NATIONAL DRUG CONTROL STRATEGY

Performance Reporting System Report

2015

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Introduction

The Obama Administration is committed to a coordinated government-wide public health and public safety approach to reduce 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 extensive interagency process that brought together subject matter experts, policy and program analysts, researchers, statisticians, and leadership from Federal drug control agencies. The original PRS report[1] 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 focused on Working Groups that developed appropriate performance measures and targets for each of the seven Objectives in the *Strategy*. The Working Groups included representatives from the following Federal agencies: 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 templates 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 second assessment of interagency progress toward achieving the 2015 *Strategy* Goals and Objectives, showing significant progress with regard to treatment, domestic law enforcement, interdiction, and international partnerships. While treatment measures pertaining to the criminal justice system generally show improvement in the direction of achieving the 2015 targets, supplemental sources of nationally representative data are required in order to assess the effectiveness of the system's reform efforts, particularly for youth. Efforts to expand access to recovery services across systems of care have not shown equivalent progress; challenges persist in the integration of substance abuse treatment services into mainstream health care. The implementation of the Affordable Care Act presents important opportunities to provide greater access to treatment for substance use disorders by efficiently integrating such treatment

[1]The report is available at: http://www.whitehouse.gov/sites/default/files/ondcp/prs_2012.pdf (Accessed January 12, 2015)

into the health care system, requiring the provision and coverage of services for mental health and substance use disorders at parity, and providing non-discrimination for coverage for pre-exiting conditions.

Significant progress is being achieved in domestic law enforcement and efforts to strengthen international partnerships, especially in regards to the disruption or dismantlement of domestic and international drug trafficking organizations. Additionally, key source and transit countries continue to demonstrate increased commitment to reducing drug trafficking and use through demand and supply reduction efforts. However, accelerated progress is needed in working with partner countries to reduce the cultivation of drugs and their production potential in Afghanistan, Burma, Laos, Mexico, and Peru.[2]

This report also discusses the significant progress and challenges observed in the area of substance use prevention. Substantial progress is being achieved in reducing prescription drug abuse among 18-25 year olds, the age group showing the greatest prevalence of non-medical use of prescription-type drugs. More work is needed to strengthen 12-17 year olds' perceptions of the great risk in binge drinking and, to a lesser extent, in smoking cigarettes including e-cigarettes. Accelerated effort is needed to prevent youth marijuana use and counter youth perceptions that marijuana (including synthetic marijuana) use is not harmful. For each of the *Strategy* Goals and Objectives, the following definitions were applied to assess progress:

- **Target met or exceeded, progress should be maintained through 2015** *(Given the data available at this time, the target has been met or exceeded*.)
- **Progress sufficient to enable meeting 2015 target** *(Given the data available at this time, there is a reasonable expectation that the 2015 target will be met*.)
- **Progressing, accelerated progress required to meet 2015 target** *(Movement toward the target is in the right direction; based on the data available at this time, accelerated progress is required to meet the 2015 target.*)
- **No Progress to Date, accelerated progress required to meet 2015 target** *(Movement toward the target is stalled; based on the data available at this time, accelerated progress is required to meet the 2015 target*.)
- **Significant (or Considerable) progress required to meet 2015 target** *(Movement toward the target is not in the right direction; based on the data available at this time, significant progress is required to meet the 2015 target*.)

The table below summarizes progress toward achieving the overall *Strategy* Goals to reduce drug use and its consequences.

[2] While coca cultivation in Colombia in 2014 was still below the 2015 target, it increased substantially over 2013 and is therefore cause for concern.

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

Strategy Goal	Measures	Progress-to-Date
Goal 1: Curtail illicit drug consumption in America	1a: Decrease the 30-day prevalence of drug use among 12–17 year olds by 15%	Progress sufficient to enable meeting 2015 target
	1b: Decrease the lifetime prevalence of 8th graders who have used drugs, alcohol, or tobacco by 15%	
	- Illicit Drugs	Significant progress required to meet 2015 target
	- Alcohol	Target met or exceeded, progress should be maintained through 2015
	- Tobacco	Target met or exceeded, progress should be maintained through 2015
	1c: Decrease the 30-day prevalence of drug use among young adults aged 18–25 by 10%	No progress to date, accelerated progress required to meet 2015 target
	1d: Reduce the number of chronic drug users by 15%	
	- Cocaine	Progress sufficient to enable meeting 2015 target
	- Heroin	No progress to date, accelerated progress required to meet 2015 target
	- Marijuana	Significant progress required to meet 2015 target
	- Methamphetamine	Progress sufficient to enable meeting 2015 target
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%	Significant progress required to meet 2015 target
	2b: Reduce drug-related morbidity by 15%	
	- Emergency room visits for drug misuse and abuse	Significant progress required to meet 2015 target
	- HIV infections attributable to drug use	Target met or exceeded, progress should be maintained through 2015
	2c: Reduce the prevalence of drugged driving by 10%	
	- Data Source: National Roadside Survey	Significant progress required to meet 2015 target
	- Data Source: National Survey on Drug Use and Health	Target met or exceeded, progress should be maintained through 2015

