NATIONAL DRUG CONTROL STRATEGY

Performance Reporting System Report

2016

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Performance Reporting System

Report 2016

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Introduction

The Obama Administration is committed to a coordinated government-wide public health and public safety approach to reduce illicit drug use and its consequences. The Office of National Drug Control Policy (ONDCP) leads this effort through the *National Drug Control Strategy* (*Strategy*), encompassing prevention, early intervention, treatment, recovery support, criminal justice reform, effective law enforcement, international cooperation, and scientific research. The Performance Reporting System (PRS) assesses interagency progress toward achieving the two Goals and seven Objectives of the *Strategy*, in accordance with the ONDCP Reauthorization Act of 2006 (P.L. 109-469).

The PRS was initially developed through an interagency process that brought together subject matter experts, policy and program analysts, researchers, statisticians, and leadership from Federal drug control agencies. The inaugural PRS report released in 2012 discussed the system's design and the assessment process in detail. Using the *Strategy's* overarching two Goals as a foundation, the PRS design process employed Working Groups that developed appropriate performance measures and targets for each of the seven Objectives of the *Strategy*. These Working Groups included representatives from the Departments of Defense, Education, Health and Human Services, Homeland Security, Interior, Justice, Labor, Transportation, Treasury, State, Veterans Affairs, and the Small Business Administration. The Working Groups drew upon current research and data to select performance measures and targets for each Objective. Research findings assisted the development of optimal performance measures for each Objective. In some cases, however, data limitations precluded the use of ideal measures. In such cases, Working Groups opted to select a suite of measures to best reflect performance. ONDCP developed a process to structure the identification of measures that were responsive to the various viewpoints of persons with different perspectives on the joint mission, diverse professional disciplines, and varying institutional and data constraints. The PRS is a tool that acts as a signal to indicate where the *Strategy* is on track, and when and where further attention, assessment, evaluation, and problem-solving are needed.

This report is the Administration's concluding assessment of interagency progress toward achieving the 2015 *Strategy's* two Goals and seven Objectives. The following Goals and Objectives focus on specific substantive areas where collective progress was deemed necessary to effectively address our Nation's drug problem:

- *Strategy* Goals
  - Goal 1: Curtail illicit drug consumption in America
  - Goal 2: Improve the public health and public safety of the American people by reducing the consequences of drug abuse

- *Strategy* Objectives
  - Objective 1: Strengthen Efforts to Prevent Drug Use in Our Communities
  - Objective 2: Seek Early Intervention Opportunities in Health Care
  - Objective 3: Increase Access to Treatment and Support Long-term Recovery
  - Objective 4: Criminal Justice Reform: Making the System More Effective and Fair
  - Objective 5: Disrupt Domestic Drug Trafficking and Production
  - Objective 6: Strengthen Law Enforcement and International Partnerships to

Reduce the Availability of Foreign-Produced Drugs in the United States

- Objective 7: Improve Information Systems for Analysis, Assessment, and Local Management

For the two *Strategy* Goals there are 13 measures[1] dealing with illicit drug use and its consequences with which to assess the Nation's progress toward achieving the Goals (see Table A-1 below). For the 7 *Strategy* Objectives there are 28 measures dealing with prevention, brief intervention, treatment, criminal justice, law enforcement, international program, and research with which to assess the Nation's progress toward achieving the Objectives (see Table A-2 below). In total, to assess the Nation's progress at achieving the *Strategy* Goals and Objectives there are 41 specific measures.

For each of the *Strategy* Goals and Objectives, the following definitions are applied to assess progress:

- **Target Met or Exceeded** *(Given the data available at this time, progress should be maintained.)*
- **Progress Sufficient to Meet Target** *(Given the data available at this time, there is a reasonable expectation that the target will be met.)*
- **Progress Required to Meet Target** *(Movement toward the target is in the right direction; based on the data available at this time, additional efforts are required.)*
- **Insufficient Progress** *(Movement toward the target is moderate; based on the data available at this time, significant progress is required to meet target.)*
- **No Progress to Date, or, Target Not Met** *(For 'No Progress to Date', movement toward the target is stalled or not in the right direction. For 'Target Not Met", based on 2015 or the most recent available data, target was not achieved.)*
- **Progress Cannot be Assessed.** *(The category 'Progress Cannot be Assessed" is used where data updates are pending or a cessation of data availability occurred before a final progress assessment could be determined.)*

Tables A-1 and A-2 below summarize progress toward achieving the overall *Strategy* Goals and Objectives to reduce drug use and its consequences. Of the total 41 measures that constitute the PRS, 21 targets, or approximately 51 percent, were met or had made sufficient progress toward achieving the target. There were 2 measures where more progress was required and 13 measures where there was no progress to date or the target had not been met. There were 5 measures where progress could not be assessed due to pending data updates or a cessation of data availability that occurred before a final progress assessment could be made.). The summary of progress for both the Strategy and Objective measures is shown in Figure 1-1 below.

[1] For the Strategy, there are seven primary measures; three of them have multiple sub-measures: 8th grade lifetime use of alcohol, tobacco and illicit drugs; people who use marijuana, cocaine, heroin or methamphetamine chronically; and drug-related morbidity, including drug-related emergency departments and diagnoses of HIV infections attributable to drug use. For the purposes of this report, these 9 sub-measures are treated as individual measures in the discussion of progress toward achieving the *Strategy* goals, thereby resulting in a total of 13 measures overall for assessing the *Strategy* goals; individual assessments are presented for each of the 13 measures in this report.

Figure 1-1: Progress Assessment Summary for Performance Reporting System Measures

Progress Assessment	Strategy Measures	Objective Measures	Total
Target Met or Exceeded	3	16	19
Progress Sufficient to Meet Target	0	2	2
Progress Required to Meet Target	0	1	1
Insufficient Progress	1	0	1
No Progress to Date	1	2	3
Target Not Met	3	7	10
Progress Cannot be Assessed	5	0	5
Total	13	28	41

Details regarding the progress for *Strategy* and Objective measures follow in Chapters 1 and 2.

For the goals and measures in the PRS, 2009 data were used as the baseline in accordance with the 2011 *Strategy*. If 2009 data were not available, the most current year was used. While this report provides progress toward achieving the 2015 targets there is considerable variation in the availability of the data used to track progress and sometimes data are not available for 2015. For this report, the most recent data available were used.

Table A-1: Summary of Interagency Progress toward Achieving the Goals of the *Strategy*

National Drug Control Strategy Goal/Measure	Progress Status
Strategy Goal 1: Curtail illicit drug consumption in America	
Strategy Measures	
1a: Decrease the 30-day prevalence of drug use among 12–17 year olds by 15%	Insufficient Progress
1b: Decrease the lifetime prevalence of 8th graders who have used drugs, alcohol, or tobacco by 15%	
- Illicit Drugs	Target Not Met
- Alcohol	Target Met or Exceeded
- Tobacco	Target Met or Exceeded
1c: Decrease the 30-day prevalence of drug use among young adults aged 18–25 by 10%	Target Not Met
1d: Reduce the number of chronic drug users by 15%	
Cocaine	Progress Cannot be Assessed*
Heroin	Progress Cannot be Assessed*
Marijuana	Progress Cannot be Assessed*
Methamphetamine	Progress Cannot be Assessed*
Strategy Goal 2: Improve the public health and public safety of the American people by reducing the consequences of drug abuse	
2a: Reduce drug-induced deaths by 15%	Target Not Met
2b: Reduce drug-related morbidity by 15%	
- Emergency room visits for drug misuse and abuse	Progress Cannot be Assessed**
- HIV infections attributable to drug use	Target Met or Exceeded
2c: Reduce the prevalence of drugged driving by 10%	
- Data Source: National Roadside Survey	No Progress to Date
* Data last updated in 2010, data updates pending. Final progress assessment cannot be made.	
**Due to cessation of data availability in 2011 final progress assessment cannot be made.	

Table A-2: Summary of Interagency Progress toward the Objectives of the *Strategy*

Objective 1: Strengthen Efforts to Prevent Drug Use in Our Communities	Assessment
Measure 1.1: Percent of respondents, ages 12–17, who perceive a great risk in smoking marijuana once or twice a week	Target Not Met
Measure 1.2: Percent of respondents, ages 12–17, who perceive a great risk in consumption of one or more packs of cigarettes per day	Target Not Met
Measure 1.3: Percent of respondents, ages 12–17, who perceive a great risk in consuming four or five drinks once or twice a week	Target Not Met
Measure 1.4: Average age of initiation for all illicit drugs	Progress Sufficient to Meet Target
Measure 1.5: Average age of initiation for alcohol use	Target Not Met
Measure 1.6: Average age of initiation for tobacco use	
- Cigarettes	Target Not Met
- Cigars	Target Met or Exceeded
- Smokeless tobacco	Target Met or Exceeded
Objective 2: Seek Early Intervention Opportunities in Health Care	**Assessment**
Measure 2.1: Percent of Federally Qualified Health Center grantees providing SBIRT services	Target Met or Exceeded
Measure 2.2: Percent of respondents in the past year using prescription-type drugs non-medically, age 12 - 17	Target Met or Exceeded
Measure 2.3: Percent of respondents in the past year using prescription-type drugs non-medically, age 18 - 25	Target Met or Exceeded
Measure 2.4: Percent of respondents in the past year using prescription-type drugs non-medically, age 26+	Progress Required to Meet Target
Objective 3: Increasing Access to Treatment and Supporting Long-term Recovery	**Assessment**
Measure 3.1: Percent of treatment plans completed	No Progress to Date
Measure 3.2: Percent of Health Center grantees providing substance abuse counseling and treatment services	Target Not Met
Measure 3.3: Percent of treatment facilities offering at least 4 of the standard spectrum of recovery services (child care, transportation assistance, employment assistance, housing assistance, discharge planning, and after-care counseling)	Target Met or Exceeded
Objective 4: Criminal Justice Reform: Making the System More Effective and Fair	**Assessment**
Measure 4.1: Percent of residential facilities in the Juvenile Justice System offering substance abuse treatment	Target Met or Exceeded
Measure 4.2: Percent of treatment plans completed by those referred by the Criminal Justice System	No Progress to Date
Objective 5: Disrupt Domestic Drug Trafficking and Production	**Assessment**
Measure 5.1: Number of domestic CPOT-linked organizations disrupted or dismantled	Target Met or Exceeded
Measure 5.2: Number of RPOT-linked organizations disrupted or dismantled	Target Met or Exceeded
Measure 5.3 Number of methamphetamine lab incidents	Target Met or Exceeded
Objective 6: Strengthen Law Enforcment and International Partnerships to Reduce the Availability of Foreign Produced Drugs in the United States	**Assessment**
Measure 6.1: Percent of selected countries on the Majors List that increased their commitment to demand reduction	Target Met or Exceeded
Measure 6.2: Percent of selected countries on the Majors List that increased their commitment to supply reduction	Target Met or Exceeded
Measure 6.3: Percent of Majors List countries showing progress since 2009 in reducing either cultivation or drug production potential	Target Not Met
Measure 6.4: Number of international CPOT-linked organizations disrupted or dismantled	Target Met or Exceeded
Objective 7: Improve Information Systems for Analysis, Assessment, and Local Management	**Assessment**
Measure 7.1: Increase timeliness (year-end to date-of-release) of select Federal data sets above their baseline by 10%	
Treatment Episode Data Set (TEDS)	Progress Sufficient to Meet Target
Measure 7.2: Increase the utilization (number of annual web hits, or number of documents referencing the source) of select Federal data sets by 10% from the baseline	
Substance Abuse and Mental Health Data Archive (SAMHDA)	Target Met or Exceeded
National Survey on Drug Use and Health (NSDUH) (Journal artides referencing NSDUH)	Target Met or Exceeded
Measure 7.3: Increase Federal data sets that establish feedback mechanisms to measure usefulness (surveys, focus groups, etc.)	
SAMHSA Funded Data Sets	Target Met or Exceeded

Data Challenges

One of the greatest impediments to acquiring a clear understanding of drug trends is the adequacy of data on the outcomes of drug control activities. The PRS development process resulted in the selection of measures that were supported by the best data available. In cases where optimal measures were not useable because of the lack of data, proxy measures were used. There are limitations to using proxy measures since they represent an option where data choices are imperfect. For instance, the absence of nationally representative data on treatment effectiveness necessitates reliance on proxy measures of rates of treatment completion. In this same vein, the lack of adequate data sources, as they relate to the effectiveness of juvenile and criminal justice reform efforts (beyond treatment provision), similarly prohibits the assessment of these efforts on recidivism. Additionally, deficiencies in national data suitable for performance monitoring required the reliance on proxy measures. An example of such a proxy measure is information collected on the Health Resources and Services Administration's (HRSA) health centers used to assess efforts to integrate substance use disorder treatment services into the nationwide network of treatment facilities. While the use of such proxies is reasonable given the limited data available, it does not provide a full understanding of the issues, challenges, and opportunities present when assessing the progress of interagency efforts toward reducing substance use and its consequences.

Another challenge is the lack of availability of some data sets which can impede understanding of trends and monitoring performance. For example, The Drug Abuse Warning Network (DAWN), discontinued in 2011, was a public health surveillance system that monitored drug-related hospital emergency department visits. DAWN provided data on the consequences of substance use nationally and for selected metropolitan areas. Other data sources on drug-related emergency department visits are in development. In another example, the most recent iteration of the study "What Americans Spend on Illicit Drugs" provided data through 2010 thereby not permitting the tracking of trends through 2015.[2] For the measures informed by DAWN and the study "What Americans Spend on Illicit Drugs" it was not possible to make a final progress assessment. While the data sources for these measures are not currently available, other data sources can provide some context regarding trends. This information is provided in the sections on the affected measures.

Periodically, many Federal data systems undergo redesigns or other enhancements to improve estimation of the variables of interest or to keep pace with improvements in survey technology. In 2015, SAMHSA implemented a long-planned partial redesign of the National Survey on Drug Use and Health (NSDUH) to clarify and provide more accurate estimates of methamphetamine use and the nonmedical use of prescription drugs (especially opioid medications). Previously, questions concerning the use of methamphetamine were asked as part of the prescription drug module. Though methamphetamine is a Schedule II drug and can be prescribed for some conditions, such as attention-deficit disorder, it rarely is. The 2015 NSDUH administered the methamphetamine questions in a manner similar to the questions on the use of other illicit drugs.

