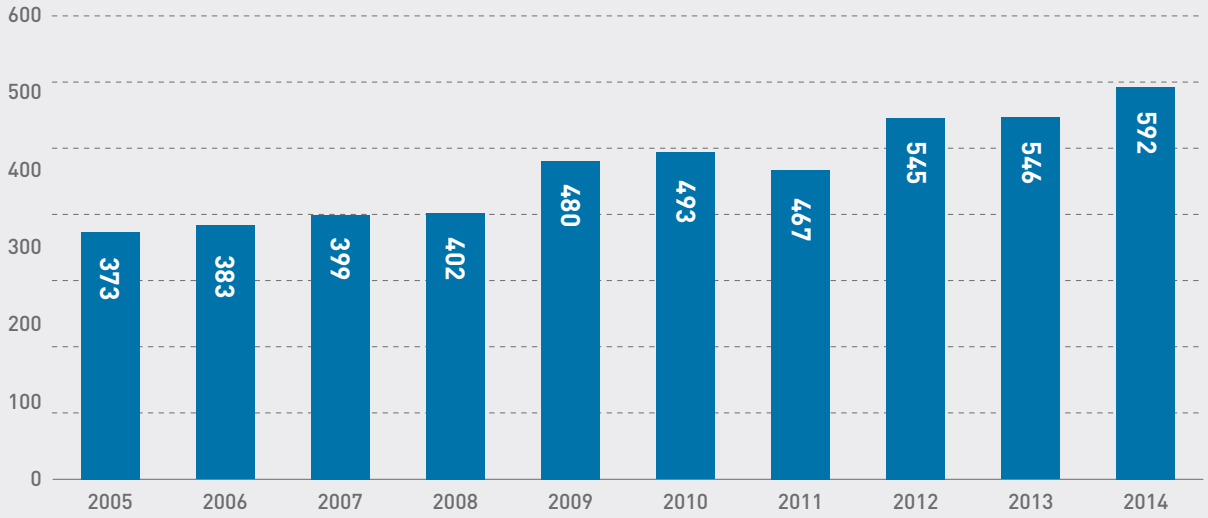
Source: Ithaca Police Department
Drug Arrests as reported by National Incident-Based Reporting System code 35A: Drug/Narcotic Violations, defined as the unlawful cultivation, manufacture, distribution, sale, purchase, use, possession, transportation, or importation of any controlled drug or narcotic substance.

Fig. 3 Misdemeanor Drug Law Violation Arrests in Tompkins County, 2005 - 2014



Source: New York State Division of Criminal Justice Services
Drug offenses include all charges listed under Penal Law Articles 220 (controlled substances) and 221 (marijuana).

Fig. 4 Misdemeanor Property Crime Arrests in Tompkins County, 2005 - 2014



Source: New York State Division of Criminal Justice Services
Property offenses include all misdemeanor charges listed under Penal Law Articles 140, 145, 150, 155 and 165.

In addition, the relationship between the community and law enforcement has become increasingly strained.

"When I think about police role in general I think about people who are supposed to protect and serve the community. Thinking about communities where I have lived, that never happens. Innocent until proven guilty, no it's guilty until proven innocent. And the racial profiling, I've been profiled. Police had a goal, it wasn't to protect and serve, it was like 'go get 'em.' I feel like they have the right to do whatever they want. To find any little thing or excuse to get your locked up. Once they get to know you and your background, you become a target."

– Participant in People of Color Focus Group

"We only have certain kinds of tools, and we know that not everything is a nail, but all we have is a hammer. We need more tools."

– Participant in Law Enforcement Focus Group

Police identify a lack of resources available to the police force and report that their capacity is over-extended. Community members highlight the use of unnecessary force and ongoing stop-and-frisk tactics that are experienced as harassment and targeting.[6] In 2014, Mayor Myrick issued an eight-point proposal to improve police-community accountability, partly in response to the expressed concerns.[7]

Behavioral Health Systems

Problematic drug use is often related to mental health; the relationship between these two health issues is intertwined. People may use drugs to self-medicate their psychological or psychiatric symptoms, and the psychoactive effect of drugs can impact mental health symptoms.[8] Unfortunately, it can be very difficult for people who use drugs to access mental healthcare and treatment. In New York State, drug treatment programs are licensed and overseen separately from mental health clinics and programs, by a different entity and under different regulations.[9] This artificial separation in the behavioral health system interferes with access to care from either provider type and with coordination between them.[10]

Moreover, mental health providers frequently exclude from their care people who are actively using drugs, citing a lack of expertise for addressing drug use, difficulty discerning mental health symptoms from the effects of psychoactive drug use, and concerns regarding the potential interactions of psychiatric medications with illicit drug use.[11] But drug treatment providers are often ill-equipped to respond to mental health issues – they are neither trained nor funded for this capacity – and so people with unresolved mental health problems and active drug use can wind up in limbo, disconnected from both systems.

"Cross addiction, alcohol, heroin, and crack. There is so much focus on chemical dependency or mental health. You have chemical dependency counselors with no training in mental healthcare and you have mental health workers who don't have training in chemical dependency."

– Participant in People in Recovery Focus Group

An additional tension arises from the abstinence-based position of many drug treatment providers. If a person participating in treatment continues to use drugs, they risk being discharged from treatment, because continued drug use represents non-compliance with an abstinence-based plan.[12] Although we have come to understand drug use as a chronic condition,[13] most drug treatment programs, including those in Ithaca, are structured with an end-goal of abstinence through a prescribed period of participation.[14] In addition, the availability of medication-assisted treatment is severely limited in Ithaca – there is no methadone maintenance treatment program, and the physicians who can prescribe buprenorphine have restricted capacity.

The Health System

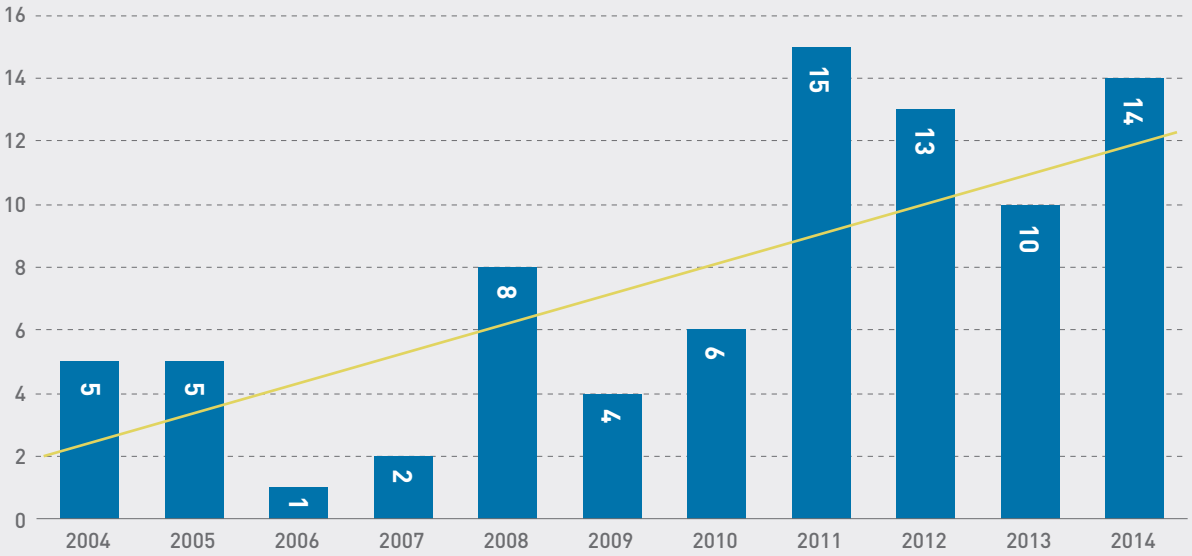
The growing problem of opioid use in Ithaca has driven more and more people into Ithaca's medical care system. Treatment providers report that the rate of participants coming in with opioid dependence has more than tripled in less than a decade, and the proportion of young people (19 to 25 years) coming in with opioid dependence has doubled.[15] In less than a decade, overdose deaths have more than tripled in Tompkins County,[16] and drug-related hospitalizations now number 15.5 per 10,000 people, up from 14.4 during 2009-2011.[17]

In Ithaca, many people who use drugs end up seeking care at Cayuga Medical Center, nearly 5 miles away from the city. Emergency room care is expensive, and ineffective for longer-term care needs, but people who use drugs are often reliant on this setting to address their immediate urgent care needs, cycling in and out without achieving overall improvements to their health or resolving their underlying drug use issues.[18]

"If people want more than a night's stay in the ER, they have to have a mental health problem or lie to get into the mental health unit."

– Participant in Healthcare FocusGroup

Fig. 5 Number of Drug-Related Deaths per Year in Tompkins County



Source: Tompkins County Health Department
Note: Population of Tompkins County in 2014 increased by 3% to 104,691 from 101,595 in 2010 (US Census Bureau).
Deaths include those where drugs were identified as the cause of death (including illicit and prescription) or may have contributed. The data may not reflect all deaths related to drugs.

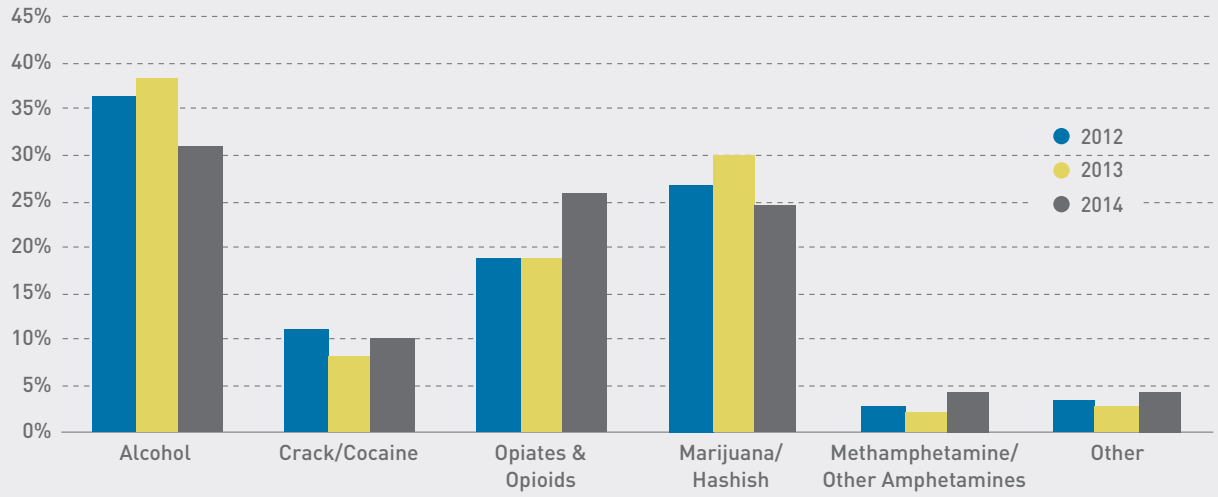
Drug Policies

In a situation not unique to Ithaca, overlap, redundancy, contradiction, and disconnection among the various components of our health system and between our health and criminal justice sectors complicate our ability to provide responsive, meaningful care and services to people who use drugs in Ithaca. Approaching the same person in such distinctly different ways, with such completely different views of the problem and how to address it, has reduced the effectiveness of our response. Our criminal justice and health sectors need to align policy and practice among our local health and health-care providers, to deliver and coordinate services to people struggling with drugs.

For example, the recent growth in heroin use is not only a local phenomenon; it has been observed at the national level, and is linked to the expanded medical use of prescription pain medication since the 1990s – opioids, such as oxycodone and hydrocodone.[19] As physicians became increasingly comfortable with prescribing these medications to patients for acute and chronic pain, two problems resulted.

First, a portion of these patients developed dependence on the medications, and when their condition became apparent to the healthcare system, their access to further prescriptions was reduced or eliminated. This, in turn, fostered the development of a new heroin market to

Fig. 6 Cayuga Addiction Recovery Services Admissions Based on Drug, 2012-2014



Source: Cayuga Addiction Recovery Services, an agency providing inpatient and outpatient substance use services to city of Ithaca and greater Tompkins County area
Total number of admissions per year: 2012: 499; 2013: 450; 2014: 540
Note: Other includes Xanax, benzodiazepam, ecstasy and hallucinogens

meet the demand from people with opioid dependence who could no longer access or afford prescription opioids.[20] Second, the over-supply of medications by physicians has resulted in an excess stock of prescription opioids in circulation in the community, whether unused in someone's medicine cabinet at home or passed along to a friend or family member who is experiencing some pain.[21]

"I'm not going to stop using dope until I get real help for my pain."

- Participant in People Who Use Drugs Focus Group

These circumstances have resulted in an expanded heroin market, which poses a problem for law enforcement and created a new group of people struggling with opioid use. For this emerging population, seeking care is often dependent on their level of access to services and their ability to avoid the criminal justice system. Policymakers are faced with the conundrum of how to balance the maintenance of public safety while increasing access to public health interventions.

Left: Free Community Film Screening of "The House I Live in" at Cinemapolis – February 2015

A Problem for the Community

Fundamentally, the community prevalence of health problems, such as problem drug useb, and social problems, such as participation in the illegal drug economy, reflect deeper issues related to social and economic opportunity. This problem is especially marked for young people, whose early experiences can give shape to their futures in distinct and long-lasting ways. Young people and people of color in low-income communities are considerably more vulnerable to negative consequences from experimentation with drug use and even brief forays into the illegal drug economy. A wealth of evidence demonstrates that criminal justice encounters, social stigma, and a lack of access to resources are more likely to affect these populations, given the structural and social discrimination found in US society.[22] These experiences are familiar to young people and people of color in low-income communities in the city of Ithaca.

"Kids will talk about Center Street as the ghetto… This is no ghetto. Anytime we are gathered together, that's a ghetto. There's a way that children live into the stereotype they were expected to fill. Unless you have a lot of people around you constantly affirming you, saying you are so smart, you are so talented, you have so many good ideas, that was so helpful and always reinforcing the positive, it's so easy to get polluted by the negative expectations of people in this community."

– Participant in People of Color Focus Group

[b] As we discuss more fully below, we lack a common language for how to talk about drug use. In fact, the definitions of drugs, substances, drug/substance use, drug/substance abuse, chemical dependency, and addiction are hotly contested. We have chosen to use "drug use" or "harmful drug use" because we feel that these terms are more neutral than some others. In addition, when we need to make a distinction between drugs whose use is against the law and those not so designated, we use the terms illicit and licit. However, where we are relying on data or literature that uses other language, we employ the terms used by the original authors.

3. Consultation Findings

Findings are structured in four areas: Prevention, Treatment, Harm Reduction, and Law Enforcement. This model reflects the framework used in European and Canadian cities, where coordinated, municipal drug strategies have been operational for decades.[c]

Although these four areas are not mutually exclusive, they represent an attempt to organize and categorize policies and practices addressing the various aspects of drug use. We heard from some of the MDPC members and focus group participants that the Treatment and Harm Reduction pillars should be integrated into one pillar, since the aims of both are often quite similar, even as the methodologies may differ. However, as our findings show, the community has much to learn about harm reduction and its important role in fostering health and safety in Ithaca.

Prevention

Finding 1: General programming for a substantial portion of young people is lacking and available programming is often inaccessible.

Boredom was described as a primary motivator for youth drug use. Young people described a lack of age diverse programming and parents explained that the high costs of after-school and summer activities largely prevented that programming from being accessible to families of various income levels.

The focus group process exposed that effective drug prevention efforts had to include the community, family, schools, peers, social infrastructure and resources. Best practices require building resiliency, and programs and initiatives that focus on this – with whole family programs demonstrating more success than youth-only or parent-only approaches.[23] In effect, drug use was recognized as being motivated by factors influencing individuals from their external environment more often than factors internally specific to the individual. Therefore, robust prevention programming and activities were seen as imperative to diminish the appeal of drug use.

Studies have demonstrated that spending on counseling and treatment costs for drug abuse produce significant savings.[24] Youth programming and afterschool activities abound for young people from well-resourced backgrounds. However, early prevention efforts targeted at young people were found to be inaccessible in Ithaca, and the wealth gap was cited as the culprit.

"There's nothing here for young people to do after 5pm, unless they have the money to pay for it."
– Participant in Parents Focus Group

Among children living at or below the poverty line, effective and affordable programs are over capacity and under-funded. These disparities are especially glaring for working-class families, who may not make enough to afford cost-prohibitive programs, while making slightly too much to qualify for programming targeting low-income families.

[c] The Four Pillars approach grew out of municipal efforts in Europe and Canada. Frustrated by the lack of progress at the federal or provincial level, cities began thinking through how they could transform their drug policies to become more effective. Bringing stakeholders from all four pillars together, these efforts are typically grounded in a harm reduction and pragmatic approach that seeks to improve public health and safety outcomes of individuals, families and communities. The model has looked different in each jurisdiction but often starts with an agreement from all sectors on a set of shared objectives and outcomes. For a detailed description of the four pillars process in Vancouver, B.C., see MacPherson, D., Mulla, Z., & Richardson, L. (2006). The evolution of drug policy in Vancouver, Canada: Strategies for preventing harm from psychoactive substance use. *International Journal of Drug Policy*, 17(2), 127-132.

Finding 2: The drug trade is a symptom of widespread unemployment of young people and adults in Ithaca.

The drug trade is an economic opportunity for people who may face barriers to entering the legal job market.[25] Several people talked about the multiple barriers to employment for people in general in Ithaca, including people with criminal records.[26] Though Ithaca is known for its low unemployment rate, unemployment is heavily skewed by the large college populations and the inclusion of higher education professionals.[27] A closer look at the stats shows a more dire situation, especially in communities most historically affected by the war on drugs – low income and people of color. For example, while 59.7% of white people own their own homes, only 25.6% of Black people and 25.6% of Latino people do. And in 1999 (the last year for which data are available), the poverty rate for whites was 14.9% compared to 20.3% for Blacks, 33.4% for Latinos, and 41.6% for Asian and Pacific Islanders.[28]

"I don't think that telling a young person that they've got opportunity and potential is enough. They're too smart and you can't sell them a bill of goods. If you tell them you've got opportunity and potential but they don't see it around them, you're lying to them."
– Participant in People of Color Focus Group

Focus group participants articulated what the research already shows – that where opportunities for economic growth were absent, participation in the illicit drug market flourishes.[29] One young person attending a focus group reported having applied to a host of different jobs, only to realize that no one wanted to hire him because he wasn't yet 18 years old. Having that experience, he could understand why some of his peers had chosen to sell drugs.

"It's fast, long money instead of short, slow money. Some people don't have money so they decide to sell."
– Participant in Young People Focus Group

The focus groups identified jobs for young people as essential to instilling a sense of purpose, connection, positivity and esteem that could function to overcome the factors leading to problematic drug use. Community disconnection, the lack of opportunities, racial bias born of structural racism were all cited as root problems that must be addressed to prevent harmful drug use or participation in the drug economy.[30] Recognizing that some people use drugs to cope with extenuating circumstances, like unemployment and poverty, people remarked that providing job opportunities could provide the motivation some need to either moderate or end their drug use.[31,32,33,34]

Finding 3: Geographic isolation, racism, and poverty contribute to hopelessness, which increases the likelihood of problematic drug use.

Among the focus groups, there were a few echoes of hopelessness about the utility of investing in prevention in Ithaca. Ultimately, some believed that prevention was an exercise in failure because individuals are bound to do what they want, and drug use is an individual choice based on people's surrounding circumstances. Participants continuously cited that some use drugs to escape their reality. Contributing factors – like isolation, racism, and poverty – can create an avalanche of poor choices and risky behavior.[35,36,37,38,39,40,41] In fact, most focus group participants identified Ithaca neighborhoods that had high crime and drug rates and noted these were geographically isolated from the rest of the community.