The following seven Objectives focus on specific substantive areas where collective progress is needed to achieve the two *Strategy* Goals:

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

Objective 2: Seek Early Intervention Opportunities in Health Care

Objective 3: Integrate Treatment for Substance Use Disorders into Health Care and Expand Support for Recovery

Objective 4: Break the Cycle of Drug Use, Crime, Delinquency, and Incarceration

Objective 5: Disrupt Domestic Drug Trafficking and Production

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

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

The table below summarizes the progress toward achieving the Objectives.

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

Strategy Objective	Measures	Progress-to-Date
Objective 1: Strengthen Efforts to Prevent Drug Use in Our Communities	1.1 Percent of respondents, ages 12–17, who perceive a great risk in smoking marijuana once or twice a week	Significant progress required to meet 2015 target
	1.2 Percent of respondents, ages 12–17, who perceive a great risk in consumption of one or more packs of cigarettes per day	No progress to date, accelerated progress required to meet 2015 target
	1.3 Percent of respondents, ages 12–17, who perceive a great risk in consuming four or five drinks once or twice a week	No progress to date, accelerated progress required to meet 2015 target
	1.4 Average age of initiation for all illicit drugs	Progress sufficient to enable meeting 2015 target
	1.5 Average age of initiation for alcohol use*	Progressing, accelerated progress required to meet 2015 target
	1.6 Average age of initiation for tobacco use	
	- Cigarettes	Progressing, accelerated progress required to meet 2015 target
	- Cigars	Target met or exceeded, progress should be maintained through 2015
	- Smokeless tobacco	Target met or exceeded, progress should be maintained through 2015
Objective 2: Seek Early Intervention Opportunities in Health Care	2.1 Percent of Federally Qualified Health Center grantees providing SBIRT services	Target met or exceeded, progress should be maintained through 2015
	2.2 Percent of respondents in the past year using prescription-type drugs non-medically, age 12 - 17	Target met or exceeded, progress should be maintained through 2015
	2.3 Percent of respondents in the past year using prescription-type drugs non-medically, age 18 - 25	Target met or exceeded, progress should be maintained through 2015
	2.4 Percent of respondents in the past year using prescription-type drugs non-medically, age 26+	No progress to date, accelerated progress required to meet 2015 target
Objective 3: Integrate Treatment for Substance Use Disorders into Health Care and	3.1 Percent of treatment plans completed	Significant progress required to meet 2015 target
	3.2 Percent of Health Center grantees providing substance abuse counseling and treatment services	Significant progress required to meet 2015 target

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

Strategy Objective	Measures	Progress-to-Date
Expand Support for Recovery	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, progress should be maintained through 2015
Objective 4: Break the Cycle of Drug Use, Crime, Delinquency, and Incarceration	4.1 Percent of residential facilities in the Juvenile Justice System offering substance abuse treatment	Target met or exceeded, progress should be maintained through 2015
	4.2 Percent of treatment plans completed by those referred by the Criminal Justice System	Progressing, accelerated progress required to meet 2015 target
Objective 5: Disrupt Domestic Drug Trafficking and Production	5.1 Number of domestic CPOT-linked organizations disrupted or dismantled	Target met or exceeded, progress should be maintained through 2015
	5.2 Number of RPOT-linked organizations disrupted or dismantled	Target met or exceeded, progress should be maintained through 2015
	5.3 Number of methamphetamine lab incidents	Progressing, accelerated progress required to meet 2015 target
Objective 6: Strengthen International Partnerships and Reduce the Availability of Foreign Produced Drugs in the United States	6.1 Percent of selected countries on the Majors List that increased their commitment to demand reduction	Target met or exceeded, progress should be maintained through 2015
	6.2 Percent of selected countries on the Majors List that increased their commitment to supply reduction	Target met or exceeded, progress should be maintained through 2015
	6.3 Percent of Majors List countries showing progress since 2009 in reducing either cultivation or drug production potential	No Progress to Date, accelerated progress required to meet 2015 target.
	6.4: Number of international CPOT-linked organizations disrupted or dismantled	Target met or exceeded, progress should be maintained through 2015
Objective 7: Improve Information Systems for Analysis, Assessment, and Local Management	7.1 Increase timeliness (year-end to date-of-release) of select Federal data sets above their baseline by 10% - (Treatment Episode Data Set)	Significant progress required to meet 2015 target
	7.2 Increase the utilization (Increase number of annual web hits or number of documents referencing the source -- Substance Abuse and Mental Health Data Archive (SAMHDA), and Journal articles referencing NSDUH)	Target met or exceeded, progress should be maintained through 2015
	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, progress should be maintained through 2015