Prior to 2015, the screening question on the nonmedical use of prescription drugs did not differentiate among the various motives for such nonmedical use, including taking more than your prescription indicated, continuing to use the medication beyond the date of the prescription, taking someone else's medication for a similar condition (i.e., to relieve pain), or for its psychoactive effect (i.e., to get

[2] The next iteration of the report is being planned; it will update the estimates through 2014.

"high"). The 2015 redesigned questionnaire now permits such disaggregation of motive for using prescription drugs non-medically, which has implications for the responses to address the varying types of motives.

While the NSDUH redesign will ultimately improve data quality and utility, these enhancements to the survey questions resulted in changes in the estimates that cannot be differentiated between methodological artifacts and actual changes in the behavior of interest; therefore, SAMHSA is recommending that data for these measures not be compared to those from 2002-2014. Since the prescription drug and methamphetamine data contribute to the summary prevalence estimate of "any illicit drug use" SAMHSA also recommends that the 2015 data for this indicator not be compared to the estimates for 2002-2014. These changes affect 10 of the 13 PRS measures informed by NSDUH data.[3] The implications for the assessment for each of the affected measures are discussed below.

Among other data challenges was tracking new and unanticipated trends in use and harmful consequences. Examples include the opioid epidemic, the efforts in some states to legalize marijuana use, and increased use of hookahs and e-cigarettes among young people over the time period covered by the PRS.

Future Challenges

A key challenge will be identifying measures and data sources suitable for tracking progress on current issues while at the same time monitoring a range of data to identify emerging threats. In the future an investment in new or expanded data sources may be necessary. There may be a need to assess current data sources to determine if new data items can or should be added. Challenges remain in securing data suitable for tracking performance. Ideally, data appropriate for performance monitoring should be able to:

- Reflect the collective work of multiple contributors;
- Allow documentation of small changes;
- Be regarded as unbiased and from a reliable source;
- Have multi-year funding and be continuous; and
- Be unambiguous and understandable.

Measures that are informed by these data should be:

- Quantifiable;
- Clear in meaning to both analysts and lay readers; and
- A valid indicator (i.e., a plausible indication of success in achieving the measure).

[3] The measures affected are: Measure 1a: Decrease the 30-day prevalence of drug use among 12–17 year olds by 15%; Measure 1c: Decrease the 30-day prevalence of drug use among young adults aged 18–25 by 10%; Measure 1.1: Percent of respondents, ages 12–17, who perceive a great risk in smoking marijuana once or twice a week; Measure 1.2: Percent of respondents, ages 12–17, who perceive a great risk in consumption of one or more packs of cigarettes per day; Measure 1.3: Percent of respondents, ages 12–17, who perceive a great risk in consuming four or five drinks once or twice a week; Measure 1.4: Average age of initiation for all illicit drugs; Measure 1.6: Average age of initiation for tobacco use (smokeless tobacco); Measure 2.2: Percent of respondents in the past year using prescription-type drugs non-medically, age 12 – 17; Measure 2.3: Percent of respondents in the past year using prescription-type drugs non-medically, age 18 – 25; and Measure 2.4: Percent of respondents in the past year using prescription-type drugs non-medically, age 26+.

Given the complexity of drug policy issues and interplay between supply and demand influences, bringing together the collective knowledge and experience of a wide range of individuals will increase the likelihood of success in designing an effective assessment approach. Participating individuals include subject matter experts, policy and program analysts, statisticians, researchers, operational experts, economists, and data experts.

Chapter 1: Progress toward Achieving the Strategy Goals

The Obama Administration's inaugural *Strategy*, published in 2010, established the following two overarching Goals to reduce drug use and its consequences by 2015:

- Goal 1: Curtail illicit drug consumption in America; and
- Goal 2: Improve the public health and public safety of the American people by reducing the consequences of substance use.

For each of the *Strategy* Goals and Objectives, the following definitions are applied to assess progress:

- **Target Met or Exceeded** *(Given the data available at this time, progress should be maintained.)*
- **Progress Sufficient to Meet Target** *(Given the data available at this time, there is a reasonable expectation that the target will be met.)*
- **Progress Required to Meet Target** *(Movement toward the target is in the right direction; based on the data available at this time, additional efforts are required.)*
- **Insufficient Progress** *(Movement toward the target is moderate; based on the data available at this time, significant progress is required to meet target.)*
- **No Progress to Date, or, Target Not Met** *(For 'No Progress to Date', movement toward the target is stalled or not in the right direction. For 'Target Not Met', based on 2015 or the most recent available data, target was not achieved.)*
- **Progress Cannot be Assessed** *(The category 'Progress Cannot be Assessed' is used where data updates are pending or a cessation of data availability occurred before a final progress assessment could be determined.)*

The *Strategy*, developed through an extensive consultation process with Federal, state, local, and tribal partners, addressed the Nation's call for a balanced policy of prevention, treatment, recovery, enforcement, and international cooperation. It also reflected the close collaboration between ONDCP and its Federal drug control agency partners in undertaking evidence-based programs, policies, and practices to achieve desired performance outcomes by 2015.

Both of the *Strategy's* Goals have been strongly supported by domestic and international programs and activities to reduce the availability of illicit drugs. Efforts to reduce the supply of drugs and enforce the laws of the United States are focused on decreasing crime, increasing the protection of U.S. borders, disrupting trafficking networks, and curtailing the international and domestic production of drugs.

The *Strategy* calls for a 10-15 percent reduction over 5 years in the rate of young adult drug use, chronic drug use, and drug-related consequences, such as drug-related morbidity and drugged driving. Seven measures (3 of the measures have more than one sub-measure so that, in effect, there are 13 measures in total) were developed to assess progress (see Table 1-1) toward achieving the two Goals of curtailing illicit drug consumption in America and improving the public health and public safety of the American people by reducing the consequences of drug use. This chapter describes each of the seven *Strategy* measures along with their baselines, 2015 targets, data sources, and assessments of progress-to-date.

Table 1-1: National Drug Control *Strategy* Goals & Measures, Baselines, Targets, and Progress to Date – *Strategy* Goal 1, Measures 1a, 1b, and 1c

National Drug Control Strategy Goal/Measure	Baseline	Progress-to-date	2015 Target	Progress Status
Strategy Goal 1: Curtail illicit drug consumption in America				
Strategy Measures				
1a: Decrease the 30-day prevalence of drug use among 12–17 year olds by 15%	10.1% (2009) NSDUH	2015: NC* 2014: 9.4% 2013: 8.8% 2012: 9.5% 2011: 10.1% 2010: 10.1%	8.6%	Insufficient Progress
1b: Decrease the lifetime prevalence of 8th graders who have used drugs, alcohol, or tobacco by 15%				
- Illicit Drugs	19.9% (2009) MTF	2015: 20.5% 2014: 20.3% 2013: 21.1% 2012: 18.5% 2011: 20.1% 2010: 21.4%	16.9%	Target Not Met
- Alcohol	36.6% (2009) MTF	2015: 26.1% 2014: 26.8% 2013: 27.8% 2012: 29.5% 2011: 33.1% 2010: 35.8%	31.1%	Target Met or Exceeded
- Tobacco	20.1% (2009) MTF	2015: 13.3% 2014: 13.5% 2013: 14.8% 2012: 15.5% 2011: 18.4% 2010: 20.0%	17.1%	Target Met or Exceeded
1c: Decrease the 30-day prevalence of drug use among young adults aged 18–25 by 10%	21.4% (2009) NSDUH	2015: NC* 2014: 22.0% 2013: 21.5% 2012: 21.3% 2011: 21.4% 2010: 21.6%	19.3%	Target Not Met
* 2015 values are not comparable due to methodological changes in NSDUH.				

See Appendix C for information about data sources

Table 1-1, continued: National Drug Control Strategy Goals & Measures, Baselines, Targets, and Progress to Date – Strategy Goal 1, Measure 1d

National Drug Control Strategy Goal/Measure	Baseline	Progress-to-date	2015 Target	Progress Status
1d: Reduce the number of chronic drug users by 15%				
Cocaine	2.7 million (2009) What Americans Spend on Illicit Drugs	2010: 2.5 million	2.3 million	Progress Cannot be Assessed *
Heroin	1.5 million (2009) What Americans Spend on Illicit Drugs	2010: 1.5 million	1.3 million	Progress Cannot be Assessed*
Marijuana	16.2 million (2009) What Americans Spend on Illicit Drugs	2010: 17.6 million	13.8 million	Progress Cannot be Assessed*
Methamphetamine	1.8 million (2009) What Americans Spend on Illicit Drugs	2010: 1.6 million	1.5 million	Progress Cannot be Assessed*
* Data last updated in 2010, data updates pending. Final progress assessment cannot be made.				

Table 1-1, continued: National Drug Control *Strategy* Goals & Measures, Baselines, Targets, and Progress to Date – *Strategy* Goal 2

National Drug Control Strategy Goal/Measure	Baseline	Progress-to-date	2015 Target	Progress Status
Strategy Goal 2: Improve the public health and public safety of the American people by reducing the consequences of drug abuse				
2a: Reduce drug-induced deaths by 15%	39,147 (2009) National Vital Statistics	2015: 55,403 2014: 49,714 2013: 46,471 2012: 43,819 2011: 43,544 2010: 40,393	33,275	Target Not Met
2b: Reduce drug-related morbidity by 15%				
- Emergency room visits for drug misuse and abuse	2,070,452 (2009) DAWN	2012: NA 2011: 2,462,948 2010: 2,301,050	1,759,884	Progress Cannot be Assessed*
- HIV infections attributable to drug use	5,799 (2009) CDC	2014: 3,852 2013: 4,366 2012: 4,342 2011: 4,513 2010: 5,138	4,929	Target Met or Exceeded
2c: Reduce the prevalence of drugged driving by 10%				
- Data Source: National Roadside Survey	16.3% (2007) NHTSA	2013-2014 20.0%	14.7%	No Progress to Date
* Due to cessation of data availability in 2011, final progress assessment cannot be made.				

Assessment of Progress

Thirteen performance measures are used to assess progress toward achieving the *Strategy's* goals of curtailing illicit drug consumption in America and improving the public health and public safety of the American people by reducing the consequences of drug use. The following paragraphs discuss the final assessment of the Nation's progress toward reaching these goals.

Of the 13 performance measures identified to assess progress in the *Strategy*, three met or exceeded the targets set in 2009. The first two measures include decreasing the lifetime prevalence of alcohol use and tobacco use among 8th graders by 15 percent by 2015. By 2015, alcohol use among 8th graders had dropped to 26.1 percent, and tobacco use had fallen to 17.1 percent. These numbers are 16 percent and 22 percent, respectively, below the targets set in 2009. The third measure, reducing HIV infections attributable to injection drug use, exceeded the target of 4,929 newly diagnosed HIV infections attributable to drug use by 22 percent (3,852) newly diagnosed HIV infections attributable to drug use) one year earlier than the target of 2015. One measure, 30-day prevalence of drug use by youth ages 12 to 17, shows insufficient progress toward its goal of 8.6 percent.

Two measures, the prevalence of lifetime illicit drug use by 8th graders and 30-day prevalence of drug use among young adults aged 18-25 did not meet their targets of 16.9 percent and 19.3 percent respectively. Two other measures, the prevalence of people who drive after using drugs and reducing the number of drug-induced deaths showed no progress to date in reaching their targets of 14.7% and 33,275 respectively. Lifetime prevalence of drug use by 8th graders increased to 20.5 percent in 2015, which is 0.6 of a percentage point above the 2009 baseline and nearly 4 percentage points above the 2015 target. The most recent prevalence data available indicate that past 30-day drug use among young adults aged 18-25 has remained unchanged since 2009. This measure is driven primarily by the prevalence of marijuana use, which was unchanged over this period of time. Prevalence of drugged driving increased to 20.0, percent which is 23 percent above the 2009 baseline of 16.3 percent.[4] Below is a specific discussion of the progress for each of the measures.

Four measures addressing chronic use of cocaine, heroin, marijuana, and methamphetamine progress could not be assessed due to a lack of availability of updated data. Though 2015 data are not available for these measures at the time of publication of this report, the available data or other related data suggest that is unlikely that the Nation will achieve these targets. The most recent data available on the use of marijuana and heroin indicate that the prevalence of use of these drugs may be moving in the wrong direction, which suggests that the number of people who use these two drugs chronically also may be increasing. Vital statistics data show that the number of drug-induced deaths rose 27 percent from 2009 to 2014, and preliminary information suggests that this metric may continue to move in the wrong direction, even though progress has been made in the implementation of overdose reversal protocols across many states. Similarly, progress could not be assessed regarding the number of drug-related emergency room visits. This measure was informed by data from the Drug Abuse Warning System (DAWN); the DAWN data system was discontinued in 2011. The Substance Abuse and Mental Health Services Administration (SAMHSA), the National Center for Health Statistics, and the Food and Drug Administration are collaborating on a new effort to collect drug-related emergency department data. Data collection began in calendar year 2016, and preliminary findings are expected to be available by the end of calendar year 2017.

[4] The 2013/2014 National Roadside Survey results are used as the terminal data for this measure.

Measure 1 a: Decrease the 30-day prevalence of drug use among 12- to 17-year-olds by 15%

The data for this measure are drawn from SAMHSA's National Survey on Drug Use and Health (NSDUH),which provides annual data on the substance use behavior of civilian, non-institutionalized populations 12 years of age and older, including ages of initiation for each substance. Included in the nearly 70,000 annual respondents are college students in dormitories, people living in homeless shelters, and civilians living on military bases. A 2009 baseline estimate of 10.1 percent was established for the measure, with a 2015 target of 8.6 percent.

After two years of trending toward achieving the 2015 target of 8.6 percent, estimates for past 30-day illicit drug use among 12-to-17-year-olds, increased from 8.8 percent in 2013 to 9.4 percent in 2014. This is approximately 9 percent above the 2015 target. This most recent increase appears to be driven by a 20 percent increase in illicit drug use other than marijuana (from 3.0% in 2013 to 3.6% in 2014). However, prior to 2014 the rate of use of illicit drugs other than marijuana among youth had been dropping steadily from 4.6 percent in 2009 to 3.0 percent in 2013.