In addition to poverty, racism was seen as playing a role in drug use. Focus group participants indicated the types of negative messages to which young people are subjected. In multiple focus groups, there were constant references to young people of color receiving messages that communicate their inferiority.

"The lack of cultural competence [in schools] is so huge, the assumptions that are being made about our kids. And kids get it. By the 2nd grade, my daughter was already saying, I'm dumb, because those were the messages she was getting."

– Participant in Parents Focus Group

This is in direct contradiction to evidence-based drug prevention messages, which focus on building self-esteem and self-efficacy.[42] Young people and adults consistently referencing racial profiling and unequal treatment by law enforcement and the school system illustrates the need for there to be additional prevention measures that focus on disrupting harmful messaging in addition to traditional drug prevention modules. The isolation and the stigma associated with living in a "red flagged" community can contribute to a community's sense of wellbeing and that is shown to translate to poor health outcomes.[43]

Integrated communities that foster support and connection among their members were essential in preventing drug use, drug problems, and drug selling[44] Because of stigma, people who use drugs often become pariahs cast out of supportive communities – and this stigma and isolation can drive more use.[45,46,47,48]

"...Coming back to a community that loved me..., people who complimented me, encouraged me, who said I deserved more, that stuck with me. Everyone in this community has played a part in who I am today. Encourage people when they are coming home, let them know we have their back. I don't stop, when I see people who are using..., we have that conversation."

– Participant in People of Color Focus Group

Many focus group participants – especially people of color – expressed a strong opinion that problems with drugs and drug policy in Ithaca constituted a proxy for more global issues of racism, social control, and structural inequality; these participants suggested that the focus group conversation, therefore, should not solely focus on drugs. In contrast, many white focus group participants expressed that the landscape of drug issues could be repaired by exclusively focusing on reforming practices related to drug treatment and enforcement. Many focus group participants, particularly participants of color, expressed that the only way to deal head-on with drug use and selling issues was to invest in the undoing of the matrix of racial inequality that produces the problem drug issues apparent in Ithaca today.

Finding 4: Drug education and prevention efforts should focus on both adults and young people and include information and skills about delaying the onset of use, preventing problem drug use, and reducing illness and death.

Drug use among youth is a concern, and the prevention of drug use, particularly among young people, is almost always a central goal in national and international policies on illicit drugs. The consequences of drug use affect every sector of society and hamper the ability of both young people and adults alike to reach their full potential. Prevention is a cost-effective and common-sense way to lessen the consequences of drug use among youth and to prevent or reduce drug use among adults.[49]

Drug education and prevention programs come in many shapes and forms, and, unfortunately many prevention programs are neither evidence-based nor effective.[50]

Much of the drug prevention programming that is directed toward youth (and parents too) is marked by exaggeration, misinformation, and misinterpretation and is rooted in scare tactics that lack credibility among young people.[51],[52] Parents, teachers, caregivers and other important adults in the lives of young people know that talking with them about drugs is an important responsibility. But, many are questioning the wisdom of the black-and-white pronouncements of "just say no" anti-drug messages that oversimplify the complex lives that teenagers lead. Scare tactics weaken young people's confidence in law enforcement, parents, and other adults.[53]

No parent wants his or her teenager to use drugs, and abstinence for teens is the safest choice. The reality, however, as the Monitoring the Future drug prevalence survey shows, by the time teens finish high school, half of them will have tried a psychoactive substance.[54] Given the prevalence of youthful experimentation and to help prevent teens from falling into abusive patterns of drug use, we need to create strategies that promote abstinence but transcend the "just say no" rhetoric of the past as well as emphasize knowledge, safety and responsibility for those teens who do try drugs.[55]

Research shows that evidence-based prevention interventions are built around building resiliency.[56] Moreover, programs and initiatives that focus on building resiliency – with whole family programs demonstrate more success than youth-only or parent-only approaches. There is also resiliency drug education.[57]

Finding 5: There is a lack of general awareness about drugs, how to navigate systems of care, and how to prevent drug-related deaths.

Ithacans consistently expressed feelings of isolation and lacked the awareness about drugs, drug use, prevention, and the dfferent kinds of help available.

In multiple focus groups, there was an expressed interest among participants for more open discussions about drugs, drug use, drug policy, and the service systems currently available to address drug misuse and addiction. Parents shared feelings of complete isolation and hopelessness when trying to navigate the system for a child or a loved one, the incredible amount of shame of telling people their family is facing a problem, and their deep desire to learn more. Service providers shared their general lack of awareness about newer drugs, policies, and general harm reduction models. People in recovery and people who are actively using drugs consistently called for a greater say in the education of providers and community members, since they are experts in their own lives and

Left: Mayor Svante Myrick, Tompkins County District Attorney, Gwen Wilkinson and gabriel sayegh – April 2014

have particularly relevant knowledge about drugs and related issues, such as overdose. In both the MDPC and the public film-screening event, participants expressed strong interest for conversations about drug policy to take place with greater regularity.

"Parents need education so they're not in denial about their kid's problems. Parents need to be supported and not ashamed that the kids have problems. Kids have a right to good treatment."
- Participant in Parents Focus Group

"Large quarters of the medical community are uneducated about addiction. This is not just an ethical or character issue at all, it's a medical issue. Until we get to that point, these specific solutions mentioned are little steps, but we need to do more educating. The mainstreaming of addiction in America is going to bring more knowledge and look at people with more compassion. [We want] mainstreaming of the conversation around addiction, more community conversation around this issue."
– Participant in People in Recovery Focus Group

Treatment

Finding 1: Abstinence-based treatment programs predominate in Ithaca, and more varied treatment modalities are needed.

The treatment programs available in Ithaca are abstinence based. Both MDPC members and focus group participants understood that it may be in the best health interest of people to have access to a variety of treatment modalities. Decades of research has consistently proven that medication-assisted treatment, for example, is very effective for treating opioid dependence but most people in Ithaca cannot access medication-assisted treatment, including methadone and buprenorphine, commonly prescribed under the names Suboxone or Subutex. Unlike methadone, which must be dispensed from a specialty substance use disorder treatment program, buprenorphine can be prescribed and dispensed from a private physician's office. Treatment does not require daily visits, like methadone, and can be provided in the privacy of the office. There are only four buprenorphine prescribers in Ithaca with 100 slots each, so only 400 people in the larger Ithaca area can obtain a buprenorphine prescription. This low number does not fit the growing need of those in Ithaca trying to manage their opioid use. Moreover, the oldest and most researched medication-assisted treatment, methadone, is not available at all in Ithaca. To participate in a methadone treatment program, Ithacans must travel to Syracuse or Binghamton; such trips, taken regularly, can quickly become costly to either the individual or to the health insurer if travel is an included benefit, as is the case with Medicaid. Additionally, the waiting time to be admitted to a methadone program can be upwards of several months.

Harm reduction as an approach was unfamiliar to many focus group participants. Some were uncomfortable with the idea that treatment's ultimate goals could be housing or stabilizing someone's use in lieu of complete abstinence. Most focus group participants understood that for a significant portion of people, abstinence based treatment models were not an effective modality for everyone, and that meeting people "where they're at" can lead to improved health outcomes over time.

Finding 2: There are gaps in treatment accessibility due to limited capacity and affordability.

"There's the timeframe kind of thing, waiting lists and capacity. There's the lack of cultural competency. The people who need the services do not look like those who provide the service. Incredible mismatch. Cultural competency issues and lots of structural racism."
– Participant in Business Community Focus Group

While Ithaca has made historic strides in providing drug treatment services in the last twenty years, there is still a significant portion of people travelling to treatment facilities in neighboring counties to receive services. This is due largely to capacity issues; the treatment facilities in Ithaca simply cannot keep up with the demand for inpatient treatment services. In addition to capacity issues, focus group participants talked about gaps in terms of who was able to receive treatment because of insurance or eligibility requirements. They noted that some

treatment facilities lacked the capability to address the specific needs of certain populations, including people from different cultural backgrounds or people who required different treatment modalities that are simply not available in Ithaca. As a consequence, for some people in Ithaca, treatment is simply out of reach.

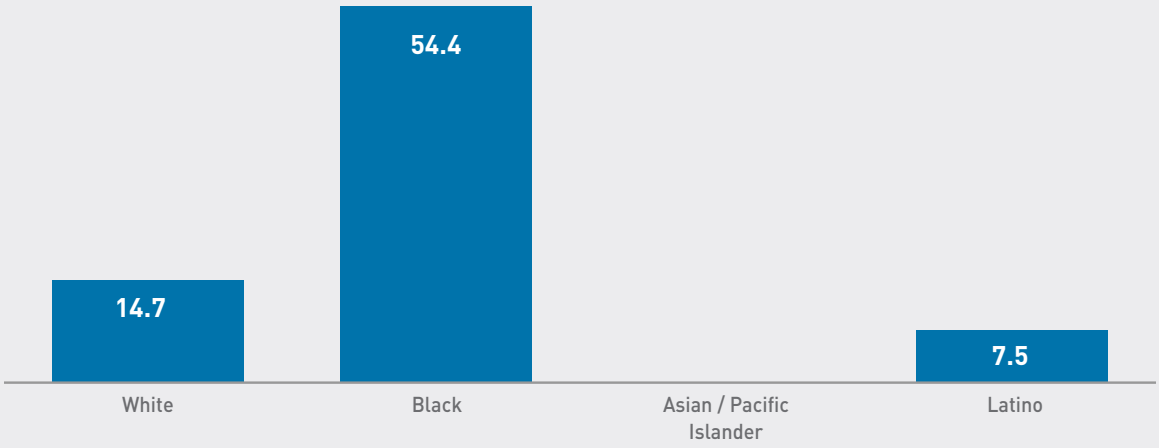
Finding 3: The lack of a detox center is putting an exorbitant amount of pressure on Cayuga Medical Center and costing hundreds of thousands of dollars to the tax payer.

In 2009, the City of Ithaca closed its only detox center. With the rise in heroin usage and increase in overall population, the lack of a detox center in town is seen as a huge gap in services for Ithaca. Without a detox center, people in need are sent to the emergency room at Cayuga Medical Center where they are typically assessed, hydrated, and then released. Sometimes the same person will return back to CMC several times a day. Between CMC, Ithaca Police Department, and Bangs ambulance there was roughly $413,526.91 spent in transporting and housing people last year. The CMC is committed to serving the Ithaca community but has been very clear that they cannot continue to provide "detox" through their emergency room. In addition, the CMC acting as a "detox" center has clear limitations. CMC is not centrally located and inaccessible for most people unless they are transported by IPD or Bangs. This is both expensive and, in the case of IPD, could unnecessarily expose people to criminal consequences.

"If we call for the ambulance, the county bears the cost, they sit in the ER and then they are kicked out – and it's repeated the next day. The cost is astronomical."

– Participant in Law Enforcement Focus Group

Fig. 7 Drug-Related Hospitalizations by Race in Tompkins County, 2012



Source: New York State Department of Health
Note: For Asian/Pacific Islander, data do not meet reporting criteria for drug-related hospitalizations.
Drug related hospitalizations defined as: The number of hospitalizations per 10,000 population with one of the following primary diagnosis ICD-9 CM codes: 292, 304, 305.1-305.0,648.3,655.5,763.5, 779.4, 779.5, 965.0, 967.0, 968.5, 969.6, 969.7, 760.70, 760.72, 760.73, 760.75, 760.79, E850-E858, E950.0-E950.2, E962.0, E980.0-E980.2.

Finding 4: Treatment programs may benefit from more cultural competency and sensitivity training.

In focus groups with people in recovery and people who are actively using drugs, many of those who had experience with treatment services expressed frustration from interactions with program staff. Some participants said they felt like staff treated them as if they were trying to game the system. For some, the experience of being treated like a child or a criminal has impacted the way they see themselves, spurring distrust and dissatisfaction with service providers, and raising obstacles to reaching out for help. Participants expressed resentment towards treatment providers, social services, law enforcement, and medical providers because of the perceived lack of sensitivity displayed in interactions. These groups in particular expressed a desire to be treated with dignity and in ways that recognized their agency and autonomy.

Research shows how culturally competent treatment programming – including for people of color, LGBTQ people, immigrants, and women – can improve health outcomes.[58]

Finding 5: Ithaca needs more medication-assisted treatment options, including but not limited to, providing methadone in town and increasing the number of buprenorphine prescribers.

The current healthcare landscape is reinforcing the importance of addressing drug use as a component of general medical care, and increasingly, medical providers can play a role in treating addiction because of the availability of new medications and integrated treatment modalities.[59] Opioid dependence can now be treated with a prescribed medication – buprenorphine (most commonly prescribed brand is Suboxone) – from a certified physician. In the Ithaca area, only four providers are offering this service. With a long waiting list for these providers, the unmet need is great. Both the MPDC treatment pillar group and numerous focus groups participants highlighted the dearth of available options for opioid dependent people seeking treatment in Ithaca and emphasized the need for more Suboxone prescribers.

"To get help out here is crazy; you have to wait weeks and then you have to have the right insurance."

– People Who Use Drugs Focus Group

Some physicians are reluctant to take on the provision of medication-assisted treatment in their practice due to lack of experience, misgivings about caring for people who use drugs, and fear of diversion. SAMHSA has created a toolkit to support doctors and healthcare providers navigate this process. Ithaca could partner with Providers Clinical Support System-MAT (PCSS-MAT) to establish mentoring arrangements with experienced providers to help them overcome these issues. With the use of technology, virtual case conference meetings could be arranged with experienced providers in other parts of the state, to develop and expand local expertise. With a concerted effort, we can expand this important resource for people who are requesting treatment in our city.

The MPDC treatment pillar group and many focus groups also advocated the opening of a methadone maintenance treatment program in Ithaca. Syracuse and Binghamton host the closest methadone treatment program available to Ithacans. While Medicaid will cover the cost of a one-hour trip in each direction for daily treatment, this travel could go on for years. Depending on the program, daily or near daily travel could be required for at least two years. Some area programs are daily for 90 days, after which a person could receive weekend doses, which would bring travel down to 5 days a week. That would go on for two years and if the person is successful, they may receive additional take home doses.

The time and distance involved represent an unnecessary obstacle to engagement.

The desire to expand methadone and buprenorphine in Ithaca was based on the knowledge that these are among the most effective treatments known for opioid dependence.[60] Numerous studies conducted in New York, in other parts of the US, and in other countries around the

Left: Ithaca stakeholders at Mayor Myrick's initial municipal drug strategy convening – April 2014

world have shown the inarguable benefits of methadone treatment for reducing the risk of death and disease in participants.[61] Methadone programs reduce the likelihood of overdose and new cases of HIV infection, while providing participants with the opportunity to stabilize their physical health and address their social needs such as family, housing, education, and employment.[62]

Historically, methadone programs have operated separately from the general healthcare system, because they are licensed by OASAS, the New York State Office of Alcoholism and Substance Abuse Services, as drug treatment programs.[63] Medical and mental health services have not often been incorporated, and methadone programs are often viewed as basic treatment stations for participants, without other available services and support. Now, with the care coordination mandate and the models offered by the Affordable Care Act, an integrated healthcare-methadone clinic is feasible for both licensing and funding.[64]

Finding 6: For some people, ancillary services such as mental health counseling, job training, and housing are necessary supportive services in addition to, or instead of, formal drug treatment

"We need a clearinghouse agency that a person could walk into and say 'I'm in crisis and I need help now."

– Participant in People Who Use Drugs Focus Group

When asked why people develop drug problems, participants continuously identified reasons ranging from homelessness, incarceration, familial issues, or joblessness. One commonly held belief, expressed in the focus groups and among some in the MDPC, is that people are using drugs as a coping mechanism to deal with other

Left: Ithaca Municipal Drug Policy Committee briefing on recommendations – November 2015

issues. Statements like, "people need jobs" or "people need housing" continuously came up. Some treatment facilities in Ithaca offered housing support but require abstinence, and facilities that did not offer housing were not equipped to make recommendations to shelters and other basic services.

In Ithaca, where both shelter and drug detoxification service options are limited, homeless people using drugs could also benefit from a crisis center service model. Shelter stays are often contingent upon abstinence and substance use is not allowed on-site, putting people at risk for infections or overdose when forced to consume their substances in public spaces. Many people are experiencing precarious housing or intermittent homelessness in combination with their drug use. Over and over again, participants called for some kind of crisis center.

This also pertained to mental health services. Mental health and drug treatment services in Ithaca have been historically disconnected despite the general consensus that for some people problematic drug use belies deeper issues. Unless basic needs and metal health issues are addressed, treating someone's addiction can be difficult if not impossible. Research shows that, for homeless people struggling with drug use, a "housing first" system of care can be successful in helping someone moderate their use.[65] General linkages to ancillary services can dramatically improve someone's outcomes in drug treatment.[66]

Harm Reduction

Finding 1: More comprehensive training is needed on how to provide services to people at different points on the substance use continuum.

Multiple groups noted that the general public as well as medical professionals needed more comprehensive training about drugs and drug use in order to provide compassionate care and support that combats stigma. In multiple focus groups and in the MDPC, participants expressed a strong interest to improve various systems of care and safety, which people who use drugs come into contact with. There was overwhelming interest among participants to make changes that could lead to better care outcomes.

Many community members' comments reflected the sentiment of a participant in the Business Community Focus Group, who noted:

"More education about what the issue is. There isn't a difference between the people dying of heroin and the people in this room. One of the people who died of overdose was a successful business owner."

– Participant in Business Community Focus Group

Participants expressed a strong interest in cross-training among different systems actors to provide active users the supports they need across agencies.

Finding 2: Harm Reduction is not widely understood, and few Ithacans know of the existing – and effective – local harm reduction programs already in operation.

Ithaca has only one human service provider that is based in harm reduction – the syringe exchange program at STAP – and other organizations have adopted formal and informal policies that are in line with the harm reduction philosophy. For example, Cornell University and Ithaca College both have Good Samaritan policies that are in addition to the statewide 911 Good Samaritan Law.

Yet a majority of focus group participants knew very little if anything about the local harm reduction programs, or the basic concept of harm reduction. Some expressed a belief that harm reduction enables drug use or contributes to drug selling, although the extensive research on harm reduction strategies shows otherwise.[67,68,69,70]

This lack of understanding of harm reduction presents a unique opportunity for education and dialogue. Evidence demonstrates that harm reduction practices – from seat belts to syringe exchanges – can be incredibly effective at reducing morbidity, mortality, and/or public disorder.[71,72,73,74] Harm reduction practices and services do not lead to higher rates of drug use.[75] Even within the space of the focus group, people's attitudes shifted when they were exposed to analogies to alcohol or the overconsumption of food.

"We've all practiced harm reduction, driving an automobile is deadly dangerous, we still do it with a seatbelt on. I know as an overweight guy, I shouldn't be eating as many Oreos as I do so I eat 10 rather than 20. That's harm reduction, right?"

– Participant in Business Community Focus Group

When addressing drugs and drug policy, evidence-based practices, like harm reduction, can aid Ithaca in improving outcomes related health and safety. Increasing awareness of such practices will be important to any coordinated strategy.

Finding 3: Harm Reduction services need to be expanded.

Aside from the establishment of a syringe exchange facility in Ithaca, other robust practices and services of harm reduction are still glaringly absent in the service landscape. In addition, some providers, families and people impacted by drug use are unsure of what harm reduction modalities exist. Harm reduction practices like ride shares to discourage drunk driving, providing free snacks and water at establishments serving alcohol, safer

injection kits, adulterant screening kits, naloxone opioid overdose prevention training, medication-assisted treatment and mental health counselors are just a few ways to expand harm reduction practices across Ithaca.