*Note: target is an ambitious stretch target consistent with the legal age for alcohol consumption.

Data Challenges

One of the greatest impediments to acquiring a clear understanding of drug trends is the inadequacy of data on the outcomes of drug control activities. 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, inadequate data sources, as it relates to the effectiveness of juvenile and criminal justice reform efforts (beyond treatment provision), similarly prohibits the assessment of these efforts on recidivism. National data deficiencies additionally required the reliance on proxy measures taken from information collected on the Health Resources and Services Administration's (HRSA) health centers in order 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 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.

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 the most current year. For this report, the most recent data available were used.

Where possible, statistically significant changes have been noted in this report. Statistical significance testing is important for interpreting and assessing apparent changes in trends over time; not all of the data cited in this report has been subjected to significance testing by the originating sources. Statistically significant changes will be designated within the text with use of words such as, "increase," "rise," "decline," and "drop." Changes not assessed or determined to be statistically significant will be discussed in terms of "trends" over time.

Chapter 1: Progress toward Achieving the *Strategy* Goals

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. A suite of seven measures has been developed to assess progress (see Tables 1-1 and 1-2) 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. Described in detail in this chapter is each of the seven *Strategy* Goal measures along with their baselines, 2015 targets, data sources, and assessments of progress-to-date.

Table 1-1: National Drug Control Strategy Goal 1: Curtail illicit drug consumption in America Measures, Baselines, Progress-to-date, Targets, and Assessment

National Drug Control Strategy Measure	Base-line	Progress-to-date	2015 Target	Assessment
1a: Decrease the 30-day prevalence of drug use among 12–17 year olds by 15%	10.1% (2009) NSDUH	2013: 8.8% 2012: 9.5%* 2011: 10.1% 2010: 10.1%	8.6%	Progress sufficient to enable meeting 2015 target
1b: Decrease the lifetime prevalence of 8th graders who have used drugs, alcohol, or tobacco by 15%				
- Illicit Drugs	19.9% (2009) MTF	2014: 20.3% 2013: 21.1% 2012: 18.5% 2011: 20.1% 2010: 21.4%	16.9%	Significant progress required to meet 2015 target
- Alcohol	36.6%* (2009) MTF	2014: 26.8% 2013: 27.8% 2012: 29.5% 2011: 33.1% 2010: 35.8%	31.1%	Target met or exceeded, progress should be maintained through 2015
- Tobacco**	20.1%* (2009) MTF	2014: 13.5%* 2013: 14.8%* 2012: 15.5%* 2011: 18.4% 2010: 20.0%	17.1%	Target met or exceeded, progress should be maintained through 2015
1c: Decrease the 30-day prevalence of drug use among young adults aged 18–25 by 10%	21.4% (2009) NSDUH	2013: 21.5% 2012: 21.3% 2011: 21.4% 2010: 21.6%	19.3%	No progress to date, accelerated progress required to meet 2015 target

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 sufficient to enable meeting 2015 target
Heroin	1.5 million (2009) What Americans Spend on Illicit Drugs	2010: 1.5 million	1.3 million	No progress to date, accelerated progress required to meet 2015 target
Marijuana	16.2 million (2009) What Americans Spend on Illicit Drugs	2010: 17.6 million	13.8 million	Significant progress required to meet 2015 target
Methamphetamine	1.8 million (2009) What Americans Spend on Illicit Drugs	2010: 1.6 million	1.5 million	Progress sufficient to enable meeting 2015 target

Data Sources: (1a) Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health; (1b) National Institutes on Drug Abuse's Monitoring the Future; (1c) Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health; (1d) What Americans Spend on Illegal Drugs
*The difference between estimate and most recent year's estimate is statistically significant.
**Measure focuses on cigarette use.