As noted above, this measure is one of the two used to assess the Nation's progress toward achieving the *Strategy's* goals that is affected by the 2015 redesign of the NSDUH. In order to achieve the target, the 2015 estimate would have had to drop by 0.8 of a percentage point. The 2015 NSDUH for the prevalence of marijuana use among youth, for which there is not a break in the trend, indicates there was no change from the 2014 estimate. Coupled with the trend for the rate of use of drugs other than marijuana, it is possible that the Nation may have achieved this target, but due to the break in the trend resulting from the 2015 re-design, it is not possible to make a definitive statement; therefore, this measure has been rated as "insufficient progress".

Measure 1 b: Decrease the lifetime prevalence of 8th graders who have used drugs, alcohol, or tobacco by 15 percent

The data for this measure are taken from the Monitoring the Future (MTF) study, which is supported by the National Institute on Drug Abuse (NIDA). The MTF data on the use of drugs, alcohol, or tobacco[5] by 8th grade students are not combined within the study and are presented here separately, resulting in three measures. The 2009 baselines are (1) any illicit drug, 19.9 percent; (2) alcohol, 36.6 percent; and (3) tobacco/cigarettes, 20.1 percent. The 2015 targets are (1) any illicit drug, 16.9 percent; (2) alcohol, 31.1 percent; and (3) tobacco/cigarettes, 17.1 percent.

According to data from the 2015 MTF study, the Nation met the targets for reducing lifetime use of alcohol and cigarettes among 8th graders: 27 percent for alcohol and 33 percent for cigarettes. Until 2012, the Nation was on target for achieving the goal for illicit drugs; however, by 2015, illicit drug use among 8th graders had increased to 20.5 percent which is 3 percent above the 2009 baseline level of 19.9 percent and 21 percent above the 2015 target of 16.9 percent; therefore, the Nation did not meet the target for this measure. Figures 2-1, 2-2, and 2-3 below depict the trends for this measure.

[5] For the purposes of the PRS, tobacco use was defined as the use of cigarettes. Although the Monitoring the Future Study —the data source for this measure—asks questions about other forms of tobacco use, including small cigars, smokeless, hookahs, dissolvable, and in 2014, e-cigarettes, some of these are asked only of seniors. The MTF does not report an overall estimate for all tobacco products combined. It was the consensus of the interagency group who assisted in developing the PRS measures that cigarette use would be the proxy measure for tobacco use.

Figure 2-1: Illicit Drug Use by 8th Graders Over Time in Reference to 2015 Target

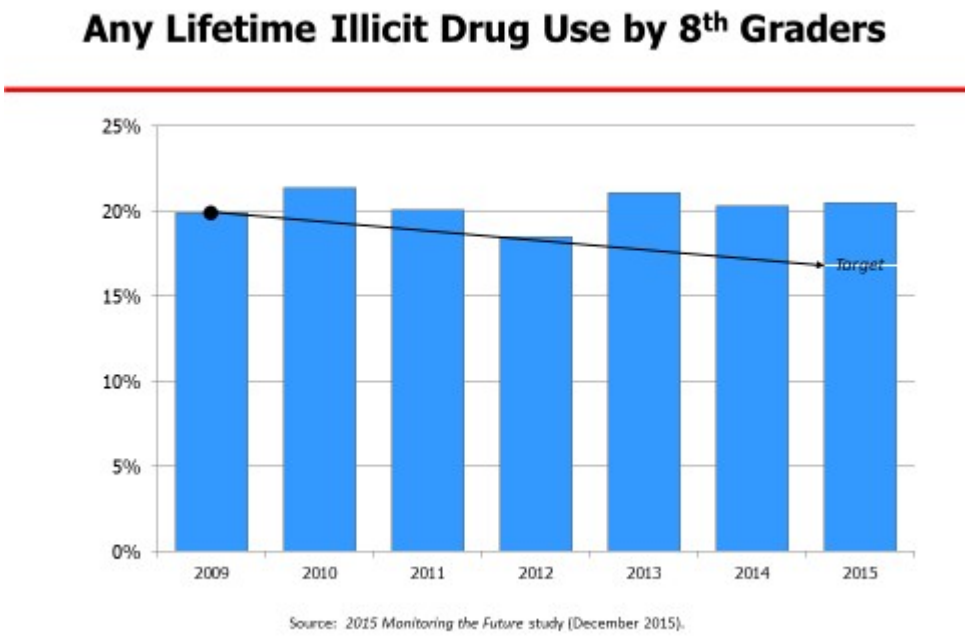


Figure 2-2: Alcohol Use by 8th Graders Over Time in Reference to 2015 Target

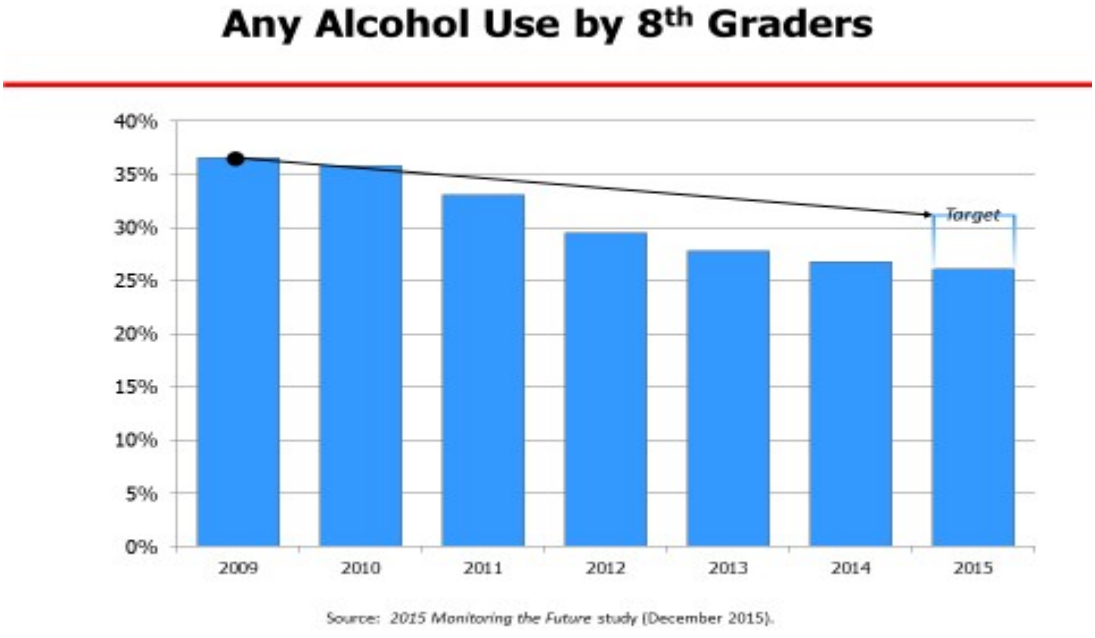
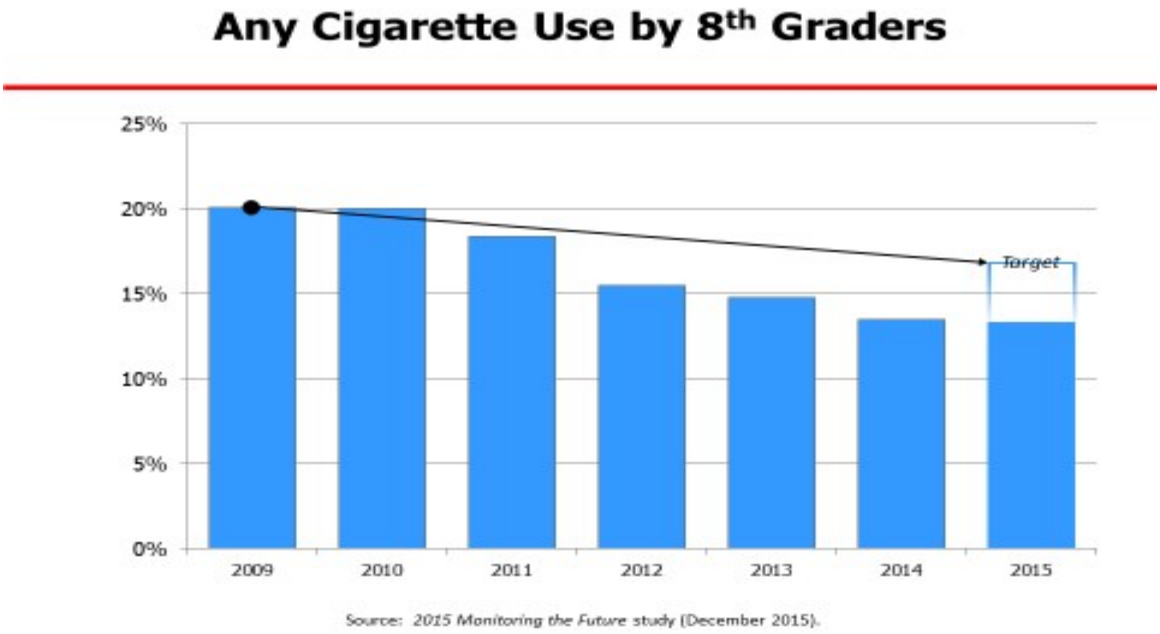


Figure 2-3: Cigarette Use by 8th Graders Over Time in Reference to 2015 Target



Measure 1c: Decrease the 30-day prevalence of drug use among young adults aged 18–25 by 10 percent

The data for this measure are taken from the NSDUH, with a 2009 baseline estimate of 21.4 percent and a 2015 target of 19.3 percent. As noted above, the 2015 NSDUH underwent a partial re-design that resulted in data from 2015 not being comparable to data from earlier years. This is the second of two *Strategy* goal measures for which there is a break in the trend due to the re-design. With respect to the reduction in the use of any illicit drug among young adults, the *Strategy* set a goal of reducing such use by 10 percent, from 21.4 percent in 2009 to 19.3 percent by 2015. Between 2009 and 2014, past 30 day use of any illicit drug showed no change from the 2009 baseline estimate. It is therefore unlikely that in the absence of the re-design the data would suggest that the Nation made up the needed deficit in one year and achieved the 2015 target. Consequently, this measure is assessed as "target not met".

The primary reason for this lack of success is the continued and unchanging high prevalence of past month marijuana use among young adults – nearly 20 percent since 2009. However, when marijuana is excluded from the estimation of illicit drug use, the Nation more than doubled the targeted reduction by 2014 – a 24 percent decline from 2009 to 2014. This decline was been driven by a 25 percent decline in past-month non-medical use of prescription drugs overall, which, in turn, was driven by a 31 percent decline in past-month non-medical use of opioid medications.

Measure 1 d: Reduce the number of chronic drug users by 15 percent

There are four measures for assessing progress in reducing the number of people who use drugs chronically, one for each of the four major drugs: cocaine, heroin, marijuana, and methamphetamine. The data for assessing these measures are from the 2010 report, What America's Users Spend on Illegal Drugs: 2000-20106 (ONDCP 2014). As noted above, data from this report are available only through 2010, and therefore, a final progress assessment for this measure cannot be made. This report estimates the retail value of the illicit drug market. In producing these estimates, two other estimates are calculated: the number of people who use (occasional and chronic) each of the four major drugs (marijuana, cocaine, heroin, and methamphetamine) and the amount of each drug consumed by these individuals. The latest estimates of drug consumption, including the number of people who used drugs chronically, are only available through 2010. Other measures such as illicit crop cultivation, mortality, seizures, and workplace drug testing positive rates provide indications of trends since 2010. Progress toward achieving each of these measures is discussed below.

Cocaine: In 2010, there were 200,000 fewer individuals estimated to be using cocaine chronically than in 2009 (2.7 million). This reduction was consistent with the downward trending estimates of the amount of drugs consumed from 2009 (161 metric tons) to 2010 (145 metric tons). However, several cocaine indicators focusing on availability and initiation appear to be moving in the wrong direction including a doubling in Colombian coca cultivation from 2013 to 2015 and a 27 percent increase the number of Americans initiating use of cocaine (601,000 in 2013 to 766,000 in 2014).

Heroin: The number of people who used heroin chronically remained stable at 1.5 million between 2009 and 2010. However, several other indicators used to measure heroin availability and its consequences suggest that the number of people using heroin chronically may have increased since 2010 including a 150 percent increase Mexican opium poppy cultivation from 2013 to 2015 and a 248 percent increase in drug overdose deaths involving heroin from 2010 to 2014.

Marijuana: The 2009 estimate of the number of people who used marijuana chronically (16.2 million) increased to 17.6 million in 2010, moving away from the 2015 target number of 13.8 million. Indicators that estimate the amount of drugs consumed increased from 5.1 metric tons in 2009 to 5.7 metric tons in 2010 and NSDUH found that marijuana use has increased from 8.7 percent in 2009 to 10.2 percent in 2014 among the general population 12 and older.

Methamphetamine: The 2009 estimate of 1.9 million people who use methamphetamine chronically decreased to 1.6 million in 2010 and it appeared to be on track to meet the 2015 target of 1.5 million people who chronically used methamphetamine. However, other data indicators of methamphetamine use and availability appear to be moving in the wrong direction. The amount of consumed methamphetamine increased during this same period from 40 metric tons consumed in 2009 to 42 metric tons consumed in 2010. Estimated methamphetamine use among individuals 12 and older doubled from 0.1 percent in 2010 to 0.2 percent 2011 and remained constant through 2014. Domestic seizure submissions to forensic labs increased 48 percent between 2010 and 2014 and Southwest Border seizures rose 215 percent between 2010 and 2015.

[6] The report defines chronic use of cocaine, heroin, and methamphetamine as use of the drug on four or more days per month—essentially once per week. For marijuana there are three categories of chronic use: weekly (4 to 10 days per month); more than weekly (11 to 20 days per month); and daily/near daily (21 or more days per month). Occasional use for all four drugs is defined as use less than four times per month.

Measure 2 a: Reduce drug-induced deaths by 15 percent

The data for this measure are taken from Vital Statistics Data compiled by the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS), which includes data from all death certificates filed in the 50 states and the District of Columbia. NCHS tabulates deaths attributable to various causes, including drug-induced mortality. Causes of death attributable to drugs include accidental or intentional poisonings by drugs, drug psychoses, drug dependence, and nondependent use of drugs. Drug-induced causes exclude accidents, homicides, and other causes indirectly related to drug use.