Some members of the harm reduction MDPC group suggested Ithaca should continue its tradition of innovation by partnering with Cayuga Medical to pilot different treatment options for people who are unable to moderate their drug use. This included exploring options like expanding available opioid maintenance therapies by piloting a heroin maintenance program, which is standard medical practice in countries like Britain and Germany[76] or reducing both public drug consumption and overdose fatalities by hosting a supervised injection facility for people who are unwilling to stop using. Both in Europe and in Canada, supervised injection facilities and heroin maintenance have been in operation for decades with great success in preventing overdose deaths, infectious disease, and bacterial infections. It has also reduced public drug use and discarded needles, and provided primary care and referrals to basic services, housing, with great success.[77] The research into these facilities also shows that the clients of these sites have increased rates of participation in drug detox services.[78]

Law Enforcement

Finding 1: Law Enforcement and community members alike do not believe that law enforcement personnel are best situated to deal with drug use.

Given the existing laws, our society is taught to respond to drug use as a crime problem. From the work of the MDPC law enforcement team and the many stakeholders who contributed t the development of this report, we found broad agreement that it is "not the job of law enforcement to solve people's drug problems." As a city, we can choose to reorient how we implement these laws and to develop an alternative pathway for police to offer services and support to people involved with drug use. In a focus group of law enforcement personnel, they expressed frustration at being responsible for drug use problems when they saw this as more appropriately handled by social service agencies. They expressed many of the same frustrations and desires of other focus group participants for law enforcement to have a different role in dealing with drug use in Ithaca.

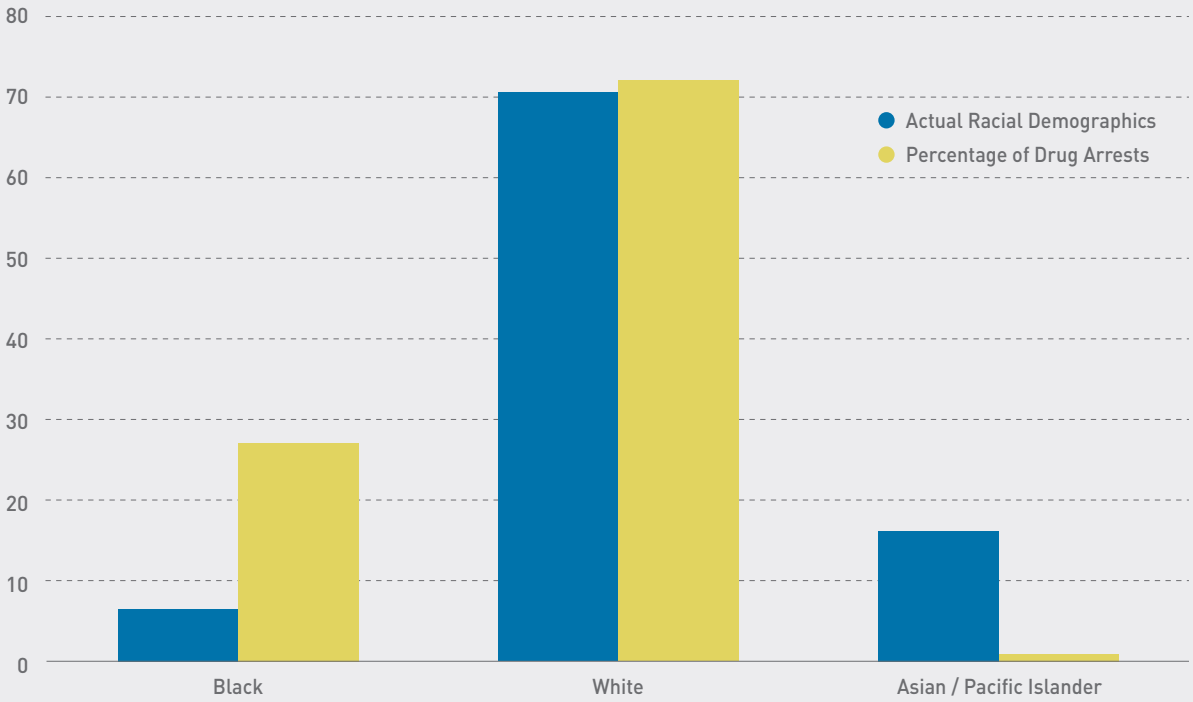
"These officers are being forced to do the work of managing community's drug problem without the proper resources, partnerships, and tools."
– Participant in Law Enforcement Focus Group

Finding 2: Perceived experiences of racial profiling, difference in treatment, and racial disparities in arrests rates have created a perception that law enforcement targets communities of color and are less willing to connect them to services than white Ithacans.

"It bothers the hell out of me that we're having a conversation about drug policies being developed for our community and our whole conversation is about drug addiction but we all know those policies are going to impact drug dealers more and differently. It's in our own conversational structure who are the people deserving of our help and who aren't."
– People of Color Focus Group

Focus group participants and MDPC members expressed concern that users in Ithaca are seen by law enforcement and the broader community as white, and sellers are largely seen as Black or Latino – and that outcomes from drug law enforcement vary, in an unfair fashion, by race. There was a geographic element to these conversations, as participants raised the upstate/downstate divide and noted the tendency for some community members or law enforcement (or both) to suggest that the "drug dealers" are from downstate. This view implies that the Black/Latino sellers are alien to the community, entering into Ithaca from downstate areas to take advantage of

Fig. 8 Percentage of Drug Law Violation Arrests by Race in Ithaca, 2014



Sources: Ithaca Police Department, US Census Bureau
Note: Ithaca Police Department does not keep track of Latino population. General Population data for 2014 is an estimate from US Census Bureau.
Drug Arrests as reported by National Incident-Based Reporting System code 35A: Drug/Narcotic Violations, defined as the unlawful cultivation, manufacture, distribution, sale, purchase, use, possession, transportation, or importation of any controlled drug or narcotic substance.

upstate markets, labeling them as interlopers instead of community members. This perceived assumption translates into a widely held belief among community members of color that law enforcement and treatment providers are more lenient and compassionate towards white community members' drug use, possession, or selling versus Black or Latino community members who use, possess, or sell.

Finding 3: Community opinion about drug courts is mixed. People like that drug courts connect those in need to resources, but most thought it would be more effective to make such resources available outside of the criminal justice system.

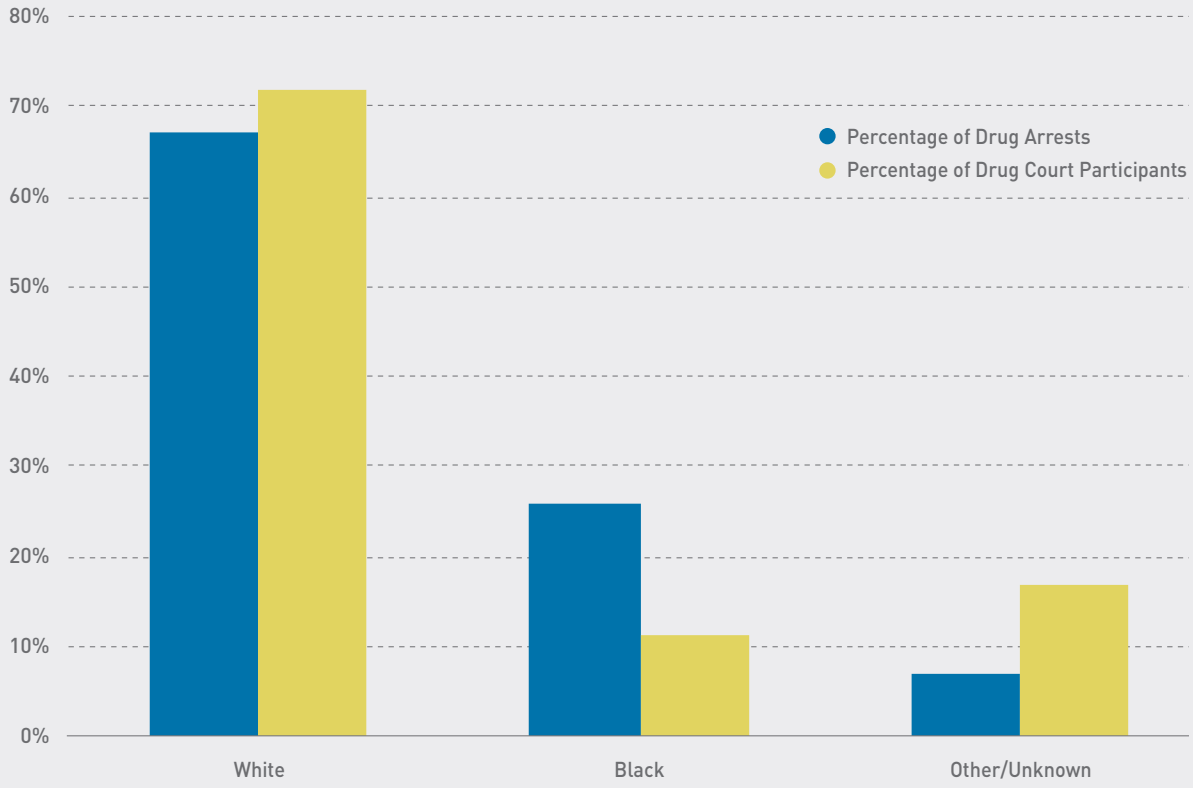
"Treatment court needs to give people chances. It's the consequence that the judge is trying to impose. I don't think jail is the answer, but it's the judge's way of showing them where they could be."
– Participant in People in Recovery in Focus Group

Reactions to the utility and effectiveness of drug courts were mixed. Many people articulated an appreciation of drug courts because they give participants an alternative to jail and a requirement of sobriety. However, criticisms of drug courts were strong and varied. Many participants noted the abstinence restrictions, the strict and narrow requirements that must be met to remain in programs, and the racial disparities in who gets presented with drug court as an option as reasons why drug courts are not a sufficient solution. These observations were confirmed by the data we collected, which shows Blacks making up only 11% of drug court participants, although they make up 26% of total drug arrests.

Some research shows that court-based programs and interventions such as drug courts and mandatory program participation can show poor outcomes and that the programs are time-intensive and scrutinizing.[79] Among people who use drugs, only some are eligible, and only some of those eligible choose to participate, in lieu of jail or prison time. Even then, because the attrition rate is high due to the stringent requirements, very few people actually complete the program.[80]

Embedding health and social service programs as components of the criminal justice system preserves the view that the issues they address are criminal problems.

Fig. 9 Race of Drug Law Violation Arrests & Race of Drug Court Participants in Ithaca, 2012



Sources: Ithaca Police Department, New York State Unified Court System
Other includes Latino population. As IPD does not track Latino population, no comparison could be made for this group.
Drug Arrests as reported by National Incident-Based Reporting System code 35A: Drug/Narcotic Violations, defined as the unlawful cultivation, manufacture, distribution, sale, purchase, use, possession, transportation, or importation of any controlled drug or narcotic substance.

For example, the threat of incarceration remains in place as an escalation tactic when a defendant struggles with continued drug use or misses program dates. This has the effect of reinforcing, rather than preventing, the criminalization of drug use. In addition, drug courts often have non-experts making therapeutic decisions best left to trained treatment providers, not court personnel. It should be acknowledged that in Ithaca and Tompkins County, treatment providers do have significant roles in the treatment court system. What we are emphasizing here is that the criminal justice system should not be the initial point of entry for drug misuse treatment services. Implementing an alternative at the front-end of the criminal justice system, before jail or prosecution, by giving service referral tools to the police and increasing access to voluntary treatment would have a greater effect on reducing incarceration, while assuring people get direct access to support and assistance to improve their health and social situation.[81]

Finding 4: People fear calling law enforcement to help with drug-related issues because of the collateral consequences it can trigger.

People repeatedly asked for another solution that did not involve the police not only because of the costs of criminalization, but also the collateral consequences associated with involving law enforcement.

"I want choices. I can't call a health person to get the user any help. The only choice we have is criminalization. We keep putting police in the place where they're dealing with things they're not equipped to deal with."

– Participant in Business Community Focus Group

The criminalization of drug use has reached far beyond the criminal justice system to establish a sprawling array of penalties related to drug use, particularly for people utilizing social support services.[82] From getting kicked out of half way houses, losing custody of children, to triggering immigration hearings, some participants described not calling for help because they feared it would cause more harm than good. These are concerns even for people who are not using drugs themselves, but may have a family member in their home that does.

"We're missing this - guys can leave their job and go to treatment. Women don't want to go to treatment because they're afraid they'll lose their children. I've seen women who don't want to come to an AA meeting because their afraid there are social workers."

– People in Recovery Focus Group

This was also a concern for people currently in mandated or outpatient treatment structures, who felt that divulging their struggles would incur consequences that would cause severe disruptions to their well-being.

Finding 5: While most community members and criminal justice system personnel recognize the good in diversion programs and treatment, more education about relapse and recovery are needed.

A significant group of participants believe many drug users manipulate treatment services and diversion programs in order to evade punishment and the larger criminal justice system. This practice of manipulation was also thought to apply to how drug users interact with medical services. There was a belief that people who use drugs play up pain in order to get prescriptions or hospital admission to avoid the street. This has had a significant impact on medical providers, who now feel pressure to police patients to avoid prescription drug abuse. Patients resent this and report being less likely to seek care or help because of stigma and fear of mistreatment.

"I have transformed from caregiver to police officer because it has become too easy to get prescriptions."

– Participant in Healthcare Focus Group

"Because you made a bad choice, you'll be carrying around a red flag for the rest of your life –to be constantly treated a certain way because of your bad choice is unfair, but it's hard to break through that."

– Participant in Healthcare Focus Group

Left: Mayor Svante Myrick speaking at the International Drug Policy Reform Conference about the Ithaca Plan – November 2015

There is a disconnect between the experiences of doctors and people who use drugs. People who use drugs expressed moments of pain, being accused of "faking it", and being turned away from needed services and medical care. Healthcare providers, on the other hand, expressed difficulty in understanding how to effectively help these patients, especially given the pressure they are facing around better control of prescription narcotics. Healthcare providers also felt ill-equipped to deal with their patients' drug use, in part, because of a lack of knowledge and, in part, because of a lack of appropriate referral services. Education for healthcare providers and law enforcement about addiction, how diversion programs work, and general mental health are desperately needed. Efforts to bridge the gap between people who use drugs and these professionals are also needed. In other jurisdictions, people who use drugs have been part of trainings for such professionals on how to most effectively meet their needs[83].

"This woman had never shot up before and she did not know how to use. I took a woman who was afraid to leave the building because she knew she would use. She showed me her arm and it was infected. They weren't compassionate at the hospital; they treated her like a junkie. They dug in her arm and she's screaming in pain and they just said she's gonna have to deal with it. If you didn't want to deal with this then you shouldn't have done it. To me it was torture. It's like no you're a junkie we can't give you pain meds. I didn't think our Ithaca medical professionals would treat someone that way. We need people in the community who aren't afraid of being compassionate."

– Participant in People in Recovery Focus Group

5. Recommendations

Governance and Leadership

Goal: Create a mayoral-level office tasked to reduce the morbidity, mortality, cost, and inequities associated with illicit drugs and our current responses to them.

1. The mayor should open an Office of Drug Policy to orient the work of all city agencies towards reducing morbidity, mortality, crime and inequities stemming from drug use and our responses to it. This new approach recognizes that criminalizing people who use drugs has not been effective and anchors Ithaca's policies in principles of harm reduction, public health, and public safety. It also recognizes that city agencies often work at cross purposes and provides a structure for coordinating their work with the simple aim of improving the health and safety of communities, families and individuals across the city.

a. The mayor should appoint a director to: run the office; advise the mayor and city agencies; implement the MDPC recommendations for how the city can improve its drug policies; coordinate the activities of various city agencies and departments; be a liaison between city, county, state and federal agencies; and act as a spokesperson for the city on drug policy matters.

The director would also chair a drug policy committee that would work with the director to implement the objectives of the Office of Drug Policy. Membership of the committee would include representatives from the public sector as well as experts and those directly impacted by the city's drug policies – to advise the director and the mayor. For example, it should include representatives from but not be limited to, representatives from the county department of health, county department of mental health, the Ithaca school district, the Ithaca police department, county department of social services, the department of human resources, the county department of probation and community justice, the speaker of the council and up to three designees of the speaker, and representatives of any other agencies that the director may designate, as well as at least eight representatives from continuum of care providers, those directly affected by drug use, those in recovery from drug use, people formerly incarcerated for drug related offenses, and experts in issues related to illicit and non-medical drug use and policies.

In addition to implementing the MDPC recommendations, the office would also be tasked to develop an annual drug policy plan and report on the status of the city's drug policies, programs, and services, and establish goals and objectives for how these can be improved to reduce morbidity, morality, crime and disparities.[84] This group would also be responsible for conducting a needs and assets assessment of the community and act on this information by recommending appropriate initiatives in an ongoing way, this would also include creating a centralized databank with all data sets associated with drug use, treatment center effectiveness, and drug related arrests.

Rationale:

Within the MDPC committee, members recognized that their fields were interconnected and that some of the limitations of their current initiatives were engineered by the structural tendency to operate in silos. While not the intent of those operating in the fields of prevention, treatment, harm reduction, and law enforcement, the disconnect often has negative impacts on the people moving through these different systems. The compartmentalization and discontinuity of the services and policies in Ithaca create a strong need for a coordinated drug strategy, especially given the rising number of heroin overdoses in Tompkins County.[85]

"I'm now in the homeless shelter. You have to break up your day to day at DSS doing paperwork to get approved for the shelter, but to get a cot you have to sit in line at 2:30. It's a full time job."

– Participant in People Who Use Drugs Focus Group

Focus group participants consistently asked for a centralized place that had the authority to call these groups together to assess what was happening in Ithaca and to address the various drug problems in town. Currently, there is no formal process to identify and reform

harmful and racially disproportionate criminal justice policies and practices. And while there are many different organizations and agencies that are working to improve the lives of people in Ithaca, they are often underfunded and working out of sync.

For example, the Community Coalition for Healthy Youth (CCHY) grew out of the Community Drug Task Force established by former Mayor Alan Cohen in the late 1990s. After successfully obtaining federal funds over several years, the CCHY is currently in a period of transition since the end of its most recent grant. While their contributions to the county cannot be overstated, the current mandate by Mayor Myrick calls for an enhanced approach that requires the scope of their work to include not only youth, but also adults and families.

New initiatives must also do more to involve community members and key stakeholders as research consistently illustrates that coalition-like structures are effective in harnessing the community's power to create change.[86] A well-functioning structure that engages residents, law enforcement, schools, nonprofit organizations, the faith community, youth and other key groups working in tandem to address community concerns, would ensure that the Office of Drug Policy is well positioned to sustain action on pervasive community problems that have eluded simple solutions. In turn, community collaboration would enable residents to contribute to making a difference and creating the political will necessary to influence the development and implementation of lasting policy.[87]

"People who make decisions about people who look like me and have problems like me, don't look like people in this room. It's important for us to be a voice in what we need in this community. "Who knows better what we need than we?"
– Participant in People of Color Focus Group

Address and Reduce Racial Disparities

Amid the growing national conversation around racial disparities and institutional racism, the Ithaca Office of Drug Policy can lead by example by thoroughly assessing the degree to which racial disparities are present in other discrete, but drug policy-related, systems in New York (criminal justice, child welfare, housing, economic development, etc.), and develop strategies to reduce them.