Assessment of Progress

The following discusses the data sources, targets, progress made to date, and future action required to achieve each of the measures comprising 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.

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 the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH). The NSDUH 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. In 2010 and 2011 the rates remained steady at 10.1 percent before trending downward to 9.5 percent in 2012. In 2013, the rate dropped to 8.8 percent, approaching the 2015 target of 8.6 percent. The NSDUH indicates

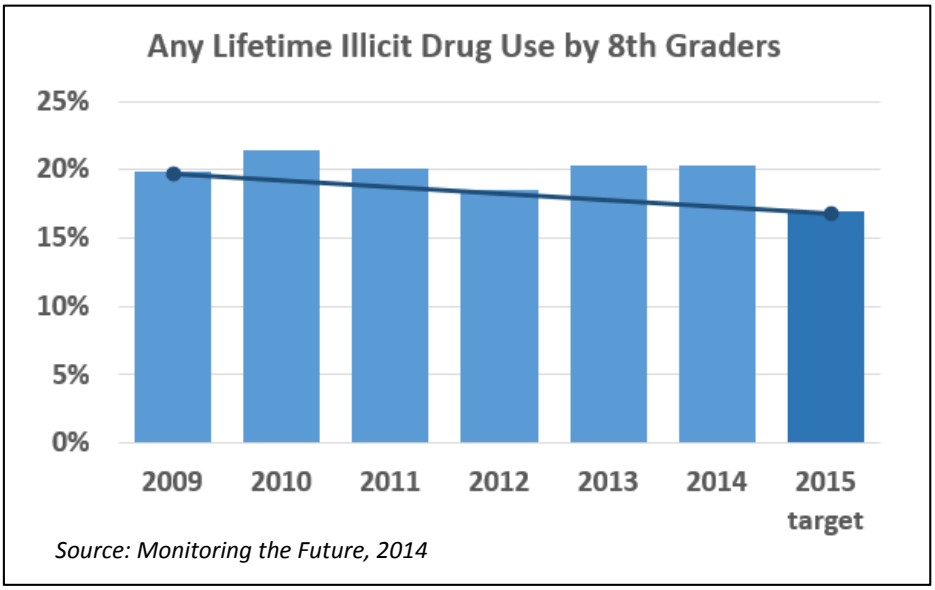
that, in 2009, the prevalence of current marijuana use among 12 to 17 year olds was 7.4 percent; a rate that has trended down to 7.1 percent by 2013. For this same cohort, NSDUH shows that rates of use for illicit drugs other than marijuana has steadily dropped from 4.6 percent in 2009 to 4.5 percent in 2010, 4.1 percent in 2011, 3.7 percent in 2012, and 3.0 percent in 2013.

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

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[3] by 8th grade students are not combined within the study and are presented here separately. The 2009 baselines are (i) any illicit drug, 19.9 percent; (ii) alcohol, 36.6 percent; and (iii) tobacco/cigarettes, 20.1 percent. The 2015 targets are (i) any illicit drug, 16.9 percent; (ii) alcohol, 31.1 percent; and (iii) tobacco/cigarettes, 17.1 percent.[4]

Any Illicit Drug: Lifetime use of any illicit drug among 8th graders is trending up in the past two years, away from the 2015 target, from 19.9 percent in 2009 to 20.3 percent in 2014.