The target has not been met in achieving the target for reducing drug-induced deaths. In 2009, there were 39,147 drug-induced deaths; 37,004 of these were drug poisoning deaths and 20,848 of those were reported to involve prescription drugs. The 2015 target strives to reduce the number of drug-induced deaths by 15 percent (33,275). In 2015, there were 55,403 drug-induced deaths, an increase of 42 percent compared to 2009. Of the 55,403 drug-induced deaths in 2015, 52,404 (94 percent) were drug poisonings, the majority of which (31,181) involved prescription drugs, especially opioid medications (24,508).[7]

Measure 2 b: Reduce drug-related morbidity by 15 percent

There are two measures assessing drug-related morbidity. The first examines drug-related emergency department visits. The data source for this measure is estimates from the Drug Abuse Warning Network (DAWN) of drug-related emergency department (ED) visits. The second measure assesses the number of people newly diagnosed with HIV who were infected through injection drug use. Data for the number of people newly diagnosed with HIV infection are compiled by CDC (CDC February 2015, November 2015).[8]

The 2009 baseline estimate for drug-related ED visits is 2,070,452. In 2011, the latest data that is available from DAWN, the number of people going to the emergency room for drug misuse and abuse was moving in the wrong direction with 2,462,948 visits in 2011. This increase was attributable to rises in visits related to both illicit drugs and prescription drugs. In 2011, there were 1,252,500 visits related to illicit drugs, up from 974,392 such visits in 2009. Likewise, in 2011, there were 1,428,145 ED visits related to prescription drugs, up from 1,243,606 in 2009.

The 2009 baseline estimate of the number of individuals with newly diagnosed HIV infection acquired through injected drug use (IDU) is 5,799 (which includes those in the transmission category of male-to-male sexual contact and IDU); the 2015 target strives to lower this number by 15 percent to 4,929. The 2014 data show that 3,852 individuals were diagnosed with drug-related HIV infection, indicating that the 2015 target has been exceeded.

[7] Of note, not all drug poisoning deaths report the drug(s) involved; a death can involve more than one drug, so any drug-specific involvement in a death should be considered floor estimates.

[8] The data source for this measure was changed in 2015 on the advice of CDC staff from cases of incidence of drug-related HIV to diagnoses of such cases since the estimates of the incident cases are not expected to be produced in time to be useful in assessing progress toward achieving this measure.

Measure 2 c: Reduce the prevalence of drugged driving by 10 percent

The data source for this measure is the National Roadside Survey conducted by the National Highway Traffic Safety Administration (NHTSA). The Roadside Survey is a nationally representative survey of drivers on U.S. roads. The baseline survey, conducted in 2007, found that 16.3 percent of weekend, nighttime drivers tested positive for the presence of at least one illicit drug or medication (with the ability to impair driving skills). The 2015 target is 14.7 percent. The follow-up survey was conducted in 2013-2014 and found that the prevalence of nighttime weekend driving after consuming drugs or medications rose to 20.0 percent. Consequently, this measure is assessed as no progress to date.

Conclusion

Progress in implementing the President's *Strategy* over this next year and beyond will require a comprehensive effort that includes Federal, state, local, tribal, and territorial government agencies, international institutions and partner nations, nongovernmental organizations, academia, private industry, and American citizens from all walks of life. The Administration looks forward to a continued partnership with Congress to address the problem of illicit drug use, which affects all of our lives.

Chapter 2: Progress toward Achieving the Objectives of the *Strategy*

The objectives of the *Strategy* include preventing drug use, seeking early intervention, integrating treatment into health care, expanding support for recovery services, breaking the cycle of drug use and crime, disrupting domestic drug trafficking and production, strengthening international partnerships, and improving information systems. Described in more detail in this chapter are the assessments of measures to gauge progress toward achieving each of the objectives using the most recent and relevant data available.

Objective 1 - Strengthen Efforts to Prevent Drug Use in Our Communities

As one of the Administration's drug policy priorities, prevention activities seek to communicate key messages about drug use through multiple sources. Preventing drug use before it begins, particularly among young people, is an effective and cost-effective way to reduce drug use and its consequences. Table 2-1 below provides a summary of the measures, baselines, targets, and progress assessments for this Objective. Information on data sources can be found in Appendix C.

Table 2-1: Objective 1 Measures, Baselines, Progress-to-date, Targets, and Assessment – Measures 1.1 to 1.5

Objective 1 Measure	Baseline	Progress-to-date	2015 Target	Assessment
Measure 1.1: Percent of respondents, ages 12–17, who perceive a great risk in smoking marijuana once or twice a week	49.0% (2009) NSDUH	2015: NC* 2014: 37.4% 2013: 39.5% 2012: 43.6% 2011: 44.8% 2010: 47.2%	51.2%	Target Not Met
Measure 1.2: Percent of respondents, ages 12–17, who perceive a great risk in consumption of one or more packs of cigarettes per day	65.5% (2009) NSDUH	2015: NC* 2014: 66.3% 2013: 64.3% 2012: 65.7% 2011: 66.2% 2010: 65.3%	68.0%	Target Not Met
Measure 1.3: Percent of respondents, ages 12–17, who perceive a great risk in consuming four or five drinks once or twice a week	39.6% (2009) NSDUH	2015: NC* 2014: 39.2% 2013: 39.0% 2012: 39.7% 2011: 40.7% 2010: 40.4%	41.4%	Target Not Met
Measure 1.4: Average age of initiation for all illicit drugs	17.6 years (2009) NSDUH	2015: NC* 2014: 19.0 2013: 19.0 2012: 18.7 2011: 18.1 2010: 19.1	19.5	Progress Sufficient to Meet Target
Measure 1.5: Average age of initiation for alcohol use**	16.9 years (2009) NSDUH	2015: 18.0 2014: 17.3 2013: 17.3 2012: 17.4 2011: 17.1 2010: 17.1	21.0 years	Target Not Met
* 2015 values are not comparable due to methodological changes in NSDUH.				
** Target of 21 years is an ambitious stretch target consistent with the legal age for alcohol consumption.				

Table 2-1, continued: Objective 1 Measures, Baselines, Progress-to-date, Targets, and Assessment – Measure 1.6

Objective 1 Measure	Baseline	Progress-to-date	2015 Target	Assessment
Measure 1.6: Average age of initiation for tobacco use*				
- Cigarettes	17.5 years (2009) NSDUH	2015: 17.9 2014: 18.6 2013: 17.8 2012: 17.8 2011: 17.2 2010: 17.3	18.0 years**	Target Not Met
- Cigars	20.7 years (2009) NSDUH	2015: 20.9 2014: 20.4 2013: 21.6 2012: 20.5 2011: 19.6 2010: 20.5	18.0 years**	Target Met or Exceeded
- Smokeless tobacco	18.9 years (2009) NSDUH	2015: NC*** 2014: 19.0 2013: 18.4 2012: 18.8 2011: 19.8 2010: 19.3	18.0 years**	Target Met or Exceeded
* Since NSDUH reports data according to tobacco product, the assessment is made separately for cigarettes, cigars, and smokeless tobacco.				
** Target consistent with legal of age of tobacco sales set forth in Family Smoking Prevention and Tobacco Control Act of 2009.				
*** 2015 values are not comparable due to methodological changes in NSDUH.				

See Appendix C for information about data sources.

Assessment of Progress

The following sections discusses the data sources, targets, progress made to date, and if future is action required to achieve each of the measures comprising Objective 1: Strengthen Efforts to Prevent Drug Use in Our Communities.

Measure 1.1: Percent of respondents, ages 12 – 17, who perceive a great risk in smoking marijuana once or twice a week

The data for this measure are from SAMHSA's NSDUH. Due to the NSDUH re-design the most recent data are from 2014. It is unlikely that in the absence of the re-design the data would suggest that the Nation made up the needed deficit in one year and achieved the 2015 target. Consequently, this measure is assessed as "target not met". The percentage of youth, 12 to 17, perceiving great risk in smoking marijuana once or twice a week has trended downward from 49.0 percent in 2009 to 37.4 percent in 2014. Additionally, the rate of those reporting great risk in smoking marijuana once a month has declined from 30.3 percent in 2009 to 22.9 percent in 2014. Perceived risk is an important variable and has been a leading indicator of use.

Measure 1.2: Percent of respondents, ages 12 – 17, who perceive a great risk in consumption of one or more packs of cigarettes per day

The data for this measure are from SAMHSA's NSDUH. Cigarette use in adolescence not only negatively affects physical health and development, but also is associated with (though not sufficient on its own) future illicit substance use (U.S. Department of Health and Human Services, 2012). Thus, perception of risk of cigarette use is an important indicator of youth drug use behavior. Due to the NSDUH re-design the most recent data are from 2014. It is unlikely that in the absence of the re-design the data would suggest that the Nation made up the needed deficit in one year and achieved the 2015 target. According to the 2014 NSDUH, the percentage of youth aged 12 to 17 who reported great risk in smoking one or more packs of cigarettes per day increased from 65.5 percent in 2009 to 66.3 percent in 2014.

Measure 1.3: Percent of respondents, ages 12 –17, who perceive a great risk in consuming four or five drinks once or twice a week.

The data for this measure are from SAMHSA's NSDUH. Binge drinking and heavy drinking are associated with a range of adverse consequences including alcohol poisoning, traffic crash injuries and fatalities, risky behavior, violent behavior, and an increased risk for alcohol use disorders. In the NSDUH, binge drinking is defined as having five or more drinks on the same occasion on at least 1 day in the 30 days prior to the survey. Heavy alcohol use is defined as five or more drinks on the same occasion on each of 5 or more days in the past 30 days.[9] According to the 2014 NSDUH, 39.2 percent of youth ages 12-17 perceived great risk in having 4 or 5 or more drinks of an alcoholic beverage once or twice a week as compared to 39.6 percent in 2009. Due to the NSDUH re-design the most recent data are from 2014. It is unlikely that in the absence of the re-design the data would suggest that the Nation made up the needed deficit in one year and achieved the 2015 target of 41.4 percent.

Measure 1.4: Average age of initiation for all illicit drugs

According to the NSDUH, about 3.0 million persons aged 12 or older used an illicit drug for the first time in 2014, averaging about 8,200 new users per day; this is similar to the number in 2013. Over half (51.5 percent) of those who reported first time illicit drug use were younger than age 18. The average age of initiation among persons aged 12 to 49 was 19.0 years; this is the same as the 2013 estimate and represents an increase over the 2009 baseline age of 17.6 years. Movement toward the target of 19.5 years is in the right direction. Given the data available at this time, progress is sufficient to meet the target.

Measure 1.5: Average age of initiation for alcohol use

The 2014 NSDUH estimates that approximately 4.7 million persons aged 12 or older used alcohol for the first time within the past 12 months; averaging approximately 12,700 initiates per day. Most (81.1%) were younger than age 21 at the time of initiation, and over one half (56.2%) initiated use prior to age 18. The average age of first alcohol use among recent initiates aged 12 to 49 years is 18.0 years. There has been some progress, however, based on 2015 NSDUH data the target has not been met. The age of 21 is a "stretch target" and was selected with the awareness it would be a challenge to achieve by

[9] These levels are not mutually exclusive categories of use; heavy use is included in estimates of binge and current use, and binge use is included in estimates of current use.

2015. The measure was selected in the context of the legal age for alcohol use, a target that is consistent with the standard set forth in the National Minimum Drinking Age Act of 1984.

Measure 1.6: Average age of initiation for tobacco use

The 2014 NSDUH reported that there were approximately 2.2 million persons aged 12 or older who smoked cigarettes for the first time within the past 12 months, which was similar to the 2013 estimate (2.1 million). This averages to about 5,900 new cigarette smokers per day. Less than half of them (44.1%) began smoking before they were 18 years old. The NSDUH provides data for specific tobacco products - cigarettes, cigars, and smokeless tobacco. Therefore, the PRS considers each as a separate measure; assessments for each measure are as follows:

Cigarettes - the 2015 target age of 18.0 (which was selected in the context of the legal age for tobacco use). According to the 2015 NSDUH, among past-year initiates aged 12 to 49, the average age of first cigarette use was 17.9 years. While the measure was not met, it was nearly met being only 0.1 years shy of the target.

Cigars - the 2015 target of 18.0 years has been exceeded. Among past year cigar initiates aged 12 to 49, the average age at first use was 20.7 years in 2009 and 20.4 years in 2014. The 2014 NSDUH estimates that 2.6 million persons, aged 12 or older, used cigars for the first time in the past 12 months, which is similar to the 2013 estimate (2.8 million).

Smokeless Tobacco - the 2015 target of 18.0 years has been exceeded. According to the 2014 NSDUH, the average age of first use among 12-49 year olds was 19.0 years, similar to the 2009 (18.9 years) and 2013 (18.4 years) averages. The numbers of persons who initiated the use of smokeless tobacco in the past year were estimated at 1.3 million in 2011, 1.0 million in 2012, 1.1 million in 2013, and 1.0 million in 2014.

Objective 2 - Seek Early Intervention Opportunities in Health Care

Full implementation of the health care reforms under the Affordable Care Act and parity[10] will extend access to substance use disorder treatment services for an estimated 62 million Americans and help integrate treatment into mainstream health care (Berino, K. et al., 2013). To meet the anticipated increase in demand for health care services, the number of specially trained professionals should be increased; the health care system should adopt and integrate evidence-based approaches; and tools to enable the detection and treatment of substance use disorders should be fully utilized, such as Screening, Brief Intervention, and Referral to Treatment (SBIRT). The treatment provided must be effective to achieve desired outcomes. Hence, assessment of progress toward achieving this Objective concentrates on the availability of SBIRT and the effectiveness of treatment for the non-medical use of prescription drugs, fatalities from which have reached epidemic proportions according to the CDC (Centers for Disease Control and Prevention, 2011). Table 2-2 below outlines the measures, targets, and progress-to-date for this Objective.

[10]The Affordable Care Act builds on the Mental Health Parity and Addiction Equity Act of 2008 to extend Federal parity protections. The parity law aims to ensure that when coverage for mental health and substance use conditions is provided, it is generally comparable to coverage for surgical and other medical care.