Absent a budget allocation to conduct such an assessment, the director should seek to partner with local academic institutions, which may have the resources available to assist this activity.

Left: Mayor Svante Myrick, MDPC co-chairs Lillian Fan and Gwen Wilkinson, and Drug Policy Alliance Kristen Maye and Kassandra Frederique

Education

Goal: Key stakeholders and all Ithacans should have access to evidence-based practices and education around drugs, preventing problematic use, reducing harms associated with drug use, and helping oneself or others who have a drug use problem.

1. The Office of Drug Policy would coordinate with existing Ithaca organizations that provide services to the community (like Southern Tier AIDS Program) to host a series of community education events every year around drugs, policies associated with drugs, and general health within the community. The Office would also coordinate training modules for service providers to ensure they are informed with the most up to date treatment options, strategies, and resources. Where possible, these training programs should include people who are directly impacted by drugs or drug policies, be evidence-based, and be grounded in a harm reduction approach.

Office of Drug Policy public education responsibilities include, but are not limited to:

a. General community awareness events (around drugs/drug policies).
b. Education events for parents and loved ones of those struggling with addiction (topics could include: recovery is not linear, medication-assisted treatment, syringe exchanges, relapse is a part of recovery, Ithaca resources).
c. Narcan and overdose response trainings for the public.
d. Education for law enforcement, healthcare providers, service providers and users on harm reduction models. Examples include a train-the-trainer curriculum based on the Enough Abuse structure that can be run by STAP.
e. Cultural competency and sensitivity trainings for treatment and medical professionals working with people in treatment and medical settings.
f. Training healthcare providers around opioid prescribing and patient education, such as a standard concise information sheet distributed by all providers when opioids are prescribed that would also include treatment resources and information for the Ithaca addiction hotline.

Rationale:
Prioritizing cultural competency in treatment and healthcare must mean equipping providers to treat disease by recognizing the structurally specific patterns of illness among Black, brown and low-income populations. Research establishes that systemic factors like racism and poverty result in Black, Latino and low-income populations suffering disproportionate rates of preventable disease and morbidity.[88] Healthcare and treatment services for people of color are consistently poorer in quality even when controlling for impediments like cost and access.[89] Incorporating practices of intentional, direct communication to assess patient needs, establish accurate diagnoses, develop effective treatment plans and evaluate results can work to mitigate these disparities in care.[90]

"There are a lot of people who are in the treatment providing profession... They've gotten it out of the textbook and you can't share my experience if you don't know what it's like to be in my shoes."
– Participant in People in Recovery Focus Group

"As a person in recovery going through many different treatment programs – I stayed in one for 28 months, 9 months, and 3 months. Didn't get clean till I was 43 What worked for me was not those treatment programs except for one because there was an African woman who helped me see things that took me a while to see. This program had an afro-centric theme. Group just for African American people and I was honest about living in a society and feeling less than white people. And she stopped me right there and told me I should never feel less than."
– Participant in People of Color Focus Group

With research connecting increasing rates of heroin use to the rise in prescription opioid dependence, there is an immediate need for education and awareness around addiction and harm reductions services as well as dosing, misuse, and adverse reactions to prescription drugs for patients and providers.[91] Research has consistently shown that medical providers receive minimal education about addiction as part of their formal training and that they remain uncomfortable with people who use drugs and with discussing drug use more generally.[92] More comprehensive training and education must be made available to prescribers in order to curb the rise of problematic prescription opiate and heroin use, increase the likelihood that patients will be made aware of potential risks, and help patients connect to available services if needed. These efforts provide opportunities to not only ensure that providers are adequately equipped to prevent and address harmful prescription drug use but harmful use of all drugs.

Recovery-Oriented Treatment, Harm Reduction, and Ancillary Services

Goal: Create a recovery-oriented treatment continuum that offers access to timely, individualized, and evidence-based, effective care, through services that are people-centered and able to meet the needs of individuals no matter their current relationship to drug use or recovery.

1. Add an on demand centralized treatment resource system to the existing Ithaca 211 directory:
   a. Conduct short screenings over the phone to assess appropriate service referral.
   b. Provide referrals for treatment centers in Ithaca with up-to-date inpatient bed numbers.
   c. Create a parent/loved one hotline (based on the Partnership for Drug Free.org)
   d. Connect people to a treatment navigator (based on the Affordable Care Act navigator) to help persons or families in trouble navigate the treatment and referral process, including after care assistance.

2. Open a freestanding 24-hour crisis center in Ithaca – medication-assisted and supervised outpatient detox, with case management services available on-site.

Activities:
   a. Law Enforcement and laypersons can voluntarily bring an intoxicated individual for safety and respite.
   b. This center will include short-term temporary beds for persons waiting for enrollment in treatment centers.
   c. The center will also include a "chill out" space for people who are under the influence to help assuage the proliferation of public intoxication. This is not the same service as detox; the purpose of this space is not primarily to help someone withdraw but to even out, provide them with health education, and potentially connect them to harm reduction services.
   d. The crisis center would also be appropriate for parents or loved ones to send their loved one in distress voluntarily, instead of a PINS or person in need of supervision process which involves putting the person through the court system and often leads to intense strain on familial relationships, usually during crucial intervention windows. Services would include support groups (abstinence based and non-abstinence), on- site counseling, case management, and family support services.

3. The Tompkins County Department of Health should be encouraged to continue implementing an aggressive public education campaign about harm reduction practices to reduce risks from underage drinking, tobacco use, and other illicit substances.

4. Increasing awareness around the New York State 911 Good Samaritan laws can also help make adults and young people aware of the resources and the legal protections afforded victims and people who call for help.

5. The city should partner with the Tompkins County Health Department and local medical providers to offer low cost or free Hepatitis A & B vaccinations and Hepatitis C treatment to people who actively inject drugs.

6. Implement a Housing First, basic, non-contingent needs model for Ithaca to increase access to housing, nutrition and healthcare services without requiring abstinence or participation in treatment.

Activities:

a. Maintaining the safety of themselves and those around them should be the criteria to receive services, which should not be dictated by whether or not a person is using a substance.
b. This model should include but not be limited to sober living facilities, low threshold housing, and housing options for people with families.

7. The city should work with relevant agencies to integrate mental healthcare options into substance use services, with an emphasis on providing more robust service options for people with dual diagnoses.

8. Increase the availability of medication-assisted treatment in Ithaca, including opening a methadone clinic and increasing the number of office-based buprenorphine (i.e., Suboxone) prescribers.

9. Continue and expand proven harm reduction programs, including but not limited to syringe exchange services, opioid overdose education/trainings, syringe disposal kiosks, and naloxone distribution.

10. Explore the operation of a supervised injection site staffed with medical personnel as a means to: prevent fatal and non-fatal overdose, infectious disease, and bacterial infections; reduce public drug use and discarded needles; and provide primary care and referrals to basic services, housing, and substance use services and treatment, including the integration a basic healthcare provider at harm reduction sites.[93] [94]

11. The city of Ithaca should request the New York Academy of Medicine or another objective research institute to study the efficacy and feasibility of heroin maintenance therapy for people who do not respond effectively to other forms of opioid replacement therapies.[95]

Rationale:

Ithaca needs an expansion of existing harm reduction services and integration of harm reduction practices in the treatment sectors. This also includes providing treatment options that are not abstinence-based. Because OASAS does not fund those treatment modalities,[96] Ithaca should identify and obtain sources of funding to address the issue. Participants also recognized that drug use for some people may be a result of different circumstances such as mental illness, joblessness, or homelessness and the treatment options for these people are deficient, as the limited supportive services are usually contingent on sobriety. Participants belabored the point that, even if someone were ready to be abstinent and seek intensive inpatient care, the current service system requires them to fail out of outpatient services before they can access inpatient services. Everyone agreed that this practice defeats the purpose of connecting someone to services.

"The only programs here are drug free – they give you no chances."

– Participant in People Who Use Focus Group

"That's what I envision when I talk about a crisis center. It would be part shelter but would walk in and say this is where I am right now. They should help meet you where you are. Most people addicted to heroin are going to be on Medicaid. In order to get into in-patient, you have to fail out of outpatient. That means that person has to go through that 3-week process of meeting at drug and alcohol counseling once a week. Preferably not dying. Maybe every other week they get drug screens. That drug screen takes 2-3 weeks to process before the counselor can even tell if they've been clean. They need to have 3 or four dirty drugs screens before they can qualify to get into inpatient, which is where they needed to be initially, which can take 3-4 months. And if they drop out, that doesn't count as failing. That's why they have people dying in Ithaca."

– Participant in Business Community Focus Group

Left: MDPC Treatment Pillar team Blue Sky exercise – September 2015

Focus group participants called for the treatment service sector to provide on demand services and support, whether it be through the referral process, treatment, or after care services. Some participants described feeling isolated and in need of a centralized place for them to navigate the treatment systems. Creating a centralized point of entry into the care system can help alleviate some feelings of isolation. One benefit of a hotline, aside from immediately assisting people, is that it can help assuage some of the stigma and shame that people face when reaching out for help. There was also a clear cry for ancillary services and better coordination as the road to non-problematic use has many stops and starts. And while people called for centralized efforts like a hotline and a crisis center, they also need multiple points of access across the systems of care and access so that they can be served regardless of their stage in use or recovery.

"We need a clearinghouse agency that a person could walk into and say 'I'm in crisis and I need help now.'"

– Participant in People Who Use Drugs Focus Group

Current developments in healthcare demonstrate the potential for growing an expansive, integrated system of care. For example, the Delivery System Reform Incentive Payment (DSRIP) model calls for the incorporation of a wide variety of stakeholders involved in health and human service delivery to members of a prescribed community, such as a geographic area. Although the model is focused on healthcare access and coordination, it is based in the recognition that many social issues impact health.[97] For example, inadequate housing can impede healthy eating, sleeping, and good hygiene, all basic needs, which impact health outcomes. Unresolved legal problems create stress, which negatively impacts health. The concept presented by the DSRIP model acknowledges these associations with individual and community health, and brings service providers into direct relationship with healthcare providers, to ensure the breadth of needs are met, to improve health. This approach illustrates a model for practical service integration for a shared goal of health among all participating providers, and suggests a developing movement for integrated systems.

Heroin maintenance and supervised injection facilities, while new to the US, have been used in dozens of jurisdictions in Canada and Europe and would meet the demand by not requiring participants to stop drug use as a means of success.[98] Research has made clear that such interventions can lower public intoxication, stabilize users' lives, and link a hard-to-reach population to services.[99]

Community and Economic Development

Goal: Support and expand existing efforts to improve youth and family development, economic opportunity, and public health of communities, targeting vulnerable communities as immediate beneficiaries and ensuring that all Ithacans have the same access to resources and investments.

1. Partner with alternative to incarceration programs that connect low level users and sellers to jobs programs (see LEAD recommendation); integrate a jobs training program as an ancillary service in treatment centers; and create an apprenticeship program in conjunction with the Downtown Ithaca Alliance and Tompkins County Chamber of Commerce and community outreach worker to encourage youth employment.

2. Pass Ban the Box legislation for private and public sector jobs and encourage Tompkins County to do the same in order to expand job opportunities for people returning from incarceration.

3. Develop a citywide training/education program on basic work skills that would be offered before the start of any potential job training course.

4. Lobby Tompkins County to create a dedicated case management program for the re-entry population.

5. Seek to reform zero tolerance programs in the school district to incorporate restorative justice systems in order to curb the rise of suspensions, expulsions, and dropout rates all of which contribute to a young person's general community disengagement and raise the likelihood of unhealthy risk behaviors.

6. Integrate comprehensive services to reduce the risks associated with drug use or alcohol poisoning at local establishments frequented by residential college students such as safe settings where patrons can sit and rest away from loud, crowded spaces; setting up syringe disposal containers in restrooms; and providing free and accessible water during school year weekends.

7. Establish a process through the Ithaca Office of Drug Policy to monitor, investigate, and address racial, gender, age, and geographic disparities in health and socioeconomic outcomes across administrative and criminal justice systems. These efforts should include surveillance, research, and analysis of the different data systems (including desk appearance tickets, Unlawful Possession of Marijuana violation, treatment admissions/graduations, drug court enrollment, etc.). ODP should issue a findings report and make recommendations to reduce unwarranted disparities.

Rationale:
Economic development and community development build healthier and safer communities.[100] In Ithaca, there are great strides being made in community development through the Downtown Commons project, coffee hour talks with the mayor and the IPD chief, and processes like the Municipal Drug Policy Committee.[101] Ithaca is working to engage its citizens in building a community in which they can live and thrive. Yet the message we heard repeatedly was the hopelessness of a small town without job opportunities, particularly for low-income communities. Research shows that areas with the highest rates of poverty are also those with the highest rates of diabetes, HIV/AIDS, other chronic diseases, and harm from drug use.[102] Building on the current initiatives to revitalize the downtown area and raise community morale alone will not help leverage resources to decrease drug use and the drug trade. We are encouraging the city to invest in an expansive jobs development initiative to help revitalize and develop low-income communities in Ithaca.

"I'm going through hell with my 14 year old, when I go to the community to help my very brilliant, very angry son. Only options were to put my son in the system and criminalized him. If I'm concerned about my kid, it's about what he's getting into. It's about the lack of opportunity. People deal drugs b/c it's economically motivated; people take drugs because it's about despair; if I didn't have my kids, I might tell you that life has kicked my ass and I might be a raging alcoholic. I'm here because it's personal."

– Participant in People of Color Focus Group

"You can't give your kids unrealistic hopes. It's not about their lack of potential or their lack of intelligence. It's about the reality that the opportunities are not there. You can't fake that for them. They see right through that. The hopelessness that impacts our young people. We live in a community with incredible educational opportunities and yet our kids stay uneducated."

– Participant in People of Color Focus Group

Recognizing the expansive and deleterious effects of mass incarceration, if the city wants to turn a new corner on drug policy, it must invest in its returning citizens by creating linkages to services, housing, treatment, and job training programs that lead directly to job placements. Efforts like President Obama's My Brother's Keeper are necessary as more attention needs to be paid to underserved communities by increasing their access to resources, especially when current strategies do not effectively benefit or target low-income communities, disadvantaged workers including young people, veterans, individuals with disabilities, and individuals with criminal records.[103]

"A young Black man that I've known forever came home from a relatively short stay in prison and got a job at Wegmans doing carts. I ran into him and he was feeling good about himself. A police officer who had known him before [he went to prison] went and told the people [at Wegmans] and – they hired him knowing he had a record, he had to get permission from his parole to work there – but the police officer went and told one of his friends in security – a number of the security officers at Wegmans are off-duty police officers – and they fired him. Despite the fact that he had been doing a fine job, he hadn't even been there that long. Doing a fine job, feeling good about himself and they got rid of him. It's one particular story, but I hear that story all the time. That's one way it (stigma) manifests itself."

– Participant in People of Color Focus Group

Vibrant local economies where large groups of underserved community members are employed can help to remediate some of the effects of mass incarceration.[104,105,106,107] Strong emphasis on youth employment, like an apprenticeship program, can improve academic achievement and lessen the likelihood of boredom, disengagement, and lack of civic engagement, all of which are factors contributing to drug use or illicit involvement in the drug trade.[108,109,110,111] People need and want opportunities to contribute to the development of their community as opposed to being outsiders looking in.

"We need to do a better job of giving people purpose."

– Participant in Healthcare Community Focus Group

"I come from the hood and I relate myself because of my experience. There are people out there because the only way to support their family is by selling drugs. I don't support it but if we had better jobs, with better pay I think we wouldn't have this problem with abuse and drug selling."

– Participant in Parents Focus Group

It is also crucially important to recognize the distinct set of circumstances that Ithaca is operating under being largely described as a "college town." Tompkins County is home to three colleges - Cornell University, Ithaca College and Tompkins Cortland Community College. The university presence brings a robust blend of young people to the area whose health and safety are bound up with that of the Ithaca community during their time as residents. Among many traditional university-aged students, the use of alcohol and other drugs is seen as normal, almost a rite of passage, even though that use is almost always illicit. Honest and responsible drug policies should not only aim to prevent drug use among youth, but also acknowledge that illicit use of alcohol and other drugs by college-aged students will not disappear with mandates and penalties that say it should. With such a robust university presence in a relatively small town, business owners whose establishments largely cater to college students should adopt pragmatic approaches to managing drug and alcohol use in and around their businesses, which can save lives.[112]

Public Safety

Goal: Redirect law enforcement and community resources from criminalization to increasing access to services. Encourage a shared responsibility for community health and safety that extends beyond the Ithaca Police Department.

1. Pilot a Law Enforcement Assisted Diversion program, modeled on the successful Seattle LEAD program (see alternatives to incarceration program).

2. Train Ithaca Police Department on the syringe exchange program annually. The trainings, conducted by the Southern Tier AIDS Program, should include how to make sure officers are safe when interacting with people who inject drugs and collaboratively identifying public spaces to place syringe and medication disposal kiosks.

Rationale:

Law enforcement officials, parents, and young people agreed that drug use is a health problem and legal intervention does little to deter the usage of drugs. Under our current system, law enforcement officials frequently act as the first point of contact for services. Services should not have to be accessed through the criminal justice system, and police encounters, as well-intentioned as they may be, often lead to criminalization and other punitive responses. Research shows that the harms associated with criminalization can outweigh the harms associated with drug use.[113] These types of encounters deepen mistrust between police and community members. All participants in this process recognize that the reliance on criminalization is impeding the kind of new direction that the MDPC wants to take. Ithaca does not have the authority to change state and federal laws governing drugs. For example, while respected civil rights and public health organizations call for decriminalization of all drugs nationwide, that falls outside the authority of the municipal government.[114,115,116,117,118,119,120] Ithaca, however, is able to shape the policies and practices of its police department, evidenced by the Mayor's directive to make marijuana arrests a low priority. Piloting a pre-arrest or pre-booking diversion program like the Law Enforcement Assisted Diversion program in Seattle, WA, Santa Fe, NM, and more recently announced in Albany, NY, can help community members re-imagine what is possible when criminalization is taken off the table.

"I believe strongly that the criminalization of what's a psychological, physical and spiritual sickness is not working at all."

– Participant in People in Recovery Focus Group

Creating multiple points of entry for services outside of the criminal system – including outside of drug courts – would also help lessen the stigma for people who use, encouraging them to seek help without fear of criminalization in the form of arrest, court sanctions, and incarceration.[121] Because of law enforcement's changing role in the conversation around health and safety, it is important that IPD be integrated in the network of service provision in the city. That includes getting more information on how to interact with people who use and people who are in recovery and having a deeper understanding of the guiding principles of harm reduction.

Law enforcement officials respecting and supporting harm reduction measures like the syringe exchange program and public kiosks for syringes and medication, will demonstrate that police officers believe in health-based initiatives that increase public safety. Trainings and familiarity with community services will enable police to make referrals, and the use of community crisis intervention teams or community response teams made up of civilians and service providers have been shown to facilitate access to appropriate services, decrease arrests and recidivism, and improve community relationships.[122] It's time for Ithaca to recognize that the burden of responding to drug use should not fall solely on the shoulders of IPD.

Conclusion

This report has illustrated that our city's drug policies have grown more harmful than the actual drug use it is charged with curbing. We are experiencing a desperate need for services among many of our most vulnerable community members and exposing others to the lure of a growing heroin market, all the while responding with a failed approach. We can no longer tackle the growing problems associated with drug use, employing a policy approach based in fear, criminalization, and punishment. Community members and those most impacted by these increasingly defunct policies have powerfully enumerated how unresponsive policies have been to their needs. As a result, unlikely allies have been made of drug users, the medical community, treatment professionals, law enforcement officials, and countless others who have joined together to insist that a new way forward is not only possible but necessary and fast approaching. We are ready to ground our city's new drug policies in science, reason, compassion, and public health.