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



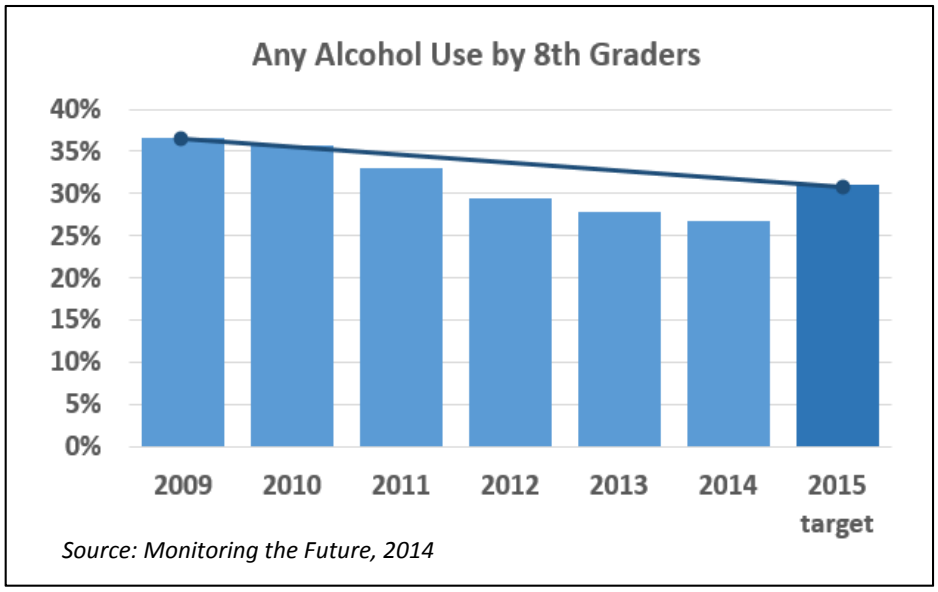
Source: Monitoring the Future, 2014

[3] 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 of only seniors. 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.

[4] In the MTF study, tobacco refers specifically to the use of cigarettes; MTF does not report an estimate of all tobacco products combined.

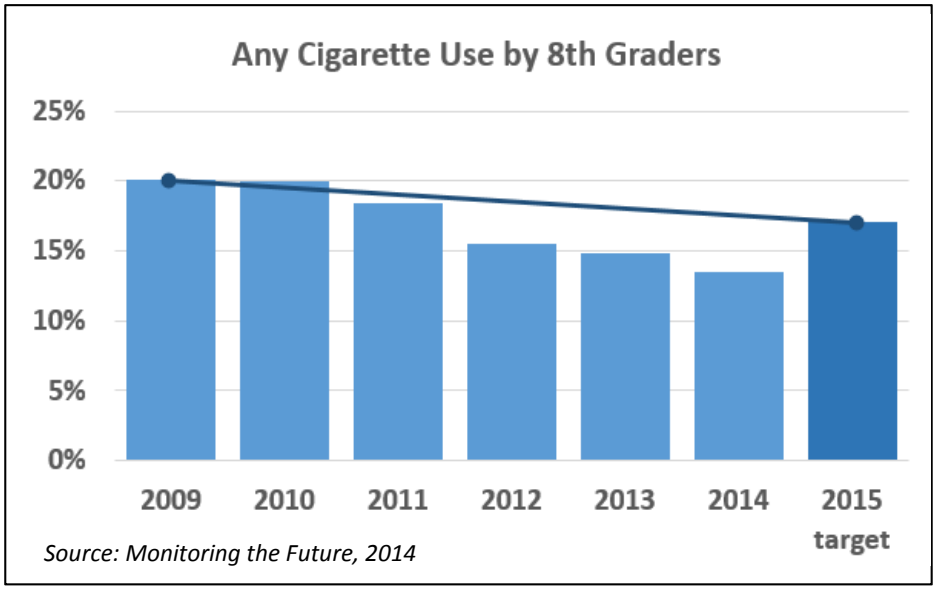
Alcohol: The 2014 estimate of lifetime alcohol use among 8th graders (26.8 percent) has dropped below the 2015 target (31.1 percent). This level of progress needs to be maintained.

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



Cigarettes: The 2015 target for lifetime cigarette use by 8th graders (17.1 percent) has been achieved since 2012 (15.5 percent). The rate continued to drop in 2014 to 13.5 percent.

Figure 1-3: Cigarette Use by 8th Graders Over Time in Reference to 2015 Target



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

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. The estimate for the measure's assessment of past month use of any illicit drug is driven by marijuana. In 2013, the level remained steady with 21.5 percent of 18 to 25 year olds having used an illicit drug in the past month; 19.1 percent had used marijuana during this time period. While these estimates have changed very little since 2009, the use of illicit drugs other than marijuana by young adults has declined from 8.4 percent in 2009 to 6.7 percent in 2013.

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

The data for this measure are from the report, *What America's Users Spend on Illicit Drugs*. This report estimates the retail value of the illicit drug market. In producing this estimate, two other estimates are calculated: the number of users (occasional and chronic) of each of the four major drugs (marijuana, cocaine, heroin, and methamphetamine)[5] and the amount of each drug consumed by these users. The 2009 baselines for the number of users are (i) cocaine, 2.7 million; (ii) heroin, 1.5 million; (iii) marijuana, 16.2 million; and (iv) methamphetamine, 1.8 million. The 2015 targets are (i) cocaine, 2.3 million; (ii) heroin, 1.3 million; (iii) marijuana, 13.8 million; and (iv) methamphetamine, 1.5 million.