Table 2-2: Objective 2 Measures, Baselines, Progress-to-date, Targets, and Assessment

Objective 2 Measure	Baseline	Progress-to-date	2015 Target	Assessment
Measure 2.1: Percent of Health Center grantees providing SBIRT services	10.3% (2009) UDS	2015: 29.5% 2014: 21.1% 2013: 16.9% 2012: 13.8% 2011: 11.3% 2010: 11.3%	15.0%	Target Met or Exceeded
Measure 2.2: Percent of respondents in the past year using prescription-type drugs non-medically, age 12 - 17	7.7% (2009) NSDUH	2015: NC* 2014: 6.2% 2013: 5.8% 2012: 6.6% 2011: 7.0% 2010: 7.4%	6.5%	Target Met or Exceeded
Measure 2.3: Percent of respondents in the past year using prescription-type drugs non-medically, age 18 - 25	15.0% (2009) NSDUH	2015: NC* 2014: 11.8% 2013: 12.2% 2012: 13.7% 2011: 12.7% 2010: 14.3%	12.8%	Target Met or Exceeded
Measure 2.4: Percent of respondents in the past year using prescription-type drugs non-medically, age 26+	4.7% (2009) NSDUH	2015: NC* 2014: 4.5% 2013: 4.8% 2012: 5.1% 2011: 4.3% 2010: 4.8%	4.0%	Progress Required to Meet Target
* 2015 values are not comparable due to methodological changes in NSDUH.				

See Appendix C for information about data sources.

Assessment of Progress

The following sections discuss the data sources, targets, progress made to date, and if future action is required to achieve each of the measures comprising Objective 2: Seek Early Intervention Opportunities in Health Care.

Measure 2.1: Percent of Health Center grantees providing Screening, Brief Intervention, and Referral to Treatment services

This measure tracks the expansion of SBIRT services among HRSA Health Center Program grantees. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with, or at risk for developing, substance use disorders. HRSA's health center grantees provide services to over 24 million people, many of whom are medically underserved, and report data annually on the services they provide for monitoring within HRSA's Uniform Data System (UDS). HRSA's UDS warehouses service provider data on its grantees; however, no national source of data is available for all health care providers. In the absence of data on the aggregate performance of all health care providers and facilities nationwide, this HRSA grantee measure is used as a proxy for the greater expansion of screening services in primary care settings.

HRSA is working with health centers to integrate SBIRT services into primary care through the SAMHSA/HRSA Center for Integrated Health Solutions, , and state and national trainings and

meetings. Based on 2015 UDS data, the 2015 target of having 15 percent of health centers providing SBIRT services has been exceeded , with 29.5 percent of them having done so.

Measure 2.2: Percent of respondents in the past year using prescription-type drugs non-medically, ages 12 – 17

The illicit or non-therapeutic use of any substance by young people is cause for concern, especially because substance use at a young age increases the likelihood of a chronic substance use disorder at a later age. (McCabe, S. et al, 2007; DeWit, D. et al, 2000) Given the data available at this time, the 2015 target of 6.5 percent has been exceeded. The 2014 NSDUH reported that the percentage of youth aged 12-17 who used prescription drugs non-medically in the past year was 7.7 percent in 2009, dropping to 6.2 percent in 2014.

Measure 2.3: Percent of respondents in the past year using prescription-type drugs non-medically, ages 18-25

Data from the 2014 NSDUH indicate that this age group (18-25) had the highest rate of past year non-medical use of prescription drugs (11.8%), as compared to the other two age groups (6.2%for 12-17 year olds and 4.5%for those aged 26 and over). Non-medical use of prescription drugs ranked second only to marijuana use among 18-25 year olds. While past- year non-medical use of prescription drugs remains a persistent risk to young adults, the 2014 estimate of 11.8 percent exceeded the 2015 target of 12.8 percent. Of note, 18-25 years is the primary age group for initiating use of all classes of prescription drugs. Among 12-49 year olds, the average ages of those initiating non-therapeutic use of prescription drugs were 21 years for pain relievers, stimulants, and sedatives and 23 years for tranquilizers.

Measure 2.4: Percent of respondents in the past year using prescription-type drugs non-medically, ages 26 and over.

Prescription drugs that present particular risk for non-therapeutic use typically fall into one of four categories: pain relievers, tranquilizers, stimulants, and sedatives. According to the 2014 NSDUH, opioid pain relievers were the primary type of prescription drugs that were used non-medically by those ages 26 and over, followed by tranquilizers. The 2014 data indicate non-medical use of prescription drugs by those 26 and older decreased to 4.5 percent compared to 4.7 percent in 2009. While movement is in the right direction, additional efforts are required to meet the target. Of note, with a 4.5 percent rate of non-medical use of prescription drugs in 2014, this 26-and-older group amounted to nearly 9.3 million people. Of those, 3.3 million were aged 26-34 and 5.9 million were 35 and older. Of those aged 26-34 who used prescription drugs non-medically in 2014, nearly 2.3 million used pain relievers and about 1.3 million used tranquilizers. Additionally, of the 5.9 million people age 35 and older who used prescription drugs in 2014, nearly 4.2 million used pain relievers and 2.0 million used tranquilizers.

Objective 3 - Increasing Access to Treatment and Supporting Long-term Recovery

Substance use disorder is a chronic disorder associated with relapse, where outcomes are greatly improved with augmentation by recovery support services. Treatment helps people achieve stable, long-term recovery and become productive members of society, reducing the public health, public safety, and economic consequences associated with substance use disorders. The Administration is working with states, tribes, local governments, treatment and recovery support services providers, and other stakeholders to develop systems and services that support sustained recovery. An essential component of this effort is promoting the use of recovery support services, non-clinical services that assist people who are in or seeking recovery. Table 2-3 outlines the measures, targets, and progress-to-date for this Objective.

Table 2-3: Objective 3 Measures, Baselines, Progress-to-date, Targets, and Assessment

Objective 3 Measure	Baseline	Progress-to-date	2015 Target	Assessment
Measure 3.1: Percent of treatment plans completed	45.1% (2007) TEDS-D	2013: 44.3% 2012: 44.8% 2011: 43.7% 2010: 44.1% 2009: 46.7% 2008: 46.6%	50.0%	No Progress to Date
Measure 3.2: Percent of Health Center grantees providing substance abuse counseling and treatment services	21.6% (2009) UDS	2015: 21.0% 2014: 20.5% 2013: 20.0% 2012: 20.2% 2011: 22.1% 2010: 22.6%	23.0%	Target Not Met
Measure 3.3: Percent of treatment facilities offering at least 4 of the standard spectrum of recovery services (child care, transportation assistance, employment assistance, housing assistance, discharge planning, and after-care counseling)	35.5% (2008) N-SSATS	2013: 41.0% 2012: 40.0% 2011: 39.0% 2010: 36.0% 2009: 36.0%	39.0%	Target Met or Exceeded

See Appendix C for information about data sources

Assessment of Progress

The following sections discuss the data sources, targets, progress made to date, and if future action is required to achieve each of the measures comprising the Objective 3: Increasing Access to Treatment and Supporting Long-term Recovery.

Measure 3.1: Percent of treatment plans completed

In the absence of nationwide data on treatment effectiveness—specifically, multi-year national data tracking clinical outcomes for individuals—the percentage of those discharged for having completed treatment was used as a proxy measure. Data for this measure are drawn from SAMHSA's

Treatment Episode Data Set on Discharges (TEDS-D), an administrative dataset on discharges of individuals aged 12 and older from alcohol or drug treatment in facilities that reported to Single State Agencies. Based on the data available at this time, progress is stalled, and accelerated progress is required to meet the 2015 target of 50 percent. In 2008, 46.6 percent of those discharged had completed treatment plans; this rate was 46.7 percent in 2009 before trending generally downward to 44.1 percent in 2010, 43.7 percent in 2011, 44.8 percent in 2012, and 44.3 percent in 2013.

Measure 3.2: Percent of Health Center grantees providing substance use counseling and treatment services

This measure focuses on the integration of counseling and treatment for substance use disorders into mainstream health care. Since there are no national records on available health care services, this measure focuses on HRSA's Health Center Program grantees and the over 24 million individuals they serve. This measure is a proxy for assessing the extent of counseling and treatment services for substance use disorders provided in primary care settings. Providing these services would show that services for substance use disorders are integrated and expansive, which would be a reasonable conclusion, because HRSA Health Center Program grantees are major providers of primary care for the Nation's medically underserved and vulnerable populations. Data for this measure are drawn from HRSA's UDS and are collected annually from HRSA grantees.

There has been progress over the past two years. According to UDS data, the percent of grantees that provide substance use disorder counseling and treatment services has remained relatively stable since 2009, with a rate of 21 percent reported in both 2014 and 2015. Progress has been impacted by the rapid growth of the Health Center Program. While the target was not met, the number of health centers providing these services has increased by 20 percent as the program has grown by 173 new grantees over the two-year period.

Measure 3.3: Percent of treatment facilities offering at least 4 of the standard spectrum of recovery services

Recovery from a substance use disorder is a lifelong process, and research has documented that treatment success is greatly improved by programs that facilitate recovery (Fisher 2014; McLellan, et al.1998; Polcin et al 2010; Reif et al. 2014). Based on the data available through SAMHSA's National Survey of Substance Abuse Treatment Services (N-SSATS), the following six services are included in the measure's definition of the standard spectrum of recovery support services: child care, transportation assistance, employment assistance, housing assistance, discharge planning, and after-care counseling. An increase in the percentage of substance use disorder treatment facilities that provide at least four of these services would indicate that the number of recovery support services is expanding. Based on data available at this time, the 2015 target of 39 percent of treatment facilities offering at least four of the standard spectrum of recovery services was achieved, with 41 percent of facilities offering this spectrum of services.

Objective 4 - Criminal Justice Reform: Making the System More Effective and Fair

At the end of 2014, about 6.85 million people were under some form of adult correctional supervision (Kaeble, D. et al, 2014.) Various studies have examined the prevalence of illicit drug use and drug use

disorder among this special population. According to the most recent information available, 45 percent of Federal prisoners met the criteria for substance use disorder (Mumola et al 2004). Nearly three-quarters of state prison inmates are in need of some substance use intervention with over 31 percent of men in prison and over 52 percent of female inmates requiring intensive treatment services, including residential treatment programming (Belenko et al 2005). However, only 25 percent of male ex-offenders returning to the community from prison and 14 percent of women ex- offenders returning to the community from prison report participating in a formal drug or alcohol treatment program while incarcerated (Belenko et al, 2005). A 2004 survey showed that 40 percent of State and 49 percent of Federal inmates took part in some kind of drug program, which, for the most part were self-help or peer counseling groups; only 15 percent of State prisoners and 17 percent of Federal prisoners took part in drug treatment programs with a trained professional (Mumola et al, 2004).

Over the past few years, the Obama Administration has sought to reform the criminal justice system to more effectively address substance use disorders and reduce recidivism. When individuals become involved with the criminal justice system, it may be their first opportunity to obtain substance use disorder treatment. Placing non-violent individuals with substance use disorders on community supervision—and providing treatment and other services—has gained wide acceptance among policymakers, academics, and practitioners. However, more can be done to incorporate appropriate supervision and services throughout the criminal justice system continuum. In addition, providing evidence-based treatment and wrap-around services to young people who have had contact with law enforcement or the justice system could prevent them from spiraling further into the system and reduce intergenerational substance use disorders.

Table 2-4: Objective 4 Measures, Baselines, Progress-to-date, Targets, and Assessment

Objective 4 Measure	Baseline	Progress-to-date	2015 Target	Assessment
Measure 4.1: Percent of residential facilities in the Juvenile Justice System offering substance abuse treatment	38.8% (2008) JRFC	2014: 43.4% 2012: 45.3% 2010: 40.5%	42.7%	Target Met or Exceeded
Measure 4.2: Percent of treatment plans completed by those referred by the Criminal Justice System	48.8% (2007) TEDS-D	2013: 47.5% 2012: 47.7% 2011: 47.5% 2010: 47.9% 2009: 49.6% 2008: 48.4%	51.0%	No Progress to Date

See Appendix C for information about data sources

Assessment of Progress

The following sections discuss the data sources, targets, progress made to date, and if future action is required to achieve each of the measures comprising Objective 4: Criminal Justice Reform: Making the System More Effective and Fair.

Measure 4.1: Percent of residential facilities in the juvenile justice system offering treatment for substance use disorders

This measure focuses on treatment available to youth in the juvenile justice system and the

importance of breaking the cycle of drugs and crime in this population at an early stage. The data are provided by the Office of Juvenile Justice and Delinquency Prevention's Juvenile Residential Facility Census (JRFC). The JRFC reports biennially on a variety of information on facility operations and services, including substance use disorder treatment.

For the initial PRS design report, the baseline was established based on the percentage of residential juvenile facilities that offered treatment for substance use disorder services in 2006, the most recent year for which data from the JRFC were then available. In the 2014 PRS report, the data were corrected from reporting on the number of juvenile facilities that provided substance use "screening" to the number of juvenile facilities that provided "treatment" for substance use disorders. As a result, the baseline was recalculated to reflect the rate of juvenile facilities that provided treatment for substance use disorders. The revised value for 2006 is 40.4 percent. With 2008 data available, the baseline year was revised to 2008 with a value of 38.8 percent. With the same degree of change--an increase of 5 percent, as reported in the PRS design report--the 2015 target also was revised, to 42.7 percent.

The target for this measure has been exceeded. In 2014, the data showed that 803 out of 1,852 (43.4%) juvenile facilities reported providing treatment for a substance use disorder. Of the facilities in the juvenile justice system offering treatment for substance use disorders, 40.2 percent were public residential facilities and 47.2 percent were private facilities providing substance use disorder services, either on-site or off-site. While this measure exceeds the 42.7 percent target for 2015, there has been a reduction from the total number of facilities from 2,450 in 2008 to 1,852 in 2014, and a reduction in the number of facilities providing treatment services from 950 in 2008 to 803 in 2014. A complete breakout of past availability of facilities providing treatment for substance use disorders by facility type can be found in Table 2-5 below.

Table 2-5: Office of Juvenile Justice and Delinquency Prevention's Juvenile Residential Facility Census (JRFC)

Availability of substance use disorder treatment								
	JRFC 2000	**JRFC 2002**	**JRFC 2004**	**JRFC 2006**	**JRFC 2008**	**JRFC 2010**	**JRFC 2012**	**JRFC 2014**
Total number of reporting facilities	3,047	2,955	2,799	2,649	2,450	2,111	1,985	1,852
N facilities providing treatment	1,147	1,252	1,149	1,071	950	854	900	803
% of total	37.6%	42.4%	41.1%	40.4%	38.8%	40.5%	45.3%	43.4%
Availability of substance use disorder treatment by facility operation								
Facility operation	**2000**	**2002**	**2004**	**2006**	**2008**	**2010**	**2012**	**2014**
Public								
Total facilities	1,200	1,182	1,187	1,166	1,150	1,074	1,007	1,008
% providing service	40.7%	45.3%	42.7%	45.4%	42.3%	42.5%	44.0%	40.2%
Private								
Total facilities	1,847	1,773	1,612	1,483	1,300	1,037	978	844
% providing service	35.7%	40.4%	39.8%	36.5%	35.6%	38.4%	46.7%	47.2%

Measure 4.2: Percent of treatment plans completed by those referred by the criminal justice system[11]

Research indicates that increased completion of treatment plans is correlated with improved treatment outcomes and is also a predictor of reduced drug use (Gerstein and Harwood, 1999). This measure is a proxy, as there are no nationwide data on the outcomes of treatment effectiveness in the criminal justice population. SAMHSA's TEDS-D data set covers areas such as treatment completion,[12] length of stay in treatment, substance use disorder characteristics, and client demographics. Based on the data available at this time, progress is stalled and accelerated progress is required to meet the target of 51 percent for 2015. According to the latest 2013 TEDS-D, the data showed that 47.5 percent (251,777 of 530,374) of those who entered treatment from criminal justice referrals completed their drug use treatment plans.