We've always known that Ithaca's greatest resource is its people. We've already proven that we have the ability to convene the minds in this town to create amazing opportunities for the benefit of everyone. Our 13-year old syringe exchange program is a testament to what we're able to do when we identify a need in our community and commit to filling it. The vision of progressive Ithacans 15 years ago to convene a similar process of re-imagining our drug policies laid the groundwork for the transformation of our city's policies today. We're continuing the tradition of living up to our greatest potential.

Rather than punish individuals and their families for drug use, we can expand services to tackle drug problems at the community level and adequately fund the range of health and social approaches to improve the health and wellbeing of individuals. We can create an environment of effective responses where drug use doesn't have to compromise the public health and safety of Ithacans, and impact the quality of life for everybody. It is time for Ithaca to take a new approach to drug policy.

Appendices

APPENDIX A: Drug Policy Innovation in Ithaca

During the 1980s, the HIV/AIDS epidemic settled in to New York City, and by 1990, NYC had earned the horrific label as the global epicenter of AIDS. People injecting heroin and other drugs were particularly susceptible to the blood-borne disease. Syringe-sharing was common, because syringes were a scarce commodity; prescription laws had been in place in New York since the early twentieth century. While four hours away from New York City, HIV/AIDS and the growing heroin epidemic were very much a part of the Ithaca, NY narrative. In the early 1990s, Ithaca recognized that it had not avoided the national problems. Over the last twenty years Ithaca has made strides to address the issue head on.

1991

A 1991 study completed by William Benjamin concluded that 72% of inmates housed at the Tompkins County Jail were alcohol and/or drug addicted. Tompkins County and Ithaca specifically were overwhelmed by the same problems that made New York City infamous Transcripts at the Cornell University library hold a rich history of local Ithaca activism to address the health problems associated with HIV/AIDs and drug use as a health problem instead of a criminal problem, including minutes from local meetings from Ithaca's ACT UP (AIDS Coalition to Unleash Power) chapter. Ithaca, smaller in size than New York City, believed then as it does now, that they could do something different and direct funds to resources that would help people.

1998

Following the lead of central New York town, Rochester, in January of 1998, Ithaca City Court opened a specialized program for defendants with charges arising from substance use, the Ithaca Drug Treatment Court. The mission of the Ithaca Drug Court was to establish coordinated mechanisms for identifying defendants at the earliest stages of the judicial process whose crimes were either directly or indirectly related to alcohol and drug addiction; insured that these defendants received appropriate drug treatment; and provided education, vocational training, and employment to those who entered and successfully completed the rehabilitation process associated with the Ithaca Drug Treatment Court.

1999

In 1999, Ithaca Mayor Alan Cohen assembled the Ithaca Drug Taskforce to address the rising prevalence of drugs in the Ithaca community. Taskforce recommendations resulted in the creation of the Community Coalition for Healthy Youth, an increase in drug education in schools, and increasing resources to law enforcement.

2002

In 2002, Southern Tier AIDS Program (STAP) began operating a fixed-site syringe exchange in Ithaca, located in Tompkins County. This exchange was the first to serve rural populations in New York and a second fixed-site opened in 2008 in Johnson City, which also serves rural communities. The initial proposal for the Ithaca site estimated service delivery to 60 individuals; by the end of 2014, STAP had enrolled over 4,200 participants between the two fixed sites, the Peer Delivered Syringe Exchange Program (PDSE), which utilizes volunteers that offer safer injection supplies to their social networks, and a mobile van unit that enables staff to reach those that are unable to access services due to transportation barriers.

2005

In 2005, Gwen Wilkinson won the Tompkins County District Attorney race on a "no more drug war" platform. In her interview with the Cornell Daily Sun, D.A. Wilkinson said her first order of business was to "get the D.A. back as an active member of the drug treatment program."

2011

In 2011, New York State passed a Good Samaritan law, which provides medical amnesty to persons involved in a medical emergency related to illicit substances and/or alcohol. The law was passed to help prevent overdose deaths by encouraging New Yorkers to call for help in the case of an emergency.

2012

In 2012, nodding to the changing public opinions around marijuana and recognizing the devastating collateral consequences associated with a marijuana arrests, Mayor Myrick instructed IPD to make marijuana possession the lowest level enforcement priority.

In August of 2012 Mayor Myrick proclaimed August 26, 2012 as "Harm Reduction Awareness Day" in the City of Ithaca.[123]

2014

In summer 2014, Ithaca Fire Department begins to carry the overdose reversal drug naloxone (Narcan) and saves a life on August 31st. A month later, Ithaca Police Department equips its officers with the lifesaving antidote to help the rising number of overdose victims in the city.

The growing rapidity of change in the city and the state's drug policy landscape represents the beginning of a transformational shift for New York, away from a criminal justice framework and towards a public health approach. In Ithaca, we can build on these successes by carrying change forward together in our city. The opportunity to improve the health and well-being of our residents and communities has never been greater.

APPENDIX B: Toward a Public Health and Safety Approach to Drug Policy

The gathering of ideas, opinions, and expertise for this report generated a common understanding of drug use – that drug use should be addressed as a health behavior, not a criminal behavior. This approach infuses our recommendations and stands in sharp contrast to traditionally moralistic assumptions about drug use based in a binary view: that no drug use is acceptable and that, where there is drug use, it must be treated as a crime. From this perspective, it is clear to see how we have arrived at the current punitive framework for US drug policy, visible in our uncoordinated law enforcement, healthcare, and human service systems and responses in place today.

Over the past forty years, harm reduction practices and concepts have occupied the space ignored by this framework – namely, to acknowledge and respond to the simple fact that there will always be some drug use in society. Harm reduction acknowledges that drug use does not simply disappear because policy dictates it should. Harm reduction recognizes that drug use happens for innumerable reasons, and that it is a behavior with physical, psychological, and social consequences, sometimes negative. If we are to be reasoned, honest and compassionate in approaching solutions to failed drug policies in Ithaca, exploring harm reduction as a lens through which we view drug intervention practices may realistically improve health and safety outcomes. While the MDPC and the Mayor are committed to being guided by a harm reduction approach as they reformulate Ithaca's drug policies, we learned that many in Ithaca are unfamiliar with the concept, so below we sketch out some of its basic tenets.

Understanding harm reduction

Drug use is a common human behavior. People use drugs for innumerable reasons - to escape a feeling, to find a feeling, to relax or get energized, etc. – as diverse as our humanity. Drug use reflects our instinctive drive to escape pain and to seek pleasure, not unlike a desire for rich or sweet food, physical intimacy, or the adrenaline rush of a rollercoaster ride. The use of drugs causes psychoactive changes in the brain, which can alter our perception and sensory experience. But drug use, in and of itself, is not a pathological behavior.

Some psychoactive drugs are legal – for example, alcohol, tobacco, caffeine, and sugar – and most drugs which have been categorized as illegal for personal use can be used safely. In fact, many drugs are frequently used for medical purposes, and researchers continue to investigate the medical value of many others. Moreover, many drugs deemed illegal for personal use in the United States and other countries carry traditional and sacred meaning in local indigenous cultures around the world (e.g. coca). Throughout history, the use of drugs has been incorporated into practices, rituals, and celebrations in ways that respect the strength of the drug and optimize the benefits of its use.

To mitigate the negative consequences of psychoactive drug use today, harm reduction introduces a health-based response. This approach acknowledges a continuum of drug use, from infrequent or episodic experimentation and recreational use, to routine use, to use that sometimes becomes frequent, escalating, and/or heavy. Harm reduction recognizes the variety of ways in which drug use happens and how it is shaped by both the individual's decision to use and the context in which that use occurs.

The theory of "drug, set, and setting" provides a framework for the harm reduction approach: what is the physical effect of the drug use, what is the mindset that drives the person to use, and what is the environment and ways in which it occurs.[124] This framework helps us shift our concern to how we can prevent or reduce all of the potential harms related to drug use.

The health harms related to drug use are not insignificant – acute and chronic illness and injury, transmission of blood-borne diseases such as HIV and Hepatitis C, overdose and death. However, much of the harm caused by illicit drug use – the use of drugs which are prohibited by law – is also related to the criminalization of the drug and the environment created by these policies in our country, rather than the effects of its use. The abstinence-based perspective shaping current drug policy is informed by this punitive, zero tolerance approach of the war on drugs. People who use drugs are punished, controlled, or excluded, simply for reason of their use. Laws and policies create and reinforce social stigma against people who use drugs, and shape the environment for illicit drug use, multiplying the harms by driving it into secrecy, shame, and an unregulated and risky market. A health-based approach to drug use could prevent and reduce these harms considerably.

The actual physical harms of drug use are related to the dose consumed, how often it is used, the way it is used, whether it is used in combination with other substances, and the chemistry of the drug itself. Understanding the risks involved with each of these factors helps to adjust for potential harm, just as we do in medicine.

The class of drugs called opioids, such as heroin, morphine, or oxycodone, can cause overdose when consumed at high doses, in combination with other drugs, including alcohol, or by a person with low or no tolerance to the drug. Using an opioid more often will increase tolerance and habituate a person to the drug, creating physical dependence and symptoms of withdrawal without it. Injecting a drug can maximize its effect, but requires sterile and careful injecting practices to prevent viral and bacterial infections. The sense of euphoria created by opioid use could temporarily interfere with intense physical activity or mental concentration. Each of these factors represent important potential harms, and managing them will reduce the potential physical harms of opioid use.

Of particular importance in shaping the experience of drug use is the mindset of an individual's drug use, and whether and how it reflects an effort to self-medicate. Many people find temporary relief in drug use. For some people, this is relief from unresolved physical pain, mental health problems, structural experiences of racism or the psychological effects of past trauma. In effect, drug use is a self-managed therapeutic intervention for some people, helping them to treat or mask feelings or sensations which they experience as problems in their lives.

Drug problems

Drug use occurs along a continuum, and many people who use drugs do so only periodically or in small, controlled doses. Among all people who use drugs, approximately 10% will develop, at some point, what is known as "drug addiction."[125] This situation is best understood through the harms of the drug and mind-set involved for that specific person. What qualifies as harmful drug use for one person may not be harmful for another. Ultimately, the loss of control, or the desire to use drugs before or in place of anything else in one's life, is a certain marker of a problem, and could be labeled "addiction."

This problem is not intractable. Often, people age out of "drug addiction," simply deciding to change their behavior. Many people are able to resolve a problem of "drug addiction" on their own, to achieve a state they may view as "recovery"[126] For those who continue to use and who experience health or social risks related to their use, it is the responsibility of public systems and services to provide services and care to reduce the likelihood of problems.

While it is our responsibility to make sure resources are available to people when they are prepared to change their drug use behavior, it is also our responsibility to ensure their health and human rights while they are using drugs.

Stigma

Stigma is the principal driver for the harms involved in the settings and environments of drug use. US drug laws and policies have criminalized drug use, forcing it into secrecy and labeling it a shameful behavior. For people with fewer material resources or less available social support, stigma drives their drug use into dangerous, often-public spaces. This experience presents a threat to their physical health because spaces are often unsanitary for drug use and a risk to their social health because of the potential for violence and the vulnerability to arrest in an unregulated public setting. Moreover, stigma reinforces discrimination and may even further the want to use drugs by decreasing a person's sense of self-worth as a result of being marginalized and treated as a lesser member of the community.

Even for people with ample material wealth, such as celebrities, the stigma of drug use can cause them to hide their behavior; we learn about this problem only after they have died from an overdose, because they were using alone, in secrecy and shame. Reducing the potential for harms created by the settings of drug use requires that we acknowledge its occurrence. Once we formally recognize the fact of continued drug use in our communities, we can address it with the health interventions that will reduce the potential for physical and social harm.

A harm reduction approach incorporates treatment, prevention, and law enforcement, with an overarching commitment to the health and human rights of all people affected by drug use. The strategy and recommendations presented in this report flow from this perspective and reflect its strength as an approach for valuing the lives and livelihoods of all members of the Ithaca community. We look forward to partnering with you all to bring this vision to fruition.

APPENDIX C: Property Crime Arrests, List of Reported Offenses and Definitions

Arson - 200

Definition: To unlawfully and intentionally damage, or attempt to damage, any real or personal property by fire or incendiary device.

Burglary/Breaking and Entering - 220

Definition: The unlawful entry into a building or other structure with the intent to commit a felony or a theft.

Counterfeiting/Forgery - 250

Definition: The altering, copying, or imitation of something, without authority or right, with the intent to deceive or defraud by passing the copy or thing altered or imitated as that which is original or genuine; or the selling, buying, or possession of an altered, copied, or imitated thing with the intent to deceive or defraud.

Destruction/Damage/Vandalism of Property - 290
Definition: To willfully or maliciously destroy, damage, deface, or otherwise injure real or personal property without the consent of the owner or the person having custody or control of it.

Embezzlement - 270
Definition: The unlawful misappropriation by an offender to his/her own use or purpose of money, property, or some other thing of value entrusted to his/her care, custody, or control.

Extortion/Blackmail - 210
Definition: To unlawfully obtain money, property, or any other thing of value, either tangible or intangible, through the use or threat of force, misuse of authority, threat of criminal prosecution, threat of destruction of reputation or social standing, or through other coercive means.

Fraud Offenses - 26
Definition: The intentional perversion of the truth for the purpose of inducing another person or other entity in reliance upon it to part with something of value or to surrender a legal right.

A. False Pretense/Swindle/Confidence Game - 26A
   Definition: The intentional misrepresentation of existing fact or condition, or the use of some other deceptive scheme or device, to obtain money, goods, or other things of value.
C. Impersonation - 26C
   Definition: Falsely representing one's identity or position, and acting in the character or position thus unlawfully assumed, to deceive others and thereby gain a profit or advantage, enjoy some right or privilege, or subject another person or entity to an expense, charge, or liability which would not have otherwise been incurred.

Larceny/Theft Offenses - 23
Definition: The unlawful taking, carrying, leading, or riding away of property from the possession, or constructive possession of another person.

A. Pocket-picking - 23A
   Definition: The theft of articles from another person's physical possession by stealth where the victim usually does not become immediately aware of the theft.
B. Purse-snatching - 23B
   Definition: The grabbing or snatching of a purse, handbag, etc., from the physical possession of another person.
C. Shoplifting - 23C
   Definition: The theft by someone, other than an employee of the victim, of goods or merchandise exposed for sale.
D. Theft From Building - 23D
   Definition: A theft within a building that is either open to the general public or where the offender has legal access.
F. Theft From Motor Vehicle - 23F
   Definition: The theft of articles from a motor vehicle, whether locked or unlocked.
G. Theft From Motor Vehicle Parts/Accessories - 23G
   Definition: The theft of any part or accessory affixed to the interior or exterior of a motor vehicle in a manner which would make the item an attachment of the vehicle or necessary for its operation.
H. All Other Larceny - 23H
   Definition: All thefts which do not fit any of the definitions of the specific subcategories of Larceny/Theft listed above.

Motor Vehicle Theft - 240
Definition: The theft of a motor vehicle.

Stolen Property Offenses - 280
Definition: Receiving, buying, selling, possessing, concealing, or transporting any property with the knowledge that it has been unlawfully taken, as by burglary, embezzlement, fraud, larceny, robbery, etc.

Robbery - 120
Definition: The taking, or attempting to take, anything of value under confrontational circumstances from the control, custody, or care of another person by force or threat of force or violence and/or by putting the victim in fear of immediate harm.

Source: US Department of Justice Federal Bureau of Investigation, Criminal Justice Information Services Division

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Major Article

A Systematic Review and Meta-analysis of the Acceptability and Effectiveness of University Smoke-Free Policies

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Abstract. Objective: Systematically review studies of support for, and effectiveness of, university campuses' smoke-free policies. **Participants/Methods**: A search was carried out for studies in English related to campus smoking bans through June 2013. Eligible studies had outcomes for student or faculty attitudes, or measures of smoking prevalence or secondhand smoke (SHS) exposure. **Results**: Nineteen eligible studies were identified, 18 from the United States and 1 from the United Kingdom. A meta-analysis found 58.94% (95% confidence interval [CI] [52.35%, 65.53%]) of students (12 studies) and 68.39% (95% CI [65.12%, 71.67%]) of faculty (7 studies) supported smoke-free policies. Both studies measuring student smoking prevalence indicated a postban reduction (16.5% to 12.8% after 1 year [$p < .001$] and 9.5% to 7.0% [$p = .036$] after 3 years). Only 5% of UK universities were smoke-free compared with 25% of US universities. **Conclusions**: A majority of students and faculty support smoke-free campus policies, which may reduce smoking and SHS exposure.

Keywords: attitudes, effectiveness, smoke-free campus

The extensive health risks from smoking cigarettes and from secondhand smoke (SHS) exposure are well documented,[1] and the World Health Organization estimates that tobacco use will kill 1 billion people in the 21st century if current trends continue.[2] Indoor bans are now common throughout North America, the European Union, Australia, and many other countries following Ireland's workplace smoking ban in 2004.[3] These bans were implemented amidst controversy, but support increased substantially as efficacy was demonstrated.[4] A review[5] of 39 studies reported consistent evidence that indoor smoking bans reduced SHS exposure in workplaces, restaurants, pubs, and public spaces. It is estimated that 5 million people had stopped smoking as a result of the new laws in 20 countries, leading to approximately 2½ million fewer smoking-related deaths.[3]

Despite indoor smoking bans, 83% of students at 10 US universities reported regular exposure to SHS[6] and it is clear that indoor bans alone do not protect smokers from SHS outdoors or from diffusing indoors,[7] especially near building entrances.[8] Consequently, there are increasing moves in several countries to restrict outdoor smoking in certain public spaces[3] and in the United States over a quarter (1,182) of colleges and universities now have smoke-free campuses,[9,10] including all space outdoors. As indoor smoking bans have been shown to reduce smoking rates and SHS exposure, campus-wide smoking bans may reduce youth smoking as well as exposure to SHS.

Most smokers start smoking in their teens and early 20s, and few tobacco control policies aimed specifically at young people have been shown to be effective. A high proportion of young people attend university, so campus-wide smoking bans may offer important opportunities for reducing youth uptake and continuation of smoking. This article reports the results of a systematic review of the literature on student and faculty support for and effectiveness of smoke-free policies at university campuses worldwide. There have been no systematic reviews of the efficacy or support among students and faculty for these policies.

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Color versions of one or more of the figures in the article can be found online at www.tandfonline.com/vach.

METHODS

Search Strategy

For published studies, the following databases were searched: PubMed, EMBASE (via Ovid), PsycINFO (via Ovid), and CINAHL Plus. These databases were searched for relevant publications in English through June 2013 with the following Boolean string: "(smoke OR tobacco OR smoking) AND (prohibited OR prohibiting OR no-smoking OR ban OR banned OR smoke-free OR tobacco-free) AND (campus OR university OR college OR campus-wide)." This yielded 1,918, 427, 123, and 116 results in PubMed, EMBASE, PsycINFO, and CINAHL Plus, respectively. Of these 2,584 results, 437 were discarded as duplicates, leaving 2,147 for screening.

The following databases were searched for unpublished literature to June 2013: greylit.org, opengrey.eu, base-search.net, scirus.com, and google.com. The search terms used for greylit.org, opengrey.edu were, "smoke free" OR "tobacco free," yielding 57 results. For base-search.net and google.com, the same Boolean string from above was used. In base-search.net, additional filtering for "thesis," "reports, papers, lectures," or "unknown type" yielded 167 results. For google.com, these search terms resulted in 7,460,000 results. For scirus.com, the following were added to the Boolean string from above: "AND (outdoor OR outdoors)," yielding 20,090 results. Results from google.com and scirus.com were examined in order by a relevance filter until 300 consecutive titles showed no relevance.

Selection and Exclusion Criteria

Inclusion criteria for studies were based on study setting (college or university), study type (cross-sectional, cluster randomized intervention, or before and after intervention), and outcome measurement (student and faculty support for a smoke-free policy or a measure of a smoke-free policy's effectiveness at reducing SHS exposure, cigarette consumption, or smoking prevalence). Primary screening was by title, excluding those not referring to tobacco use at a university setting. Secondary exclusion was by abstracts if available, screened for study setting, study type, and outcome measurements as outlined above. The remaining publications and unpublished studies were read in their entirety, and those meeting the inclusion criteria were examined for quality. We assessed quality of studies with cross-sectional surveys by sampling strategy, sample size, sample population, response rate, and survey instruments. For studies with cluster randomized or before and after interventions, additional quality assessments were presence of a control university, similarity of control and intervention university, and blinding of outcome assessors.

The term "smoke-free policy" is defined here as a 100% ban on indoor and outdoor smoking on campus. Some of the US universities (792) had a completely tobacco-free campus, where smokeless tobacco was also banned,[9] and as tobacco-free includes smoke-free, studies from these campuses are included in the review.

Study Synthesis

A narrative synthesis of student and faculty attitudes toward, and the effectiveness of, campus-wide smoke-free policies was carried out. The meta-analysis of student support for smoke-free policies was carried out using a random-effect model to calculate mean pooled student support for studies reporting support as a percentage. The degree of homogeneity was tested using Cochran's Q test and the I^2 test, where I^2 values less than 25, between 25 and 75, and greater than 75 indicate low, moderate, and high heterogeneity, respectively.[11] Sensitivity analysis was conducting using the leave-one-out method. Publication bias was tested using Egger's regression method, a quantitative measure of publication bias calculated via regression of each study's standardized effect size on study precision.[12] All statistical analysis was conducted using Excel for Mac 2011 as described previously.[13]

As the only non-US eligible study was from the United Kingdom, to better compare the situation in the countries, university Web sites and student handbooks were examined to determine the current smoking policy at all UK higher education institutions,[14] as this has not previously been done. Policies were examined for smoking regulation: indoor ban (nonaccommodation), university-owned accommodation ban, building entrance perimeter ban, designated smoking areas only, and entirely smoke-free.

RESULTS

Literature Search

Results from published literature were combined and duplicates discarded, resulting in 2,147 publications. The abstracts of 129 publications with relevant titles were examined, leading to 43 studies selected for full review, of which 33 were excluded (Figure 1, Table 1). No additional relevant publications were found in the references of the remaining 9 studies. In total, 724 unpublished reports were examined by title from the gray literature search, with 36 meriting further review of abstracts and 15 full review, leading to 9 selected for inclusion (Table 2). The 39 studies were excluded because the setting was not a college or university campus ($n = 10$), the population was not students or faculty ($n = 1$), they dealt only with indoor smoking bans ($n = 7$), they involved only partial outdoor restrictions ($n = 5$), they did not have necessary outcome measures ($n = 10$), or their quality did not meet requirements for inclusion outlined above ($n = 6$).

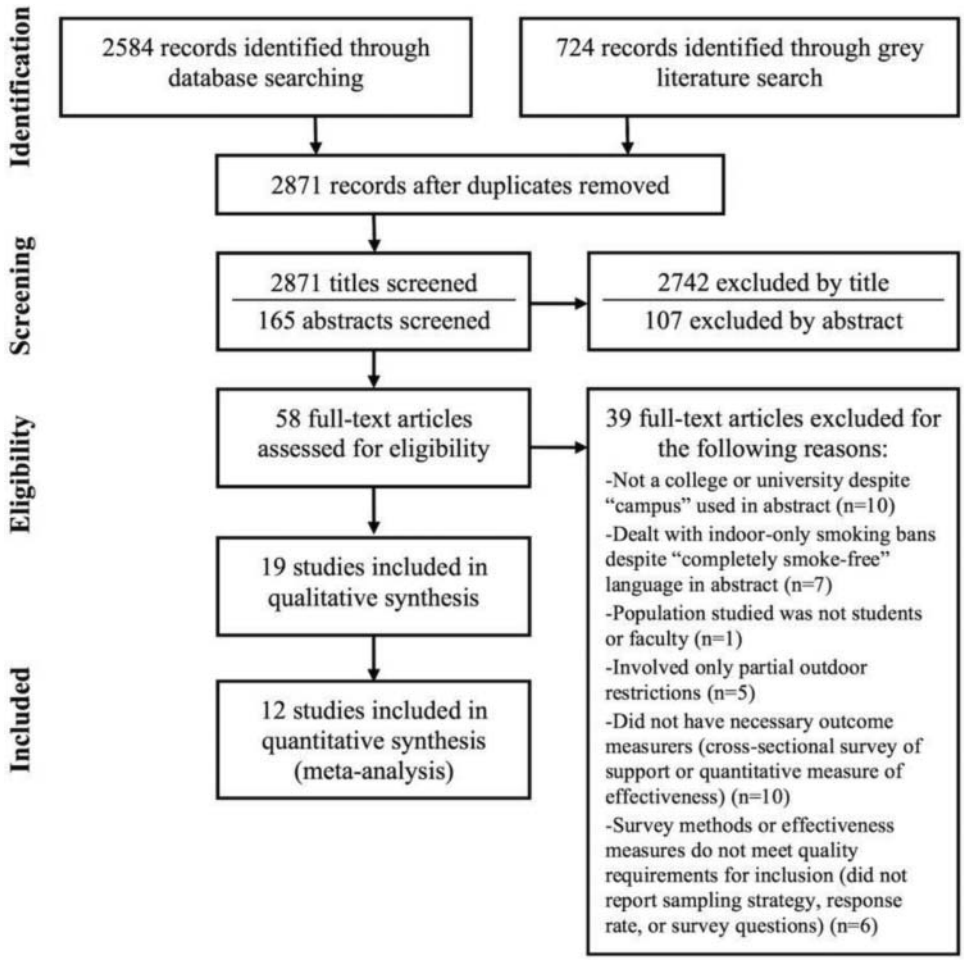

FIGURE 1. Systematic review PRISMA flowchart of published and unpublished literature related to smoke-free policies at higher education institutions.

Of the 58 full-text articles assessed for eligibility, 47 focused on settings in the United States, 6 focused on universities in Canada, 2 used data from multiple countries, 1 was conducted in Israel, 1 was conducted in Lebanon, and 1 in the United Kingdom. Of the 19 studies meeting inclusion criteria, 1 was from the United Kingdom and the rest related to colleges and universities in the United States. The 6 Canadian studies were excluded because they were from primary schools rather than university settings and did not have the required outcome measures. The 2 multicountry studies were excluded because they did not focus on colleges or universities, or they dealt with an indoor-only smoking ban. The study in Israel did not involve students or faculty, and the study in Lebanon dealt with a smoking ban that did not include outdoor space.

Attitude Toward Smoke-Free Policies Before Policy Implementation

Six publications[15–20] covering 40 US universities and 1 study[21] surveying students at 7 universities in the United Kingdom reported measurements of student support before smoke-free policy implementation. The proportions of US students supporting such policies in 3 of the publications were 56%,[15] 57.5% (control campus),[16] 61.1% (intervention campus),[16] and 66%.[17] One US study, using a 1–7 scale of support, reported an average response of 4.57, on the supportive side of neutral.[18] Two[19,20] US studies stratified responses by smoking status, both reported higher levels of support among never smokers (3.08[19] on a 1–4 scale, with 4 being strongly agree and 43%[20] support) compared with current smokers (1.83[19] and 6.9%[20]). The latter[20] was the only study to report less than majority support (43%) for a smoke-free policy among never smokers.[20] In this study, the question was "Which of the following outdoor policies would you prefer on campus?"[20(p588)] whereas the other studies asked the level of agreement with a smoke-free policy without other policy options. The one survey from outside the United States reported that 45.3% of undergraduates from 7 UK universities agreed with a total smoking ban.[21] The odds of daily smokers supporting this statement was 0.05 (95% confidence interval [CI] [0.03, 0.09]) compared with occasional or never smokers, indicating that the majority of the

TABLE 1. Eligible Published Literature Found Through Systematic Review

Citation	Location	Focus	Methods
El Ansari and Stock, 2012[21]	United Kingdom	Attitudes (students)	Before survey
Garget al., 2011[17]	USA: California	Attitudes (students)	Before survey
Lechner et al., 2012[18]	USA: Oklahoma	Attitudes (students) Effectiveness (students)	Before and after survey
Lee et al., 2011[35]	USA: North Carolina	Effectiveness	Cross-sectional counts
Loukas et al., 2006[19]	USA: Texas	Attitudes (students)	Before survey
Mamudu et al., 2012[33]	USA: Tennessee	Attitudes (faculty/staff)	After survey
Meier et al., 2013[34]	USA: Oklahoma	Effectiveness (students)	Before and after survey
Mishra et al., 2011[15]	USA: Alabama	Attitudes (students, faculty)	Before survey
Seo et al., 2011[16]	USA: Indiana	Attitudes (students) Effectiveness (students)	Before and after survey; Longitudinal survey
Thompson et al., 2006[20]	USA: Northwest	Attitudes (students)	Before survey

45.3% of students agreeing with the policy were occasional and nonsmokers.

Fourteen US institutions in 10 different states conducted in-house surveys of students and staff attitudes before implementing smoke-free policies. A further report focused on multiple institutions in Utah, reporting a median smoking prevalence of 19.1%, similar to the 2007 national undergraduate smoking prevalence of 18.6%.[22] Nine[23–31] of these reports were eligible for inclusion, as they provided detailed methodologies, including sampling strategies, response rates, and survey questions. Support for a smoke-free policy ranged from 46.3% to 76% ($Mdn = 58.5\%$)[23–30] among students and from 63.8% to 76% ($Mdn = 70.0\%$) among faculty and staff members.[24–26,28–31] Where both were reported, faculty and staff support was always higher than student support.[24–26, 28–30]

Four published US surveys (in 3 studies), 1 published UK survey, 7 US institutional surveys, and 1 statewide survey presented student support for smoke-free policies as percentages. As heterogeneity was high ($Q = 1386$, $I^2 = 99.21$), a random-effect model was used, giving a weighted mean of 58.94% student support for a smoke-free campus (95% CI [52.35%, 65.52%]) (Figure 2).[21,15–17,23–30] A sensitivity analysis removing Utah's results ($Q = 331$, $I^2 = 96.68$), which had 76% student support and 10,186 students, decreases the weighted mean of student support to 57.57% (95% CI [53.37%, 61.78%]). Excluding only the UK study ($Q = 1000$, $I^2 = 98.90$) increases the weighted mean of student support to 60.12% (95% CI [53.95%, 66.28%]). Including only the 4 studies published in peer-reviewed journals ($Q = 193$, $I^2 = 94.29$) yielded mean student support of 57.56% (95% CI [50.66%, 64.46%]). The weighted mean of the 6 surveys given from 2006 to 2008 ($Q = 955$, $I^2 = 98.85$) was 56.79% (95% CI [44.19%, 69.39%]) compared with 60.65% (95% CI [55.98%, 65.32%]) for the 7 surveys given from 2009 to 2012 ($Q = 152$, $I^2 = 92.77$). Of the 7 studies involving US faculty and staff members ($Q = 34.2$, $I^2 = 67.85$), a random-effect model gives a weighted mean of 68.39% support for a smoke-free campus (95% CI [65.12%, 71.67%]) (Figure 3).[24–26,28–31]

Using the Egger method[12] to test for publication bias, we analyzed the 4 published studies on student attitudes and found significant publication bias toward studies reporting greater student support ($p = .017$). This positive publication bias was eliminated when all 12 studies were included in

TABLE 2. Eligible Unpublished (Gray) Literature Found Through Systematic Review

Institution(s)	Focus	Method
Colorado State University[24]	Attitudes (students, faculty/staff)	Before survey
Minnesota State Community and Technical College[26]	Attitudes (students, faculty/staff)	Before survey
Minnesota State University at Moorhead[25]	Attitudes (students, faculty/staff)	Before survey
Nine Utah universities[23]	Attitudes (students)	Before survey
Texas State University[27]	Attitudes (students)	Before survey
University of Minnesota Twin Cities Campus[29]	Attitudes (student, faculty/staff)	Before survey
University of Montana[28]	Attitudes (students, faculty/staff)	Before survey
University of Oregon[31]	Attitudes (faculty/staff)	Before survey
University of Wisconsin, River Falls[30]	Attitudes (students, faculty/staff)	Before survey

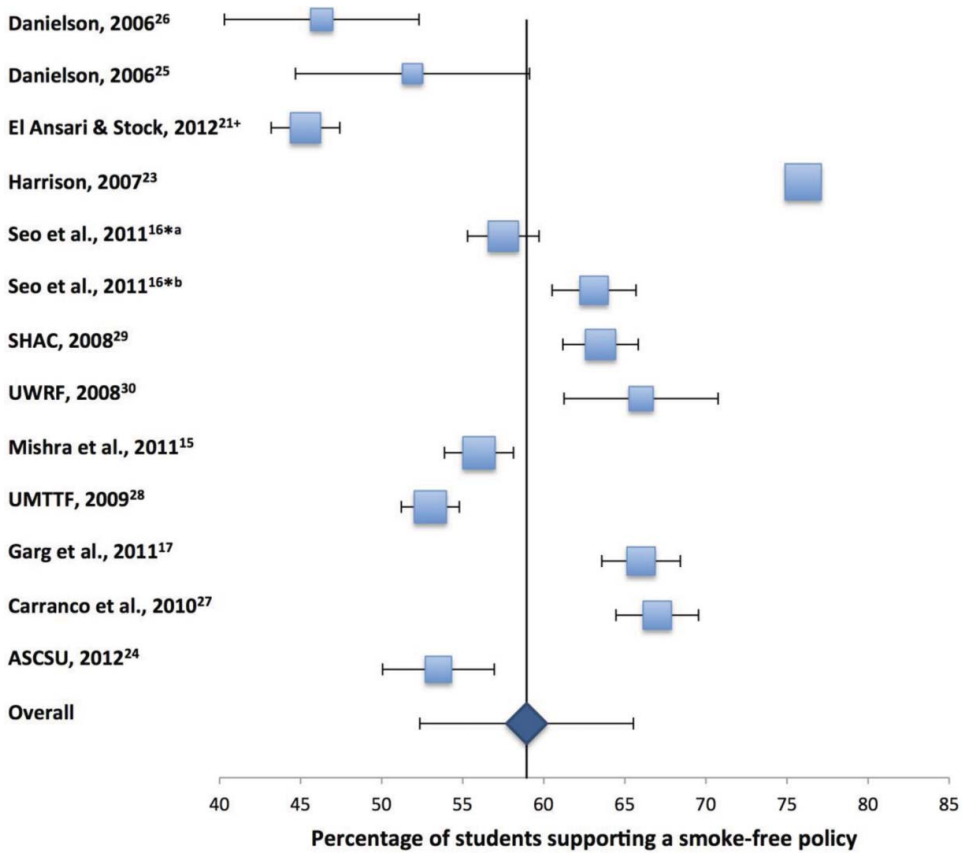

FIGURE 2. Student support for smoke-free policies prior to implementation. Error bars indicate 95% confidence interval. Studies are organized chronologically from oldest (top) to newest (bottom) by date of survey. Box sizes are proportional to the natural log of the survey sample size. [+]The UK study; [*a]Control campus; [*b]Intervention campus.

the analysis, which instead resulted in a significant negative publication bias ($p < .000$) toward studies reporting lesser student support. Although this indicates that the meta-analysis may underestimate the proportion of students supporting smoke-free policies, these differences could be due to decreased reliability of tests for publication bias with smaller numbers of heterogeneous studies.[32] Alternatively, it may be that this negative publication bias is due to true differences across the 12 studies because of different sociopolitical contexts. For example, publication bias is eliminated ($p = .356$) after excluding only the Utah study, which has the largest sample size and greatest student support but was conducted in a single US state. Repeating the Egger test for the faculty studies revealed a mildly significant publication bias ($p = .045$) toward studies reporting greater faculty support.

Attitudes Toward Smoke-Free Policies After Implementation

Two US publications reported student attitudes after implementation of the smoke-free policy. One reported 62.5% student support 2 years after becoming smoke-free, compared with 57.5% before implementation.[16] The second study reported increasing average student support at 5.33, 5.47, and 5.77 on a 1–7 scale 1, 2, and 3 years after the ban, compared with 4.57 preban.[18] One publication surveyed university employees only after implementation, reporting 79% support for the smoke-free policy.[33]

Student Exposure to Secondhand Smoke

Seven surveys explored SHS exposure among US students prior to smoke-free implementation. In one published survey, 45%[15] of students reported finding outdoor SHS exposure difficult to avoid; in another, 46%[17] reported often being bothered by outdoor SHS. Four unpublished surveys reported prevalence of regular (at least once a week) SHS exposure outdoors, with students' exposure ranging from 42.6% to 79.0% ($Mdn = 56.65\%$)[24–26,30] and among faculty and staff from 49.1% to 76.1% ($Mdn = 60.7\%$).[24–26,30] In the final survey, 79% of students and 73% of faculty reported that campus was where they were most exposed to SHS in their daily life.[28]

Effectiveness of Smoke-Free Policies

Four studies conducted in the United States measured effectiveness. One study[16] examined the efficacy of a

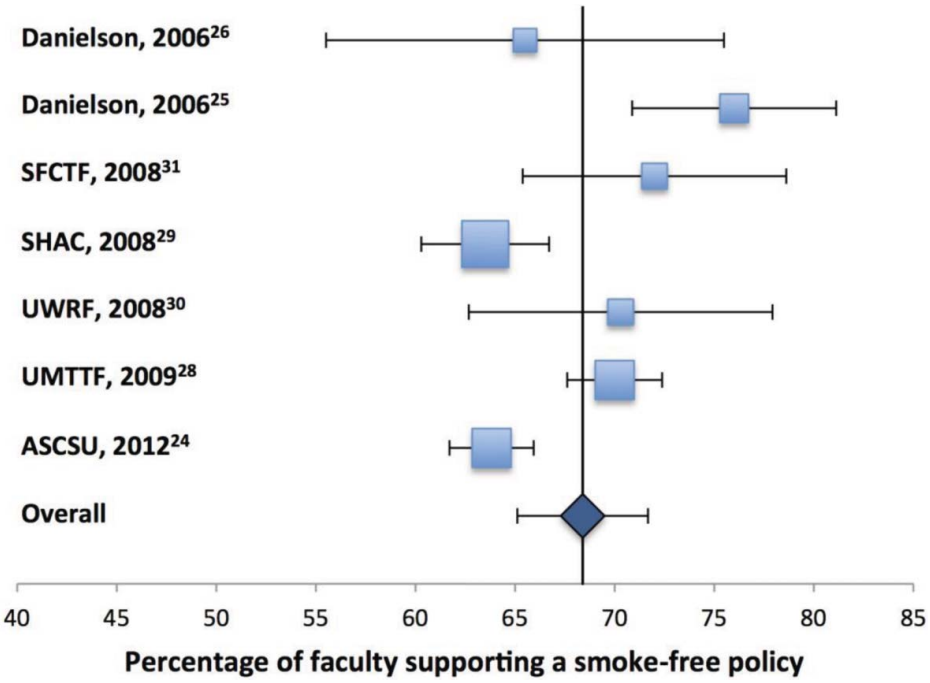

FIGURE 3. Forest plot of faculty support for smoke-free policies prior to implementation. Error bars indicate 95% confidence interval. Studies are organized chronologically from oldest (top) to newest (bottom) by date of survey. Box sizes are proportional to the natural log of the survey sample size.