Objective 5 - Disrupt Domestic Drug Trafficking and Production

The *Strategy* focuses on disrupting domestic drug trafficking and production within the United States through the implementation of a range of counterdrug efforts. The measures listed in Table 2-6 below collectively assess the progress for Chapter 5 of the *Strategy* toward limiting the availability of illicit drugs by targeting the organizations that produce and distribute them.

The output measures for this objective are related to increasing the number of Drug Trafficking Organizations (DTOs) disrupted or dismantled, and decreasing the number of methamphetamine lab incidents. The number of DTOs reported are further delineated by their criminal associations, or "linkages" to Consolidated Priority Organization Targets (CPOTs) or Regional Priority Organization Targets (RPOTs).

CPOT designation identifies heads of drug or money laundering organizations, clandestine manufacturers or producers, and major transporters and distributors – all of whom play significant roles in the supply of illicit drugs to the United States. RPOTs are those individuals, organizations, and facilitators, whose drug trafficking and/or money laundering activities have a significant impact in the nine designated Organized Crime Drug Enforcement Task Forces (OCDETF) regions[13] as determined by the U.S. Department of Justice (DOJ) and its partner agencies. Reduction of methamphetamine labs is used as a positive outcome for law enforcement, since seizure rates are assumed to be fairly constant; therefore, fewer lab seizure incidents suggest reductions in methamphetamine lab activity.

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[11] TEDS-D defines "criminal justice referral" as a referral by any police official, judge, prosecutor, probation officer, or other person affiliated with a Federal, State, or county judicial system. This includes referral by a court for DWI/DUI, clients referred in lieu of or for deferred prosecution, or during pretrial release, or before or after official adjudication.

[12] "Treatment Completed" is defined as "All parts of the treatment plan or program were completed."

[13] The nine OCDETF regions are the Florida Caribbean, Great Lakes, Mid-Atlantic, New England, New York/New Jersey, Pacific, Southeast, Southwest, and West Central.

Table 2-6: Objective 5 Measures, Baselines, Progress-to-date, Targets, and Assessment

Objective 5 Measure	Baseline	Progress-to-date	2015 Target	Assessment
Measure 5.1: Number of domestic CPOT-linked organizations disrupted or dismantled	296 (2009) PTARRS (DEA)	2015: 491 2014: 550 2013: 475 2012: 455 2011: 488 2010: 429	380	Target Met or Exceeded
Measure 5.2: Number of RPOT-linked organizations disrupted or dismantled	119 (2009) OCDETF MIS	2015: 162 2014: 153 2013: 170 2012: 156 2011: 164 2010: 116	156	Target Met or Exceeded
Measure 5.3 Number of methamphetamine lab incidents	12,858 (2009) NSS	2015: 7,635 2014: 9,384 2013: 12,057 2012: 13,442 2011: 13,423 2010: 15,217	9,639	Target Met or Exceeded

See Appendix C for information about data sources

Assessment of Progress

The following sections discuss the data sources, targets, progress made to date, and if future action is required to achieve each of the measures comprising Objective 5: Disrupt Domestic Drug Trafficking and Production.

Measure 5.1: Number of Domestic CPOT-linked Organizations Disrupted or Dismantled

U.S. law enforcement agencies and their partners focus on the CPOT list with the intent of having the greatest effect in disrupting drug production and trafficking. The data source used for this measure is the Priority Target Activity and Resource Reporting System (PTARRS) maintained by DEA. PTARRS is used to capture and report domestic and international CPOT-linked Priority Target Organizations (PTO) investigative activities and dispositions (disruptions and dismantlements, including disrupted pending dismantlement). In 2009, 296 domestic CPOT-linked organizations were disrupted or dismantled. In FY 2012, FY 2013, FY 2014, and FY 2015 PTARRS reported 455, 475, 550, and 491 domestic CPOT-linked disruptions and dismantlements, respectively. The fluctuations in the data from 2009 through 2015 reflect the natural and temporal variabilities that occur when reporting investigative or enforcement-based data. The target for this measure (380 disruptions or dismantlements) was exceeded.

Measure 5.2: Number of RPOT-linked Organizations Disrupted or Dismantled

Similar to CPOT-linked organizations, RPOTs are drug trafficking organizations that are primarily responsible for a specific region's drug threat. The RPOT list enables a coordinated regional focus for Federal, state, local, and tribal law enforcement efforts.

The primary data source for the number of RPOT-linked organizations disrupted or dismantled is the OCDETF database to which OCDETF regions report data concerning disruptions or dismantlements.

The number of RPOT-linked organizations that law enforcement identifies fluctuates each year, greatly influencing the number of disruptions and dismantlements. The 2009 baseline for this measure is 119 and the 2015 target is 156.

The most recent data show that the target was exceeded, ending the fiscal year with 162 RPOT disruptions and dismantlements. OCDETF will continue to focus available resources on only the highest level organizations engaged in regional, national, or international organized activities related to the importation, manufacture, distribution, crop cultivation, diversion, sale, financial support, and/or money laundering associated with the illicit trafficking of any illegal drug or narcotic substance; including pharmaceuticals trafficking and the diversion, purchase, and use of precursor chemicals.

Measure 5.3: Methamphetamine Laboratory Activity

An actual measure of methamphetamine laboratory activity is unknown. A proxy measure for this activity is the number of methamphetamine lab seizure incidents.[14] The underlying logic for this proxy measure it that as laboratory activity increases, more are seized; as laboratory activity decreases, the number of them seized decreases (assuming law enforcement resources and priorities are stable). This measure assesses progress in reducing domestic methamphetamine lab seizure activity and associated consequences, such as methamphetamine laboratory and dumpsite clean-up costs. Methamphetamine laboratory seizure incident data are compiled by the National Seizure System (NSS), an intelligence database maintained by the El Paso Intelligence Center (EPIC).

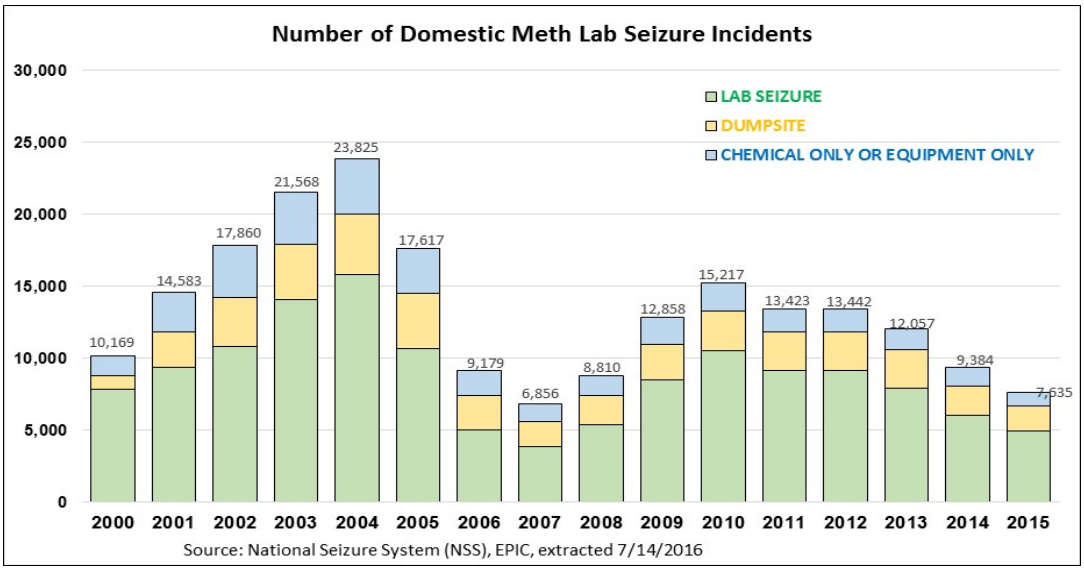
Since this measure was established a number of activities have occurred that may have affected the laboratory seizure trends. In 2005, with the enactment of the Combat Methamphetamine Epidemic Act, precursor chemicals for domestic labs were restricted and the number of methamphetamine laboratory seizures declined dramatically. In 2007, Mexico banned the primary precursor chemicals used in the illicit manufacture of methamphetamine: pseudo ephedrine and ephedrine. This altered the amount and quality of Mexican-produced methamphetamine sent to U.S. markets. Federal funding for methamphetamine laboratory clean-up ended in early 2011, but was restored later that year. There also was an adjustment to the accounting of domestic methamphetamine laboratory seizure incidents. Prior to 2011 two Federal data systems tracked methamphetamine laboratory seizure incidents. The Hazardous Waste Disposal System (HWDS), which accounted for Federal funding to methamphetamine clean-ups, was maintained by DEA. The NSS, collected detailed methamphetamine laboratory seizure reporting from each state. In 2011, the HWDS non-duplicative incidents were integrated into the NSS for all previous years. Subsequent methamphetamine laboratory clean-up incident reporting was tabulated in the NSS to avoid future NSS under-reporting. Since the initial PRS report, the number of methamphetamine laboratory incidents, as tabulated by the NSS, increased for all years when data from the HWDS was integrated into the existing NSS. As states and localities continue to provide updated data to NSS, the laboratory seizure incident data also are updated. The data in this report reflect updated data.

Figure 2-4 compares the number of methamphetamine lab seizure incidents before and after the adjustment. Taking the updated NSS data, the 2009 baseline has been revised to 12,858. Since 2010, there has been an overall downward trend from 15,217 to 7,635 in 2015. The 2015 target of 9,639

[14] Lab seizure incidents can be categorized as: 1) pre-labs (equipment and glassware seized), operating labs, 2) active labs, or 3) post-operation labs (dumpsites). Various state reporting may define each of these categories differently, therefore, for this report a sum of all three types is used as the measure of activity and are called methamphetamine lab seizure incidents".

represents a revised target identified in the 2015 PRS report.

Figure 2-4: Number of Methamphetamine Lab Seizure Incidents



While progress has been made on the part of U.S. law enforcement in reducing the number of domestic methamphetamine laboratories, other factors likely have contributed to this decrease. Since 2010, other data on methamphetamine indicates that the quality and quantity of methamphetamine from Mexican production has been increasing. Methamphetamine seizures at the Southwest border have increased 215 percent from 2010 to 2015, indicative of increased flow of the drug into the United States (DOJ 2016a; DOJ 2016b). Purity also rose from 83 percent to 93 percent over the same period (DOJ 2015). Drug overdoses involving psychostimulants (which are primarily due to methamphetamine) increased 132 percent from 2010 to 2014. In addition, restrictions of precursor chemicals in the United States contributed to reduced domestic production (DOJ 2016a). The target of 9,639 was met.

Objective 6 - Strengthen Law Enforcement and International Partnerships to Reduce the Availability of Foreign Produced Drugs in the United States

Partnering with foreign nations to disrupt and dismantle violent criminal enterprises that traffic illicit drugs into the United States is key to reducing the supply of drugs and promoting the rule of law. There is global recognition that addressing the use, production, and trafficking of drugs is a shared responsibility among all nations. In the *Strategy*, strengthening international partnerships is an instrumental part of helping to reduce the production and trafficking of drugs smuggled into the United States.

This objective focuses on a range of international drug control efforts supported by U.S. Federal agencies. This includes initiatives to curb the amount of drugs that enter the United States by developing criminal cases, capturing major kingpins, and seizing drugs and the illicit proceeds from their sale. The emphasis on supporting drug transit and producing countries in their supply reduction efforts is intended to substantially reduce the flow of foreign-produced drugs into the United States.

There also is a focus on building institutional capability, supporting economic alternatives to drug production, and promoting collaborative efforts in prevention, treatment, and research, thereby assisting global partners in acquiring the capabilities to overcome the consequences of drug use. The effort assists host nations in building their capacity to address the full range of drug threats they face. For measures 6.1 and 6.2, the progress of selected countries is presented in aggregate and does not compare countries' efforts in curbing drug supply or demand. This objective's measures listed in Table 2-7 below collectively assess the progress in strengthening international partnerships and reducing the availability of foreign-produced drugs in the United States.

Table 2-7: Objective 6 Measures, Baselines, Progress-to-date, Targets, and Assessment

Objective 6 Measure	Baseline	Progress-to-date	2015 Target	Assessment
Measure 6.1: Percent of selected countries on the Majors List* that increased their commitment to supply reduction	2009 State Dept	100% (progress to date)	100%	Target Met or Exceeded
Measure 6.2: Percent of selected countries on the Majors List* that increased their commitment to demand reduction	2009 State Dept	100% (progress to date)	100%	Target Met or Exceeded
Measure 6.3: Percent of Majors List countries** showing progress since 2009 in reducing either cultivation or drug production potential	2009 ONDCP	2015: 0.0% 2014: 43.0%	100%	Target Not Met
Measure 6.4: Number of international CPOT-linked organizations disrupted or dismantled	65 (2009) PTARRS	2015: 78 2014: 72 2013: 77 2012: 69 2011: 51 2010: 66	60	Target Met or Exceeded
*The countries selected for this measure are: Afghanistan, Mexico, Colombia and Peru.				
** The available data varies among countries; countries selected for this measure are: Afghanistan, Burma, Laos, Mexico, Bolivia, Colombia, and Peru.				

See Appendix C for information about data sources.

Assessment of Progress

The following discusses the data sources, targets, progress made to date, and if future action is required to achieve each of the measures comprising Objective 6: Strengthen Domestic Law Enforcement and International Partnerships to Reduce the Availability of Foreign Produced Drugs in the United States.