campus-wide smoke-free policy through cross-sectional surveys at 2 matched public universities in the United States in 2008, one implementing a full smoke-free policy and the other an outdoor ban only within a certain distance of doorways, acting as a control. Undergraduate smoking prevalence at the university with the smoke-free campus decreased significantly from 16.5% baseline in 2007, to 12.8% ($p < .001$) in 2008, whereas the control university's undergraduate smoking prevalence increased nonsignificantly from 9.5% to 10.1%.[16] Longitudinal data were collected for a subset of students. Students in the intervention university reduced daily cigarette consumption from 8.9 to 3.6, significantly more ($p < .05$) than students at the control campus (3.1 to 2.8).[16] Additionally, students who thought that more than 25% of their peers used tobacco decreased from 73.6% to 66.8% ($p < .001$) at the intervention university, but increased from 59.2% to 67.1% ($p < .001$) at the control.[16] There was a significantly greater increase in student support for a smoke-free policy at the intervention university (5% increase) compared with the control (2.8% decrease; $p < .001$).[16]

Another study[18] conducted a cross-sectional, before and after survey at a US university to evaluate a complete campus tobacco ban of the use, sale, and advertising of all tobacco including smokeless, combined with smoking cessation support and a university-led anti-tobacco media campaign. This study had no control campus. The authors[18] present evidence that the smoke-free policy was followed by a significant ($p = .04$) decrease in prevalence of smoking from 9.5% 3 months before, to 7.6%, 6.6%, and 7.0% 1, 2, and 3 years, respectively, after implementation. These measurements are from cross-sectional surveys rather than longitudinal cohorts, so the decreases in smoking prevalence may include fewer students starting to smoke, more students quitting smoking, or a combination of both. This study reported changes in SHS exposure on a self-reported scale from *very high exposure* (0) to *no exposure* (5).[18] Average student scores for SHS exposure near building entrances were 3.10 at baseline and 3.85, 3.95, and 3.91 1, 2, and 3 years post intervention, respectively, indicating a significant decrease in exposure at all time points compared with baseline ($p < .001$). Average self-reported SHS exposure elsewhere on campus was 2.89 at baseline and 3.50, 3.60, and 3.66 1, 2, and 3 years post intervention, respectively ($p < .001$ at all time points compared with baseline). By 3 years after the intervention, pro-tobacco beliefs, including smoking being a weight loss option, had decreased significantly compared with baseline ($p = .011$).[18] A companion study at this institution examined smokeless tobacco use, to address concerns that tobacco use might shift to smokeless tobacco, but the prevalence of smokeless tobacco use also decreased from 23.2% at baseline to 15.1%, 14.2%, and 16.4% 1, 2, and 3 years after implementation, respectively ($p = .046$ at 3 years compared with baseline).[34]

The final study examined cigarette butts left near building entrances on 19 college campuses in the United States,[35] which may indirectly indicate SHS exposure to

students entering buildings. There were 0.6, 1.7, and 2.6 butts per day per building entrance, respectively, at universities with full smoke-free, entrance buffer, and no outdoor policies, respectively, indicating over 4-fold greater number of butts at campuses with no outdoor smoking restrictions compared with smoke-free campuses ($p = .04$).[35] There appears to be a dose-response relationship.

Comparison With Smoking Policies at UK Universities

No published or unpublished reports on the effectiveness of smoke-free campus policies at higher education institutions outside of the United States were identified in this review, and only 1 non-US study on student support was identified. To determine if this was a result of fewer 100% smoke-free campus policies outside of the United States, we reviewed smoking policies in the United Kingdom published on university Web sites and in student handbooks to determine the most current smoking policies of 159 UK institutions[14] (Figure 4, Table 3). Of the 145 universities with a smoking policy in the student handbook or online, 120 (82.8%) banned smoking indoors and in university-owned accommodation. There were 119 (82.0%) institutions with some level of restriction near building entrances, with 76 (52.4%) banning smoking 3 m or more from entrances, and 42 (29.0%) banning smoking 6 m or more from entrances. Twenty-four (16.6%) institutions restricted smoking to designated areas outside. As of June 2013, only 8 (5.5%) UK institutions had a full smoke-free campus policy, including all outdoor space. Several universities represented their policies as a "smoke-free campus," but most of these had limited or no outdoor smoking restrictions. England had only 3.5% smoke-free campuses compared with 22.2% in Wales and 11.1% in Scotland.

COMMENT

Principal Findings

Universities in the United States are rapidly adopting smoke-free campus policies, with over a quarter of US universities now fully smoke-free.[9] This paper examines evidence for these policies' efficacy and support among students and faculty. Of the 2,871 articles screened, only 19 were eligible for inclusion in this review, and all but one were from the US. There is good evidence that US university students support smoke-free policies, and that support increases once smoke-free policies are implemented. This echoes support for indoor smoke-free policies, where less than a decade ago, many viewed them negatively but now the large majority of the populations affected are supportive and many cannot imagine going back to smoke-filled pubs and restaurants.[4]

It is not surprising that there has been little research on effectiveness. Smoke-free campuses are relatively new even in the United States and a difficult aspect of evaluating the efficacy is to control for the background rate of decline in smoking prevalence, as smoking prevalence among 18–24-year-olds and university students in the United States has been declining over the last decade.[36,37] The best way to control for this is to analyze the before and after

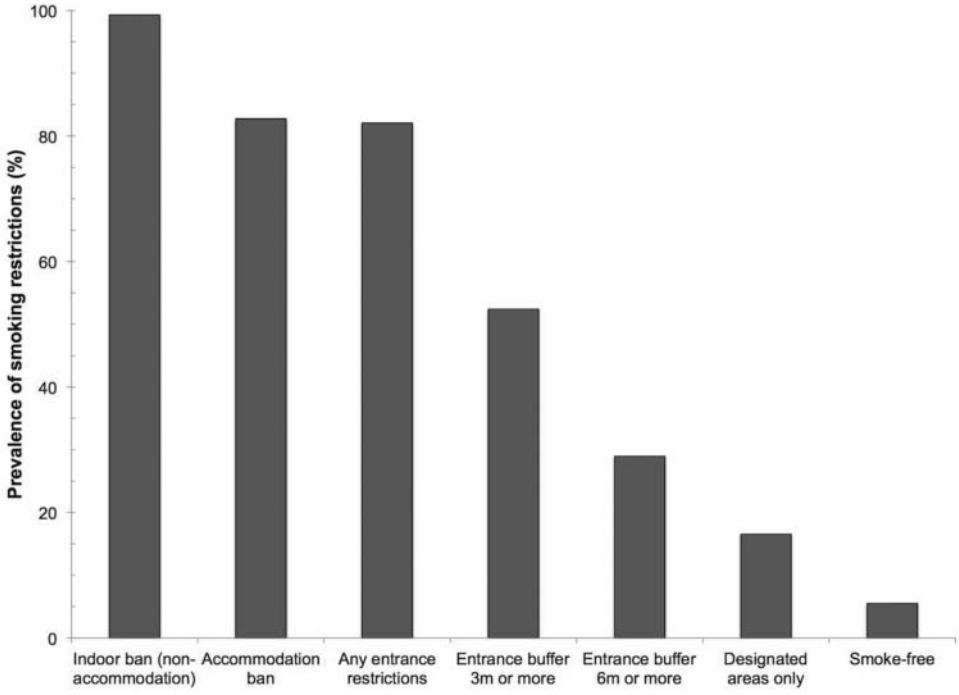

FIGURE 4. Smoking restrictions at UK universities as of June 2013.

TABLE 3. Published Smoking Policies at UK Universities in June 2013

	England		Wales		Scotland		Northern Ireland		United Kingdom	
Smoking restrictions	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
Indoor ban (nonaccommodation)	114	99.1	9	100	17	100	4	100	144	99.3
Accommodation ban	93	80.9	9	100	14	82.4	4	100	120	82.8
Any entrance restrictions	94	81.7	9	100	13	76.5	3	75.0	119	82.1
Entrance buffer 3 m or more	60	52.2	8	88.9	7	41.2	1	25.0	76	52.4
Entrance buffer 6 m or more	32	27.8	4	44.4	5	29.4	1	25.0	42	29.0
Designated areas only	20	17.4	1	11.1	2	11.8	1	25.0	24	16.6
Smoke-free	4	3.5	2	22.2	2	11.8	0	0.0	8	5.5
Policy updated in last 1.5 years	37	35.9	2	25.0	4	28.6	1	25.0	44	34.1

differences in attitudes or behavior at a university implementing a smoking ban compared with a university that has no change in smoking policy. One study did this, and reported a significant decrease in student smoking prevalence in the intervention compared with the control university, although the control university had lower initial baseline smoking prevalence.[16] Another study[18] did not include a control university but found a significant decrease in SHS exposure after implementation of a smoke-free policy. For indoor smoke-free policies, the evidence for efficacy accumulated only some years following implementaion,[38] and their importance has become apparent through synthesis of studies[5] and modeling.[3] The published evidence on smoke-free campuses does already indicate favorable changes to student attitudes, SHS exposure, and student behavior.

No studies explicitly analyzed the cost of implementing and enforcing a smoke-free policy. A 2009 study of 113 hospital administrators examined the differences between anticipated and actual costs of implementing a comprehensive smoking ban on hospital campuses, reporting that actual costs were 50% to 90% lower than had been anticipated.[39] Studies reviewing the cost-effectiveness of other tobacco control policies have reported that tobacco control interventions generally, including public smoking bans, are highly cost-effective.[40,41]

Many US campuses have implemented less than full smoke-free policies. Studies of 25-foot buffers near building entrances have shown this to be ineffective at reducing SHS exposure.[25,42,43] Another policy option, designated smoking areas outside, was associated with a 45% higher odds of students smoking in a survey of 13,000 students at 12 universities in Texas.[44] This higher prevalence may be due to designated smoking areas concentrating smokers, giving the impression that smoking is normative, or simply that universities that have more students who smoke, adopt such policies.

In the United Kingdom, which generally has a high level of tobacco control policies, only just over 5% of university campuses are smoke-free. Smoking prevalence peaks at ages 20–24 years and has increased for this age group in the past 2 years on record from 26% in 2009 to 29% in 2011[45] and almost doubles between ages 16–19 and 20–24 years.[45] (This compares with smoking among US undergraduates, which declined from 18.6% in 2007 to 14.7% in 2012.[22,36]) As nearly 50% of UK young people go to university,[46] this prevalence increase may be due partly to smoking initiation at university. A 2007 survey of students from universities in Wales, England, and Northern Ireland reported that 28% of students identified themselves as occasional or daily smokers of cigarettes, pipes, cigarillos, or cigars,[21] which is much higher than the 19% smoking prevalence for US students in 2007.[22] With smoking prevalence among university students continuing to decline in the United States while increasing among 20–24-year-olds in the United Kingdom, such policies could be considered for campuses in the United Kingdom as well as for other countries, most of which have higher rates of smoking at these ages.

Limitations and Conclusions

This study represents the only review of the acceptability of smoke-free university policies, and their effectiveness, and shows that such policies are acceptable to the majority of students and faculty surveyed. The few studies of effectiveness all reported significant reduction in smoking prevalence or exposure to smoke, although all had some weakness and only one included a control university. However, most of these universities became smoke-free only very recently.[9] Population-based smoking interventions are difficult to evaluate, and it took years for the efficacy of indoor smoke-free policies to become clear.[38]

There are concerns about the reliability of unpublished reports, although all these institutional surveys had their own review board approval. Most surveys were distributed online, which may explain their low response rates, and as smokers may be more or less likely to respond, results may be biased toward or against support for greater smoking restrictions. There may also be biases in the universities that chose to conduct surveys, as they may be more receptive to smoke-free campus policies.

The review indicates that smoke-free campuses may be successful in reducing the amount of smoking on campus

and SHS exposure. A recent publication indicated that 83% of US students are regularly exposed to SHS,[6] so these significant decreases are encouraging. The United States has relatively low student smoking rates compared with other countries such as the United Kingdom, and there may be higher long-term efficacy on student attitudes, SHS exposure, and student behavior at institutions with higher baseline smoking prevalence, even if initial student support were lower. Institutions in other countries could take advantage of their influential position with young people by implementing effective tobacco control policies at this crucial age.

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CONFLICT OF INTEREST DISCLOSURE

The authors have no conflicts of interest to report. The authors confirm that the research presented in this article met the ethical guidelines, including adherence to the legal requirements, of the United Kingdom and received approval from the Institutional Review Board of the London School of Hygiene and Tropical Medicine.

NOTE

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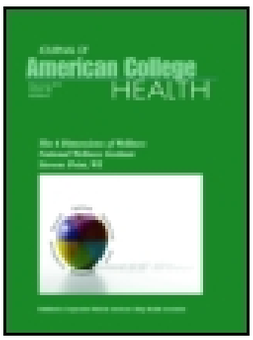

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Going tobacco-free on 24 New York City university campuses: A public health agency's partnership with a large urban public university system

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ABSTRACT

The New York City Department of Health and Mental Hygiene partnered with the nation's largest university system, the City University of New York (CUNY), to provide technical assistance and resources to support the development and implementation of a system-wide tobacco-free policy. This effort formed one component of *Healthy CUNY* - a larger initiative to support health promotion and disease prevention across the university system and resulted in the successful introduction of a system-wide tobacco-free policy on all CUNY campuses. Glassman, et al (2011) published a blueprint for action related to tobacco policies

which informed our work. This paper describes the policy development and implementation process and presents lessons learned from the perspective of the Health Department, as a practical case study to inform and support other health departments who may be supporting colleges and universities to become tobacco-free.

BACKGROUND

Following the introduction of smoke-free legislation governing restaurants, bars and other workplaces nationwide,[1] university and college campuses (campuses) have emerged as key tobacco control areas. Broad public support for smoke-free policies has led to increased student support,[2,3,4] removing an obstacle to introducing campus-based smoking bans.[5] In 2009, the American College Health Association adopted a "No Tobacco Use" position, encouraging campuses to introduce tobacco-free policies, governing all indoor and outdoor areas.[6] Today, at least 1,372 United States campuses have introduced smoke-free policies banning indoor and outdoor smoking, of which 983 are entirely tobacco-free.[7] However, many campuses have not updated their policies; and for those that have, administrators have struggled with enforcement, rendering new policies only partially effective.[8,9,10]

Researchers have highlighted the importance of collaboration between university administrators and local, state and federal public health agencies in order to develop multi-component, public health approaches to going tobacco-free.[8,9,11] Providing practical guidelines to support the implementation of this recommendation, Glassman et al. (2011) published a blueprint for action – a step-by-step guide to the policy development process and to overcoming barriers to successful implementation.[12] A key recommendation was introducing a formal process to guide policy development and implementation. Components included defining project milestones and timeframes for completion, establishing clear communication with students, faculty, staff, administrators and other stakeholders, conducting consensus-building activities, and developing strategies to ensure compliance with the new policy.

In New York City (NYC), the Department of Health and Mental Hygiene (DOHMH) with support from the Centers for Disease Control and Prevention's Communities Putting Prevention to Work (CPPW) program,[13] partnered with the nation's largest urban university system, the City University of New York (CUNY), to provide them with technical assistance as they developed and implemented a system-wide tobacco-free policy. This effort formed one component of *Healthy CUNY* - a larger initiative to support health promotion and disease prevention across the CUNY system.[14] CUNY comprises 24 campuses throughout NYC, housing 11 senior colleges, 7 community colleges, 6 professional or graduate schools and numerous administrative buildings, employing nearly 40,000 faculty and staff and educating 271,000 degree-credit and 270,000 adult continuing and professional education students. Working with CUNY to introduce a tobacco-free policy citywide represented a key opportunity for expanding DOHMH's mission to protect the health of New Yorkers. In this brief report, we will review and highlight applications of Glassman et al.'s recommendations and describe lessons learned, presenting a health department's perspective on developing and implementing tobacco-free policies (see table 1).

DEVELOPING A TOBACCO-FREE CAMPUS POLICY

Glassman et al. recommended six practical steps to develop tobacco-free policies: 1) create a committee to drive the process; 2) develop committee initiatives; 3) allow student debate of proposed changes to existing policy; 4) generate publicity; 5) draft potential policy; and 6) focus communication efforts on the Board of Trustees to ensure passage. At CUNY these steps were operationalized with modifications to accommodate the DOHMH-CUNY partnership.

CUNY's Chancellor convened a senior level Tobacco Policy Advisory Committee headed by CUNY's Provost/Executive Vice Chancellor. Committee members included content experts from the Healthy CUNY Initiative, CUNY's School of Public Health and representatives from other faculties, labor unions, student council and university administration. DOHMH staff served as technical advisors. The committee reviewed and considered expanding the existing tobacco control policy, which had been in place since 1995 and prohibited smoking inside all facilities CUNY owned, leased or operated.

The Tobacco Policy Advisory Committee determined that policy expansion was warranted and launched a six-month development process, from January – June 2010. DOHMH attended several Committee meetings as a technical expert, answering tobacco control-related questions and providing resources, such as campus policies from around the nation to serve as models. Ultimately, three recommendations were forwarded to the Chancellor:

1) Prohibition of tobacco on all grounds and facilities under CUNY jurisdiction, including indoor and outdoor locations (such as playing fields, entrances and exits to buildings, and parking lots);

2) Prohibition of tobacco industry promotions, advertising, marketing and distribution of marketing materials on campus properties; and
3) Prohibition of tobacco industry sponsorship of athletic events and athletes.

The committee defined tobacco products as cigarettes, smokeless tobacco and electronic or e-cigarettes.

Following the Chancellor's approval, the recommendations were posted for public comment on the CUNY website during July – September 2010. Publicity in the form of email notifications and public postings was generated to encourage public comment via the CUNY website. During this public comment period, 579 students, faculty and staff sent feedback to the Vice Chancellor's office. Students (62%) comprised the majority, but faculty (22%) and staff (16%) contributed. Overall, 78% of respondents expressed full or partial support, while 15% considered the proposed policies too restrictive (7% did not respond). The most common concern expressed by students and faculty was secondhand smoke exposure. A limited number of respondents (5%) raised smokers' rights issues, and several (2%) reported that other issues (such as the high cost of tuition) should be a higher priority for the university.

During Fall 2010, comments were reviewed and discussed, after which the policy expansion recommendations were submitted to the CUNY Board of Trustees in January 2011. The Board voted in favor of expanding the CUNY tobacco policy, creating an 18-month pre-implementation window by setting September 2012 as the deadline for implementation.

ADDRESSING BARRIERS: STRATEGIES FOR SUCCESSFUL IMPLEMENTATION

According to Glassman et al., successful implementation relies on a multicomponent approach: 1) involving students in the tobacco-free movement; 2) generating administrative and staff support for the new policy; 3) providing resources to support implementation; and 4) enforcing the new policy. All of these steps were incorporated in CUNY's plan; however, CUNY asked the DOHMH to help them focus on providing resources, including developing CUNY's

ability to provide cessation support to interested students; and creating a culture of compliance to enforce the new policy.

After approving the Tobacco Policy Advisory Committee recommendations, CUNY's Chancellor designated the Director of Mental Health and Wellness Services, in the Central Office of Student Affairs, to supervise the policy implementation. All 24 campuses were required to convene a tobacco policy working group to develop campus-specific policy implementation plans, to be approved by the Chancellor's office. The Central Office of Student Affairs developed a four-component template to guide plan development, and made it available on the "Tobacco-Free CUNY" webpage on the *Healthy CUNY* website. The template required each campus to develop an action plan, a communications plan, compliance strategies and smoking cessation resources. DOHMH provided technical assistance to the campus specific working groups throughout the pre-implementation phase.

To support the development of cessation services for students, DOHMH offered training sessions for CUNY's 18 Student Health and Counseling Centers. Training was offered to clinic managers and to front-line staff. Sixteen of CUNY's 18 Student Health and Counseling Centers sent 50 staff for training. Clinic managers were trained on integrating tobacco cessation services into existing clinic structure. Front-line clinical and counseling staff were trained to conduct tobacco use screenings and to provide counseling and treatment to tobacco users seeking cessation assistance. Advanced training was provided for select counseling staff on engaging students in more tailored interactions, using motivational interviewing techniques and the Transtheoretical Model of Change [15]. Staff training evaluations showed high program

satisfaction. In parallel to these training efforts, CUNY worked with Human Resources to assure that staff and faculty were given information on how to access smoking cessation services through their primary care provider, CUNY's Employee Assistance Program or through a specialized DOHMH program for city employees called ESCAPE (Employee Smoking Cessation Assistance Program).

To publicize and disseminate information on the new tobacco policy, CUNY campuses employed different communications strategies including email, websites, newsletters, electronic bulletin boards, videos, staff meetings and student forums. DOHMH worked with the Central Office of Student Affairs to develop a "frequently asked questions" page about the new policy for the *Healthy CUNY* website, business cards describing the new policy and identifying smoking cessation resources, and educational brochures emphasizing the health risks of smoking and benefits of quitting. Over 134,000 brochures, in English, Spanish, Russian, Chinese and other languages, were distributed to students and staff at Student Health and Counseling Centers, health fairs and wellness expos. DOHMH also shared public service announcements which were shown on CUNY TV (CUNY's cable television channel).

To assist campuses with enforcement, DOHMH contracted with the National Center on Tobacco Policy, an organization supporting campuses in developing tobacco-free policies since 1997, to provide training sessions for CUNY operations, facilities and security staff on tobacco-free enforcement. In addition, 12 campuses requested and received site visits from the National Center for Tobacco Policy to help them develop focused strategies specific to their campus's needs.

All 24 campuses successfully introduced the new tobacco-free policy on time in September 2012. A summary of the DOHMH-CUNY process is presented in comparison to Glassman et al.'s recommendations in Table 1.

LESSONS LEARNED

CUNY's commitment to health formed the foundation of the DOHMH-CUNY partnership. With the introduction of the *Healthy CUNY* initiative, CUNY set a goal of becoming the nation's healthiest urban university by 2016. Moving from a smoke-free to a tobacco-free policy aligned with this goal, creating an impetus for action. Furthermore, commitment at the highest administrative levels facilitated the policy development and implementation process. DOHMH provided technical assistance, training and resources which allowed CUNY to realize its goals, but the initiative remained CUNY-driven with CUNY's Chancellor in a leadership role, supported by content experts from DOHMH and from within CUNY's faculty.

The value of introducing a step-by-step process under designated leadership cannot be overstated. Instituting a formal process allowed DOHMH and CUNY to work productively as partners; and establishing a dedicated section of the CUNY website for the initiative facilitated clear communication with faculty, staff and students about this process. By adhering to deadlines and achieving targets, CUNY leadership kept the process moving and brought stakeholders along, anticipating the need for DOHMH expertise at various junctures and calling upon our team as needs arose.

Information gathered during the public comment period and throughout discussions on many campuses indicated concerns that the new policy would stigmatize smokers. This concern

helped shape messaging so the campaign promoted health for all and avoided discrimination against tobacco users. The phrase, "Out of Respect for Others and the Environment, CUNY is Going Tobacco-Free," was developed as an educational – rather than punitive – message to convey CUNY's approach.

PRELIMINARY EVALUATION AND ADDITIONAL CONSIDERATIONS

While the DOHMH-CUNY partnership resulted in the successful development and launch of CUNY's tobacco-free policy, a comprehensive evaluation is needed. Early post-implementation evaluation results showed that CUNY campus referrals to the New York State Quitline increased from 10 in the 2010-2011 school year to 68 during 2011-2012, and to 131 referrals during 2012-2013. Support for the policy was high, at 83% of those surveyed which included 1136 respondents comprised of faculty (50%), staff (12%), and students (38%). Respondents reported decreased exposure to secondhand smoke and less tobacco related litter following policy implementation and felt the policy enforcement was successful. Nonetheless, further efforts are needed to evaluate success.

DOHMH had a unique ability to support CUNY due to funding from the CDC for this initiative. Designing and purchasing signage, printing and distributing brochures and other informational resources, developing training curricula, conducting trainings and contracting with external experts required substantial resources. However, even with limited resources, campus and health department partners can realize successful policy development and implementation. As noted by Glassman et al.,[Error! Bookmark not defined.] a resource assessment must be included early to identify low- or no-cost resources to facilitate policy development and adoption and generate

support among campus leaders and stakeholders, both within and beyond the university. A realistic assessment of potential challenges alongside a practical vision for the policy's reach can support success.

CONCLUSIONS

Despite DOHMH's substantial progress in introducing smoke-free legislation in NYC, no city or state ordinances currently require campuses to go smoke-free. By providing information, resources and training in a phased approach, DOHMH successfully advised and supported CUNY throughout the development and implementation of a tobacco-free policy. Our experience demonstrates that Glassman et al.'s recommendations provide an excellent starting point for this work.[12] We encourage universities and health departments to utilize these recommendations to form tailored approaches to introducing tobacco-free policies that protect the health of students, faculty and staff on campuses nationwide.

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Table 1. Tobacco-free policy development and implementation process: recommendations and operationalization

Recommendations (Glassman et al.)		Operationalization (DOHMH/CUNY)
Policy Development		
1)	Create a committee	CUNY establishes TPAC
2)	Develop committee initiatives	TPAC receives technical guidance from DOHMH, reviews current CUNY policy and policies from campuses across the nation; develops draft policy changes and submits to Chancellor for approval
3)	Allow student debate	Solicitation of student/public comments
4)	Generate publicity	
5)	Draft policy	TPAC incorporates comments, finalizes draft policy
6)	Communicate with Board of Trustees to ensure passage of new policy	TPAC submits policy to Board of Trustees for approval
Implementation		
1)	Involve students	CUNY disbands TPAC; transfers responsibility to COSA
2)	Generate administrative and staff support	Tobacco Policy Working Groups are convened to develop campus-specific implementation plans
3)	Provide resources to support implementation	With DOHMH support, COSA launches "Tobacco-Free CUNY" webpage

		DOHMH provides cessation support training for Student Health and Counseling Center staff
		DOHMH develops signage starter kit and promotional materials; helps COSA promote the new policy through various media
		DOHMH engages NCTP to support development of enforcement policies
4)	Enforce the new policy	NCTP/DOHMH trains CUNY staff to enforce new policy

COSA: Central Office of Student Affairs

CUNY: City University of New York

DOHMH: Department of Health and Mental Hygiene

NCTP: National Center on Tobacco Policy

TPAC: Tobacco Policy Advisory Committee

Tobacco use is the leading cause of preventable death and disease

We can help change this terrible human and economic toll which affects the entire campus community.

23,600
ADULTS DIE each year in NYS from tobacco-related illness

3,000
ADULT NON-SMOKERS DIE
in NYS annually from diseases (including heart disease, lung cancer and stroke) caused by secondhand smoke exposure

280,000
YOUTH (<18 YEARS OLD)
living in NYS today will ultimately die early from using tobacco, given current smoking levels

Tobacco-related health care costs New Yorkers
$10.4 billion ANNUALLY

Lost productivity from smoking costs NYS over
$6 billion ANNUALLY

Source: Smoking and Tobacco Use – Cigarettes and Other Tobacco Products. Retrieved May 14, 2014, from http://www.health.ny.gov/prevention/tobacco_control/.

College leaders recognize the benefits of having a tobacco-free campus policy

Why go Smoke or Tobacco-Free on Campus?

- Promote respect for others and for the campus environment;
- Send a strong message that health and addiction-free living is important and taken seriously by the school;
- Create an environment that helps students, staff and faculty to stop using tobacco or never start (evidence suggests that tobacco-free campus policies reduce smoking prevalence among those on campus);
- Avoid undermining the health of our young people by unintentionally supporting the development of what is often a lifelong addiction;
- Reduce exposure to secondhand smoke and potential liability to the college for smoking-related health problems (secondhand tobacco smoke is classified by the Environmental Protection Agency as a Class A carcinogen, the same as asbestos, and there is no safe level of exposure. Evidence suggests that short-term exposure to secondhand smoke, even outdoors, puts people at risk, especially those with pre-existing cardiac and respiratory conditions);
- Reduce staff time spent on maintenance, including picking up cigarette butts and other tobacco waste and decrease cleaning needs;
- Enhance the campus' image as a clean and healthy environment for visitors such as parents, prospective students, donors, as well as for the larger community.

60% of people in New York support a ban on smoking in outdoor public areas. That is up 11% since 2005.

Source: 2012 Independent Evaluation of the New York State Tobacco Control

Putting a Tobacco-Free Campus Policy in Place Takes Time and Strong Leadership

With time and effective leadership, tobacco-free policies can be implemented with high compliance and lead to a healthier, more attractive campus environment. If a college president does not make it a priority, is not a visible champion, and ignores important constituencies, there will likely be significant compliance problems.

If on the other hand, college leadership is fully engaged in the process and is speaking about the rationale for the policy to staff and the various campus stakeholder groups, the tobacco-free policy process will go more smoothly. Once the decision has been made to adopt a tobacco-free policy, the following checklist can serve as a basic guideline. More detailed resources are available via the links listed below.

Student Tobacco Policy Survey

1. Do you know the current smoking policy on the Ithaca College campus?
   - o Yes
   - o No
   - o Somewhat (Not very clearly)

2. Please mark with your appropriate responses whether you agree or disagree on each of the statements provided below:

1 Strongly Disagree 2 Disagree 3 Neither Agree nor Disagree 4 Agree 5 Strongly Agree

Exposure to secondhand smoke is a health issue.	1 2 3 4 5
I am concerned about the health consequences of being exposed to secondhand smoke.	1 2 3 4 5
Litter caused by smoking (cigarette butts, empty packages, etc.) detracts from the appearance of this campus.	1 2 3 4 5
I have been exposed to secondhand smoke on campus in the last 30 days.	1 2 3 4 5
Tobacco products are mostly used at social gatherings such as parties.	1 2 3 4 5
Presence of ashtrays on campus suggests that we are supporting this behavior.	1 2 3 4 5
The policy regarding tobacco use on campus is strongly enforced.	1 2 3 4 5
When I see people using tobacco products on campus it makes me think about their and others health.	1 2 3 4 5
I have seen people not following the current tobacco policy on campus in the last 30 days.	1 2 3 4 5

Ithaca College does not have any problem with the secondhand smoke exposure.	1	2	3	4	5

3. How likely are you to support a completely tobacco free policy on all campus property? (Both indoor and outdoor)

- o Very Unlikely
- o Unlikely
- o Undecided
- o Likely
- o Very Likely

4. If Ithaca College had a tobacco-free campus when you applied to attend, how would that have affected your decision to enroll at Ithaca College?

- Encouraged you to enroll.
- Discouraged you to enroll.
- I don't know.

5. I have been exposed to secondhand smoke in the following areas. (Check all that apply)

- o Walking across campus
- o Entrance to buildings
- o Outdoor seating areas or bus stops
- o Parking lots
- o Inside buildings (smoke drifting in buildings)
- o Sporting events
- o Dorm buildings
- o Dining Halls
- o Not at all

6. Have you smoked at least 100 cigarettes in your lifetime?*

- o Yes
- o No

7. Do you now smoke cigarettes?
    - Every day
    - Some days
    - Not at all

8. Do you now use electronic cigarettes?
    - Every day
    - Some days (1-3 in 30 days)
    - Not at all

9. I have used the following tobacco products within the last 30 days. (Check all that apply)
    - o Hookah
    - o Smokeless Tobacco (chew, spit, snus)
    - o Tobacco pipes
    - o Cigars
    - o Other vaping
    - o Other
    - o None

10. When did you start smoking?
    - Before high school
    - During high school
    - College
    - I have never smoked

11. If you are a smoker or use e-cigarettes, what is your current smoking status? (Please choose appropriate option)
    a. I am currently a smoker, and do not intend to stop smoking in the next six months.
    b. I am currently a smoker and am seriously considering quitting in the next six months.
    c. I seriously plan to quit smoking within the next thirty days and have made at least one attempt to do so within the past year.
    d. I am a former smoker and have continuously quit for less than six months.
    e. I am a former smoker and have continuously quit for longer than six months
    f. I am not a smoker

12. If you use e-cigarettes every day or some days, would you like to quit now?
    - Yes
    - No
    - I do not use e-cigarettes

DEMOGRAPHICS

13. Please indicate your gender
    - Male
    - Female
    - Other

14. What year student are you?
    - Freshmen
    - Sophomore
    - Junior
    - Senior
    - Graduate Student

15. Where do you live?
    - On campus
    - Circle Apartments
    - Off campus

*The CDC definition of a "smoker" is someone who has smoked at least 100 cigarettes in their lifetime, and now smokes everyday or some days.

Employee Tobacco Policy Survey

1. Do you know the current smoking policy on the Ithaca College campus?
    - o Yes
    - o No
    - o Somewhat (Not very clearly)

2. Please mark with your appropriate responses whether you agree or disagree on each of the statements provided below: [SAME AS STUDENT SECTION]

3. How likely are you to support a completely tobacco free policy on all campus property? (Both indoor and outdoor)
    - o Very Unlikely
    - o Unlikely
    - o Undecided
    - o Likely
    - o Very Likely

4. Do you think the Ithaca College campus community is more receptive to a tobacco-free campus policy today, when compared to 5 years ago?
    - o Yes
    - o No
    - o I don't know
    - o I wasn't working here 5 years ago

5. If Ithaca College had a tobacco-free campus when you applied for your position, how would that have affected your decision to work at Ithaca College?
    - Encouraged you to work here.
    - Discouraged you to work here.
    - I don't know

6. I have been exposed to secondhand smoke in the following areas. (Check all that apply)
    - o Walking across campus
    - o Entrance to buildings
    - o Outdoor seating areas or bus stops
    - o Parking lots
    - o Inside buildings (smoke drifting in buildings)
    - o Sporting events
    - o Dorm buildings

- o Dining Halls
- o Not at all

7. Have you smoked at least 100 cigarettes in your lifetime?
   - o Yes
   - o No

8. Do you now smoke cigarettes?
   - o Every day
   - o Some days (1-3 in the last 30 days)
   - o Not at all

9. Do you now use electronic cigarettes?
   - o Every day
   - o Some days
   - o Not at all

10. I have used the following tobacco products within the last 30 days. (Check all that apply)
    - o Hookah
    - o Smokeless Tobacco (chew, spit, snus)
    - o Tobacco pipes
    - o Cigars
    - o Other vaping
    - o Other
    - o None

11. When did you start smoking?
    - Before high school
    - During high school
    - College
    - Post college
    - I am not a smoker

12. If you are smoker, what is your current smoking status? (Please choose appropriate option)
    a. I am currently a smoker, and do not intend to stop smoking in the next six months.
    b. I am currently a smoker and am seriously considering quitting in the next six months.

c. I seriously plan to quit smoking within the next thirty days and have made at least one attempt to do so within the past year.
d. I am a former smoker and have continuously quit for less than six months.
e. I am a former smoker and have continuously quit for longer than six months
f. I am not a smoker

13. If you use e-cigarettes every day or some days, would you like to quit now?
- Yes
- No
- I do not use e-cigarettes

DEMOGRAPHICS

14. Please indicate your gender.
- o Male
- o Female
- o Other

15. How many years have you worked at Ithaca College?

16. What is your employment status?
- Faculty
- Staff
- Other

17. Are you a current member of the Mind, Body, Me wellness program at Ithaca College?
- Yes
- No

CREDIT:
Development and Evaluation of Health Programs, Ithaca College, Prof. S. Bajracharya
Jaime White, Sarah Dermady, Rachelle Sartori (April 30, 2015)

Following are:

1. What Cornell Wellness offers to employees with regard to tobacco cessation.
2. What the insurance companies offer for smoking cessation.

Cornell Wellness Offers:

1. How to Quit Smoking lectures to departments by request.
2. Individualized consultations to plan for and set a quit date; includes unlimited number of follow up sessions.

Insurance:

Endowed employees/covered dependents:
Aetna offers $0 copay for OTC nicotine replacement with a prescription for 2 per year.
There is a possibility to extend that coverage.
Rx for Welbutrin: 30 pills, $50; generic Buproprin: 30 pills, $5
Rx for Zyban: also $50, generic Proprian is $4.15/month

Contract College insurance:
Each carrier seems to treat these medications differently meaning; applying some apply a $0.00 co-pay for health care reform. It's important to note, the carriers encourage members to call to verify coverage as medications can move within their pharmacy formulary; tiers, co-pays, exclusions.

Empire, (CVS Caremark RX) Plan:

- Chantix= Yes covered, for a 30 day supply filled either at local retail or home delivery with a, $25 co-pay
- Welbutin= Needs Prior Authorization for the brand name. The generic (Bupropion) is covered, for a 30 day supply filled either at local retail or home delivery with a, $5 co-pay
- Zyban= Needs Prior Authorization for the brand name. The generic (Bupropion) is covered, for a 30 day supply filled either at local retail or home delivery with a, $5 co-pay
    - All three can be filled for a 90-day supply either at Home Delivery or Retail as well.
- Chantix = Home Delivery & Retail fills are a $50 co-pay
- Welbutin & Zyban = Home Delivery is a $5 co-pay and Retail fills are a $10 co-pay

HMO-Blue CNY Plan:

- Chantix= Yes covered, for a 30 day supply filled either at local retail with a, $0.00 co-pay (this medication falls under healthcare reform)
- Welbutin= Needs Prior Authorization for the brand name. The generic (Bupropion) is covered, for a 30 day supply filled either at local retail or home delivery with a, $10 co-pay
- Zyban= Needs Prior Authorization for the brand name. The generic (Bupropion) is covered, for a 30 day supply filled either at local retail or home delivery with a, $10 co-pay
    - All three can be filled for a 90-day supply at Home Delivery only. Retail pharmacy is limited to a 30-day fill.
- Chantix = Home Delivery $0.00 co-pay (this medication falls under healthcare reform)
- Welbutin & Zyban = Home Delivery is a $20 co-pay

HMO- MVP CNY Plan:

- Chantix= Yes covered, for a 30 day supply filled at local retail with a, $0.00 co-pay (this medication falls under healthcare reform)
- Welbutin= Not covered/ excluded medication.
- Zyban= Brand name Not covered/ excluded medication. The generic (Bupropion) is covered, for a 30 day supply filled either at local retail or home delivery with a, $0.00 co-pay
    - All three can be filled for a 90-day supply at Home Delivery only. Retail pharmacy is limited to a 30-day fill.
- Chantix = Home Delivery $0.00 co-pay (this medication falls under healthcare reform)
- Welbutin & Zyban (Generic Bupropion) = Home Delivery is a $0.00 co-pay (this medication falls under healthcare reform)