Measure 6.1: Percent of selected countries on the Majors list that increased their commitment to supply reduction

An assessment of a particular country's commitment to addressing its unique supply reduction challenges is based on the data available from that country and includes information on budget, programs, and policies. Supply reduction efforts include financial resources dedicated to drug crop eradication, drug interdiction, judicial and law enforcement programs and institutional strengthening focused on drug trafficking. The countries selected for assessment during the PRS design process were Afghanistan, Bolivia, Colombia, Guatemala, Mexico, Pakistan, Peru and the

Dominican Republic. ONDCP and the State Department decided that a pilot project was needed to determine whether it was feasible to obtain the required information. The results of the pilot indicated that data for Bolivia, Guatemala, Pakistan and the Dominican Republic were more challenging to collect on a systematic and yearly basis at this time. The State Department has been able to systematically collect data from Afghanistan, Mexico, Colombia and Peru. These countries are central to collaboration with the United States in reducing the supply of illicit drugs and are therefore used for the purposes of this report.

The political will to sustain counternarcotics efforts with host nation resources has continued, and the target for this measure has been met. The selected countries' commitment to supply reduction have all increased since 2009. The progress for each country is described separately below:

Afghanistan's Ministry of Counternarcotics (MCN) has increased its capacity to plan and implement counternarcotic efforts. Afghan President Ashraf Ghani approved a National Drug Action Plan (NDAP) in October 2015 that outlines Afghanistan's strategy to pursue a balanced, comprehensive, coordinated, and sustainable approach to combat illegal drug production, trade, and usage over the next four years. The NDAP highlights the actions necessary to counter the cultivation, production, trafficking, and use of narcotics; the timeframe, goals, and metrics to evaluate progress on the plan; the role the Afghan MCN and other ministries will play in executing the plan; and the ways in which the international community can support the plan. Furthermore, under the Ministry of Interior, the U.S.-mentored Afghan counternarcotics police-vetted units have successfully initiated, planned, coordinated, and executed – without any significant non-Afghan tactical support – multiple large-scale interdiction operations.

Colombia's budget from 2009 to 2015 shows significant increases in the drug policy programs of the Justice and Interior Ministries and in its Defense spending for supply reduction. The combined total of Justice and Interior Ministry spending on drug policy was $2.7 million in 2009 and increased to $6.9 million in 2015. The Defense budget for drug policy programs was $12.5 million in 2009 and $213.6 million in 2015. Colombia also has taken fiscal responsibility for the helicopter safety program and absorbed the direct cost of the herbicide used in aerial eradication operations, which came to an end on October 1, 2015. On January 20, 2014, President Juan Manuel Santos signed a comprehensive Asset Forfeiture law (no. 1708) to counter money laundering. Colombia and the United States also signed November 21, 2016, a forfeited asset sharing agreement to facilitate the sharing of assets seized during criminal investigations in the two countries. Colombia also has increased its commitment to state presence in and around coca-growing areas through increases in membership of its Public Security Forces, from 429,793 in 2009 to 451,000 in 2015. Colombia also assumed greater responsibility for drug interdiction in the region by taking over control of the Air Bridge Denial program.

Mexico's budget from 2009 to 2016 shows a steady increase in funding for drug supply reduction and security efforts, from $8.0 billion in 2009 to over $9.4 billion in 2016 (U.S. Department of State, 2014a). Funding is used to combat organized crime, expand crime prevention programs, improve interagency coordination, consolidate police forces, support justice reforms, and encourage citizen participation in crime control.

Peru's budget from 2009 to 2015 shows an increase in overall drug supply reduction spending from $42.5 million in 2009 to $167.7 million in 2015. Included in the total budget is the drug supply

reduction funding for the National Commission for Development and Life without Drugs (DEVIDA), the Public Ministry, Ministry of Defense, Judicial Power, and Ministry of Interior Effective Management Program for Drug Supply Control. In 2012, Peru adopted and began proactively implementing its billion-dollar, five-year counternarcotics strategy. The Peruvian counternarcotics strategy is comprehensive – including eradication, interdiction, alternative development, precursor controls, and combating money laundering. In 2015, Peru eradicated a record high of 35,868 hectares (ha) of coca and the target for 2016 is 30,000 ha. In 2014, DEVIDA, with USAID support, created more than 18,000 new jobs and assisted over 31,000 families on over 43,000 ha of alternative crops, 20,000 ha of which were newly planted. Projected spending for the National counter-narcotics strategy decreased from $91.6 million to $70.9 million in 2016.

Measure 6.2: Percent of selected countries that increased their commitment to demand reduction efforts

The countries for this measure were selected in the same manner as those for Measure 6.1 to explore options to refine the data collection process. Budgets and actions taken for demand reduction efforts conducted by Afghanistan, Mexico, Colombia, and Peru were examined. The political will to sustain counternarcotics efforts with host nation resources has continued, and the target for this measure has been met. The selected countries' demand reduction budgets and activities have all increased since 2009. The progress for each country is described below:

Afghanistan has expanded the number of treatment programs, with U.S. support, from zero to over 100 since 2007, including inpatient, outpatient, home-based and village-based programs, as well as services tailored specifically to meet the needs of women and children within the Afghan cultural context. The Ministry of Public Health independently manages over 30 programs and is working with the State Department to implement a transition program to take increasing leadership and responsibility for treatment programs within the country. The United States is encouraged by senior-level Afghan government support for a public health approach to drug demand reduction.

Colombia, as a result of overall decreases to its budget due to a decrease in oil prices, reduced its spending on demand reduction and prevention in 2015. Funding was $6 million in FY 2009 and $7.2 million in FY 2013 (the latest year for which budget data are available). However, the government also announced a new anti-narcotics strategy in 2015, which declared prevention and treatment to be two key pillars of the national response. This change in policy has led to an unprecedented level of cooperation between the Ministries of Health and Justice who are now focused on working together to expand the availability of evidence-based prevention campaigns and treatment programs.

Mexico's 2012 budget for Demand Reduction was $84 million, increasing to $95.8 million in 2013, and $103.8 million in 2014; this is a significant increase from the $29.2 million funded in 2009 (U.S. Department of State, 2014a). The U.S.-Mexico Drug Abuse Prevention Research Fellowship reflects Mexico's support of demand reduction programs. The program provides 12 months of postdoctoral training in the United States for a Mexican citizen or permanent resident. In addition to conducting mentored prevention research, fellows participate in professional development activities and learn about the U.S. National Institutes of Health (NIH) grant application process. Through this fellowship, participants are gaining essential networking contacts and are increasing their professional development, which has resulted in published articles in professional medical journals and an increase in research funding through grants. Through another NIDA international fellowship and NIDA and

State Department grants, Mexico established a university-community treatment provider network based on the NIDA Clinical Trials Network to conduct treatment clinical trials, and completed the first study, Motivational Enhancement Treatment to Improve Treatment Engagement and Outcome for Spanish-Speaking Individuals Seeking Treatment for Substance Use Disorders. Mexico also has hosted Demand Reduction conferences focused on research. From 2009 to 2014, NIDA awarded 20 grants for various projects – most of which were focused on drug-related HIV – to U.S. principal investigators working with partners in Mexico.

Peru's allocation of funds from 2009 to 2015 shows an increase in its overall demand reduction budget from nearly $1 million in 2009 to $11 million in 2016. Included in the total budget is drug prevention and treatment funding for DEVIDA, Peru's Counternarcotics strategy for prevention, treatment, and rehabilitation, as well as for the Ministry of Women, Judicial Power, The National Penitentiary Institute, Ministry of Education, and Peru's Health Services Institute. NIDA continues to support domestic grants to U.S. principal investigators working with partners in Peru on HIV Testing and Treatment to Prevent Onward HIV Transmission among high-risk men. In January 2014, NIDA and the Peruvian Instituto Nacional de Salud signed a bi-national agreement to facilitate scientific exchange activities focused on collaborative drug use research. NIDA and NIH's Fogarty International Center approved the use of funds from a training grant to a U.S. principal investigator working with colleagues in Peru to support a workshop for researchers on drug use issues from Andean States in conjunction with the 2014 NIDA International Forum, held June 13-16, 2014 in Puerto Rico.

Measure 6.3: Percent of Majors List countries showing progress in reducing either cultivation or drug production potential

Reducing the cultivation or drug production potential of selected countries represents success in the international effort to reduce the flow of illicit drugs. The countries selected to track this measure are Afghanistan, Burma, Laos, Mexico, Bolivia, Colombia, and Peru. For these countries, the cultivation or production of opium poppy, heroin, coca, and marijuana were estimated using either U.S. data (ONDCP 2015; for Afghanistan, Mexico, Bolivia, Colombia, and Peru) or data from UNODC (2014; Burma and Laos) to determine an improvement in reducing either cultivation or production since 2009. As in previous measures, countries are not compared to one another.

The target calls for 100 percent of the selected countries showing progress by 2015 in reducing drug cultivation or production from their individual baseline figures in 2009. The target for this measure has not been met. Accelerated progress is needed for all the countries to meet the 100 percent target. The progress of each country is described below:

Afghanistan experienced an increase in poppy cultivation and a concomitant increase in potential opium production. Poppy cultivation totaled 131,000 ha in 2009 and increased to an estimated 201,000 ha in 2015. Potential opium production remained relatively stable; it was 4,300 metric tons in 2009 and 4,100 metric tons in 2015, largely because of poor growing conditions in 2015.

Bolivia saw several years of relatively stable coca cultivation and potential pure cocaine production from 2009-2013, but experienced a rise in both areas in 2014 and 2015. Coca cultivation totaled 29,000 ha in 2009 and increased to 36,500 ha in 2015. According to the most current estimates, production

potential for pure cocaine increased from 150 metric tons in 2009 to 230 metric tons in 2015.

Burma experienced a significant increase in poppy cultivation and opium production. Due to poor weather conditions that stunted cultivation in 2009, 2010 was chosen for the baseline. Poppy cultivation increased from 45,500 ha in 2010 to 52,000 ha in 2014. Potential opium production also rose from 530 metric tons in 2010 to 900 metric tons in 2014. Potential heroin production was 29 metric tons in 2009 and 85 metric tons in 2014.

Colombia, after a notable decline in coca cultivation and potential cocaine production between 2009 and 2013, experienced a resurgence of coca cultivation and potential production starting in 2014. Coca cultivation totaled 116,000 ha in 2009 and rebounded to 159,000 ha in 2015. Potential pure cocaine production increased from 265 metric tons in 2009 to 420 metric tons in 2015.

Laos experienced substantial increases in the production and cultivation of poppy. Poppy cultivation estimates increased from 2009 to 2014, with nearly 940 ha grown in the region of Phongsaly in 2009 to 6,200 ha grown in three primary growing areas in 2014. Potential opium production for Phongsaly totaled 11.5 metric tons in 2009 and the primary growing areas surveyed in 2014 (Bokeo, Houaphan, Louang Namtha, Louangphraband, Oudomxai, Phongsaly, Xiangkhoang, and Xaignabouri) potentially produced 92 metric tons of opium.[15]

Mexico experienced an increase in opium poppy cultivation and relatively stable marijuana cultivation. Poppy cultivation areas totaled 10,500 ha in 2012 and increased to 28,000 ha in 2015, while marijuana totaled 11,500 ha in 2012 and 11,000 ha in 2014, the most recent year for which data are available. A change in the estimation methodology for opium poppy cultivation in 2011 precludes a direct comparison with prior cultivation estimates. Potential pure heroin production was 70 metric tons of pure in 2015. There is no marijuana production estimate due to a lack of yield data for Mexico.

Peru experienced an increase in coca cultivation and potential cocaine production from 2009 to 2015. Coca cultivation increased from 40,000 ha in 2009 to 53,000 ha in 2015. Potential pure cocaine production increased from 195 metric tons of cocaine in 2009 to 345 metric tons in 2015.

Measure 6.4: Number of CPOT-linked international organizations disrupted or dismantled

DOJ's CPOT list represents the most significant international drug trafficking and money laundering organizations primarily responsible for the Nation's drug supply. Disrupting and dismantling CPOT-linked international organizations is thought to have had an impact on the Nation's illicit drug supply and the flow of foreign-produced drugs into the United States on efforts to Combat Transnational Organized Crime.

Internationally, the State Department works closely with DOJ, including DEA, and the Department of Homeland Security in disrupting and dismantling foreign CPOT-linked organizations. The data source for this measure is DOJ's PTARRS, which captures domestic and international CPOT-linked disruptions and dismantlements, including disrupted pending dismantlement, from Federal law enforcement.

[15] The United Nations Office of Drugs and Crime conducted the estimates for Laos. The United States Government conducted all other estimates cited in this report.

In FY 2009, PTARRS recorded that 65 international CPOT-linked organizations were disrupted or dismantled. In FY 2012, FY 2013, FY 2014, and FY 2015, DEA reported 69, 77, 72, and 78 CPOT-linked disruptions and dismantlements, respectively. The fluctuations from 2009 through 2015 reflect the natural and temporal fluctuations that occur when reporting investigative or enforcement-based data. The target of 60 for this measure was exceeded.

Objective 7- Improve Information Systems for Analysis, Assessment, and Local Management

Using data for evidence-based decision making is the cornerstone of a strategic approach to both supply and demand reduction efforts. A range of data is available to inform policy and decision making, including national level information on drug use and health behaviors, the criminal justice population, the economics of the drug trade and drug use, and the supply of illicit drugs.

Table 2-8 below outlines the measures, baselines, progress-to-date, targets, and assessments for this Objective. The measures assess three general performance criteria: (1) timeliness of data release, (2) utilization of data, and (3) expansion of the use of feedback mechanisms for data consumers.

Assessment of Measures

The following sections discuss the data sources, targets, progress made to date, and if future action is required to achieve each of the measures comprising Objective 7: Improve Information Systems for Analysis, Assessments, and Local Management.

Table 2-8: Objective 7 Measures, Baselines, Progress-to-date, Targets, and Assessment

Objective 7 Measure	Baseline	Progress-to-date	2015 Target	Assessment
Measure 7.1: Increase timeliness (year-end to date-of-release) of select Federal data sets above their baseline by 10%				
Treatment Episode Data Set (TEDS)[a]	17.5 Months (TEDS-A)	2012: 17.5 2011: 23.5 2010: 19.5	15.8 Months	Progress Sufficient to Meet Target
Measure 7.2: Increase the utilization (number of annual web hits, or number of documents referencing the source) of select Federal data sets by 10% from the baseline				
Substance Abuse and Mental Health Data Archive (SAMHDA)	200,000 web hits/year	2014 565,670 2012 356,782	220,000 web hits/ year	Target Met or Exceeded
National Survey on Drug Use and Health (NSDUH) (Journal artides referencing NSDUH)	37 per year	2014 113 2012: 148	41 per year	Target Met or Exceeded
Measure 7.3: Increase Federal data sets that establish feedback mechanisms to measure usefulness (surveys, focus groups, etc.)				
SAMHSA Funded Data Sets	0	1 (progress to date)	1	Target Met or Exceeded

See Appendix C for information about data sources

Measure 7.1: Increase timeliness (year-end to date-of-release) of select Federal data sets above their baseline by 10%

By improving timeliness and reducing lag times between an event and reporting on it, policy makers can more quickly address new and emerging threats. The more quickly data are published post-collection and available for review, the more actionable and relevant they become. The Treatment Episode Data Set Admissions (TEDS-A) was identified as an important data source and good candidate for reducing lag times between collection and reporting. Two TEDS-A reports are published each year. Through calendar year (CY) 2007, the first report presented highlights, and the second one was the final full report. From CY2008 forward, the first report presented national measures, and the second report provided information on state measures. For 2012, the baseline for release of TEDS data from the completion of data collection to release is 17.5 months, with a target of 15.8 months. Given the data available at this time, there is a reasonable expectation the target will be met.

Measure 7.2: Increase the utilization (number of annual web hits, or number of documents referencing the source) of select Federal data sets by 10% from the baseline

The rate of utilization of Federal data sets is a clear indication of the relevance, utility, and importance of the data that are being reported. Improved data sets can better inform policy and program development and management. The PRS focuses on citations to the NSDUH, the Federal government's primary data system for monitoring drug use and related behaviors. Two key sources of data for this measure are information from SAMHSA regarding journal articles referencing NSDUH and the Substance Abuse and Mental Health Data Archive (SAMHDA) which houses the NSDUH, the Behavioral Health Services Information Systems (TEDS-A and TEDS-D, the N-SSATS, and the National Mental Health Services Survey), and the DAWN data. SAMHDA promotes the access and use of the Nation's preeminent substance use disorder and mental health research data by assuring accurate public use data files and documentation. Reports that use NSDUH and other relevant data supported through SAMHSA are accessed through SAMHSA's data page. The NSDUH is a key source of data on drug use in the United States. The baseline for SAMHDA web hits per year is based on current SAMHSA information and sets a target of 220,000 web hits per year by 2015. In 2014, SAMHSA received 937,643 hits to its data page and 565,670 hits to the SAMHDA data site. The baseline for NSDUH journal articles is based on current information and sets a 2015 target of 41 journal articles/year referencing NSDUH data. SAMHSA identified 113 journal articles using NSDUH data published in 2014.[16] Both data sets have exceeded their targets as of 2014.

Measure 7.3: Increase Federal data sets that establish feedback mechanisms to measure usefulness (surveys, focus groups, etc.)

A key approach to improving the usefulness of data for both Federal partners and the public is receiving feedback from data users. This information can be helpful in enhancing websites, data formats, data reports, etc. Feedback mechanisms can also take a variety of forms, including online surveys, conferences, or contact information on agency websites. For this measure SAMHSA sought to hold a data users conference by 2015. The target was met for this measure. In August 2012, the agency held its first Behavioral Health Data Users Conference. The Conference provided overviews of what types of data are available and trained attendees on how to access and analyze data.

[16] The most recent year for which data are available is 2014. Updated information will be available with completion of contract re-competition.

Beyond the measures discussed previously, the *Strategy* outlines a series of actions focused on sustaining and enhancing existing Federal data systems, developing and implementing new data systems and analytical methods to address gaps, developing data on drug use and its consequences that are useful at the community level, and improving data on drugged driving. Progress has been made in all of these areas.

The DAWN emergency department data system was discontinued at the end of 2011. Efforts are underway to transition data collection from SAMHSA to the newly consolidated National Hospital Care Survey by the National Center for Health Statistics. SAMHSA and NCHS are working together on a range of issues such as, pretesting a revised data collection approach, recruiting the required number of hospitals, conducting secondary sampling of emergency department visits, and identifying potential data outcomes to address research questions. With growing public health concerns surrounding the non-medical use of prescription drugs, particular emphasis will be placed on this area.

For the NSDUH, a re-design was implemented in 2015 to improve the quality of the data collected, expand the number of prescription drugs covered, and address changing substance use and mental health policy and research needs. As a result, a new baseline will be established for certain measures. The Behavioral Health Services Information System provides valuable information on treatment facilities and client outcomes; work is ongoing to ensure the continuing viability of the system. Assessing the price and purity of illicit street drugs provides essential information for understanding the economics of the drug market. DEA is working to enhance its systems for managing and tracking forensic analyses.

Efforts have also been made to develop new data systems and analytical methods to address knowledge gaps. This includes the transitioning of the Federal-wide Drug Seizure System to the National Seizure System (NSS). Several agencies have also sought to enhance a range of data sources that can inform a better understanding of global illicit drug markets and facilitate efforts to more accurately, rapidly, and transparently estimate the cultivation and yield of marijuana, opium, and coca around the world.

As drug use and its consequences vary considerably among localities, developing data that are useful at the community level will be helpful in both understanding local problems and identifying approaches to mitigate the harm to public health and public safety. SAMHSA is currently working to develop a community early warning and monitoring system to track substance use and problem indicators at the local level. Meanwhile, expanding understanding of patterns and risks associated with drugged driving will support better public safety efforts. ONDCP has partnered with NHTSA and NIDA to support driver simulator research to examine driving impairment as a result of marijuana and combined marijuana and alcohol use and correlate these findings with the results of oral fluid testing to identify behavioral indicators of impairment.

Appendix A: Abbreviations & Acronyms

ADAM	Arrestee Drug Abuse Monitoring Program, U.S. Department of Justice
ATR	Access to Recovery, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, U.S. Department of Health and Human Services
ATF	Bureau of Alcohol, Tobacco, Firearms, and Explosives
BOP	Bureau of Prisons
CBHSQ	Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
CPOT	The Consolidated Priority Organization Target (CPOT) List identifies the most significant international drug trafficking and money laundering organizations and those primarily responsible for the nation's drug supply.
CPOT-linked	An organization is considered linked to a CPOT if credible evidence exists (i.e., from corroborated confidential source information, phone tolls, Title III intercepts, drug ledgers, financial records or other similar investigative means) of a nexus between the primary investigative target and a CPOT target, verified associate, or component of the CPOT organization.
DAWN	Drug Abuse Warning Network, U.S. Department of Health and Human Services
DEA	Drug Enforcement Administration, U.S. Department of Justice
DHS	U.S. Department of Homeland Security
DOD	U.S. Department of Defense
DOI	U.S. Department of Interior
DOJ	U.S. Department of Justice
DOL	U.S. Department of Labor
DOS	U.S. Department of State
DOT	U.S. Department of Transportation
DUI/DWI	Driving Under the Influence/Driving While Intoxicated

DTO	Drug Trafficking Organization; complex organization with a highly defined command-and-control structure that produces, transports, and/or distributes large quantities of one or more illicit drugs.
EPIC	El Paso Intelligence Center, U.S. Department of Justice
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration, U.S. Department of Health and Human Services
HWDS	Hazardous Waste Disposal System
JRFC	Office of Juvenile Justice and Delinquency Prevention's Juvenile Residential Facility Census, U.S. Department of Justice
MIS	OCDETF's Management Information System
MTF	Monitoring the Future. This survey is conducted by researchers at the University of Michigan's Institute for Social Research, funded by research grants from the National Institute on Drug Abuse.
NIDA	National Institute on Drug Abuse
NMHSS	National Mental Health Services Survey
NSS	National Seizure System
NSDUH	National Household Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
N-SSATS	National Survey of Substance Abuse Treatment Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
OCDETF	Organized Crime Drug Enforcement Task Forces, U.S. Department of Justice
OJJDP	Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice
ONDCP	Office of National Drug Control Policy, Executive Office of the President
PTARRS	DOJ's Priority Target Activity and Resource Reporting System; reports the majority of data concerning the number of CPOT-linked organizations collected by the Department of Justice's Drug Enforcement Administration (DEA) and the Organized Crime Drug Enforcement Task Forces (OCDETF).
PTO	Priority Target Organization

RPOT	The Regional Priority Organization Target (RPOT) Lists identify those significant regional drug trafficking and money laundering organizations that are primarily responsible for regional drug threats.
RPOT-linked	The RPOT Lists consist of those organizations having a significant impact on the drug supply within the designated OCDETF Regions. OCDETF participants apply the same standards for establishing a "link" to a RPOT as they use to establish a credible link to a CPOT.
SAMHSA	Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
SBIRT	Screening, Brief Intervention, and Referral to Treatment, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
TEDS-A	Treatment Episode Data Set on Admissions, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
TEDS-D	Treatment Episode Data Set on Discharges, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
UDS	Uniform Data System, Health Resources and Services Administration, U.S. Department of Health and Human Services

Appendix B: Definitions and Performance Terms

Dismantlement	Dismantlement occurs when the identified organization's leadership, financial base and drug supply network have been destroyed to the extent that the organization is incapable of operating and/or reconstituting itself.
Disruption	A disruption occurs when the normal and effective operation of the organization has been significantly impacted. Evidence of "disruption" may be seen in changes in price/purity of the drug or changes in methods of operation; increases in fees paid to couriers or transporters; movement of the organization to a neighboring district; and/or a reduction in availability of a drug on the streets, even if only temporarily. A drug seizure, the execution of a search warrant or another enforcement activity, by itself, does not constitute a "disruption" unless the action truly results in the alteration of the organization's operations or membership.
Impact Target	Impact of policies, programs, and initiatives.
Intermediate Outcome	Result or event occurring from actions taken by entities other than the agencies responsible for the joint outcome and that are likely to lead to the achievement of desired outcomes. These usually occur between outputs (services or products delivered) and outcomes reflecting the purpose of the policy or program.
Majors list	Countries that are classified as major drug transit or drug producing countries for the purpose of the Foreign Assistance Act of 1961; Currently the following countries meet the Act's criteria for illicit drug production or transit: Afghanistan, the Bahamas, Belize, Bolivia, Brazil, Burma, Colombia, Costa Rica, the Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, India, Jamaica, Laos, Mexico, Nicaragua, Nigeria, Pakistan, Panama, Paraguay, Peru, and Venezuela.
Performance Measure	Represents the specific characteristic or aspect of the program (or policy) that is used to gauge performance. For instance, a measure for "drug use" might be the percent of the population that used drugs in the past 30 days.

Performance Reporting System (PRS)	Performance monitoring and assessment mechanism for gauging the effectiveness of the *Strategy*.
Performance Target	Desired level of performance to be achieved during a specified fiscal year for that measure.
PRS Process	Collaboration of drug control agencies to identify performance outcome measures and targets, and an interagency assessment of progress toward the *Strategy's* Objectives.
PRS Steering Committee	Comprised of senior agency officials familiar with drug control issues, policies, and programs. This Committee's primary roles are to advise the Director of ONDCP on the design and implementation of the PRS, serve as primary liaisons with their agencies, bring individual agency concerns to the table for discussion, and to review the recommendations of the PRS Working Groups.
PRS Working Groups	Representatives from the Federal drug control agencies whose purpose was to address the seven Objectives of the *Strategy*; working groups included agency subject matter experts, policy and program analysts, statisticians, researchers, line managers, and other drug program or data experts knowledgeable of drug control programs, policy, and research. Representatives from the following Federal agencies participated in the Working Group activities: the Departments of Defense, Education, Health and Human Services, Homeland Security, Interior, Justice, Labor, Transportation, Treasury, State, Veterans Affairs, and the Small Business Administration.
Reporting Agency	Agency responsible for ensuring that the data are collected and reported to ONDCP. However, multiple agencies contribute to achieving the *Strategy's* Goals and Objectives through programs, policies, etc.
SUDs	Substance use disorders.
The *Strategy*—2010 *National Drug Control Strategy*	Guide for the nation in controlling the use and consequences of the illicit use of drugs.

Appendix C: Data Sources

***Strategy* Goal 1**

NSDUH - Center for Behavioral Health Statistics and Quality. (2015). Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from http://www.samhsa.gov/data/

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***Strategy* Goal 2**

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Objective 1

NSDUH - Center for Behavioral Health Statistics and Quality. (2015). Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from http://www.samhsa.gov/data/

Objective 2

NSDUH - Center for Behavioral Health Statistics and Quality. (2015). Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from http://www.samhsa.gov/data/

UDS - Health Resources and Services Administration's (HRSA) Uniform Data System. Information available at http://bphc.hrsa.gov/datareporting/.

Objective 3
TEDS-D - Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Episode Data Set – Discharge. Information available at http://www.samhsa.gov/data/client-level-data-teds.

UDS - Health Resources and Services Administration's (HRSA) Uniform Data System. Information available at http://bphc.hrsa.gov/datareporting/. Information available at http://bphc.hrsa.gov/datareporting/.

N-SSATS - Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey of Substance Abuse Treatment Services. Information available at http://www.samhsa.gov/data/substance-abuse-facilities-data-nssats.

Objective 4
JRFC – U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention's Juvenile Residential Facility Census (Biennial Census);

TEDS-D -- Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Episode Data Set – Discharge

Objective 5
PTARRS -- Priority Target Activity and Resource Reporting System maintained by U.S. Department of Justice, Drug Enforcement Administration

OCDETF MIS - Organized Crime and Drug Enforcement Task Forces Management Information System maintained by U.S. Department of Justice

NSS - National Seizure System maintained by El Paso Intelligence Center, U.S. Department of Justice

Objective 6
U.S Department of State special data collection

Office of National Drug Control Policy

PTARRS -- Priority Target Activity and Resource Reporting System maintained by U.S. Department of Justice, Drug Enforcement Administration

Objective 7
TEDS-A -- Substance Abuse and Mental Health Services Administration's Treatment Episode Data Set Admissions

SAMHDA -- Substance Abuse and Mental Health Services Administration's Substance Abuse and Mental Health Data Archive

NSDUH - Substance Abuse and Mental Health Services Administration National Survey on

Drug Use and Health (NSDUH) special data run on journal articles referencing NSDUH)
Substance Abuse and Mental Health Services Administration - conference generated
recommendations from users of SAMHSA's data sets.

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