Cocaine: The 2009 estimate of chronic drug users (2.7 million) is on track to meet the 2015 target (2.3 million) with 2.5 million drug users in 2010. This is consistent with the downward trending estimates of the amount of drugs consumed from 2009 (161 metric tons) to 2010 (145 metric tons).

Heroin: Heroin use remained stable at 1.5 million users in 2009 and 2010. No progress toward achieving the 2015 target number of heroin users (1.3 million) has been observed.

Marijuana: The 2009 estimate of chronic drug users (16.2 million) increased to 17.6 million in 2010; moving away from the 2015 target number of users (13.8 million). There has also been an increase in the estimate for the amount of drugs consumed from 5.1 metric tons in 2009 to 5.7 metric tons in 2010.

Methamphetamine**:** The 2009 estimate for chronic methamphetamine users has decreased from 2009 (1.8 million) to 2010 (1.6 million) and is progressing toward the 2015 target (1.5 million). The amount of consumed methamphetamine has increased during this same period from 40 metric tons consumed in 2009 to 42 metric tons consumed in 2010.

[5] The report defines chronic users of cocaine, heroin, and methamphetamine as those who use the drug on four or more days per month—essentially once per week. For marijuana there are three categories of chronic users: 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 users for all four drugs are those who use less than four times per month.

Table 1-2: National Drug Control Strategy Goal 2: Improve the public health and public safety of the American people by reducing the consequences of drug use Measures, Baselines, Progress-to-date, Targets, and Assessment

National Drug Control Strategy Measure	Base-line	Progress-to-date	2015 Target	Assessment
2a: Reduce drug-induced deaths by 15%	39,147 (2009) National Vital Statistics Data	2013: 46,471 2012: 43,819 2011: 43,544 2010: 40,393	33,275	Significant progress required to meet 2015 target
2b: Reduce drug-related morbidity by 15%				
- Emergency room visits for substance use disorders	2,070,452 (2009) DAWN	2011: 2,462,948	1,759,884	Significant progress required to meet 2015 target
- HIV infections attributable to drug use	5,799 (2009) CDC	2010: 5,138 2011: 4,513 2012: 4,342 2013: 4,366	4,929	Target met or exceeded, progress should be maintained through 2015
2c: Reduce the prevalence of drugged driving by 10%				
- Data Source: National Roadside Survey	16.3% (2007) NHTSA	2013: 20.0%	14.7%	Significant progress required to meet 2015 target
- Data Source: National Survey on Drug Use and Health	4.4% (2009) NSDUH	2013: 4.0% 2012: 4.2% 2011: 3.9% 2010: 4.4%	4.0%	Target met or exceeded, progress should be maintained through 2015

Data Sources: (2a) SAMHSA's Drug Abuse Warning Network drug-related emergency room visits; (2b) Centers for Disease Control and Prevention (CDC). HIV Surveillance Report-Diagnoses of HIV Infection in the United States, 2013. Vol. 25 (February 2015).; (2c) and National Highway Traffic Safety Administration Roadside Survey.

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

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. 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 2013, there were 46,471 drug-induced deaths, an increase of 19 percent compared to 2009. Of the 46,471 drug-induced deaths in 2013, 43,982 (95 percent)

were drug poisonings, the majority of which (22,767) involved prescription drugs, especially pain relievers (16,235).[6]

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

There are two separate sources of data for this measure. The primary source is drug-related emergency department (ED) visits for substance use disorders of illicit drugs or pharmaceuticals from the Drug Abuse Warning Network (DAWN).[7] The second source is the number of people with HIV who were infected through injection drug use. The 2009 baseline estimate is 2,070,452 drug-related ED visits; the 2015 target aims to lower this number by 15 percent to 1,759,884. To date, this measure is trending in the wrong direction with 2,462,948 such visits in 2011. The movement is attributable to rises in visits related to both illicit 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. Data for the number of people diagnosed to be infected with HIV are compiled by CDC. The 2009 baseline estimate of the number of individuals diagnosed with HIV infection through injected drug use (IDU) is 5,799 (which includes those in the transmission category of male-to-male sexual contact and IDU);[8] the 2015 target strives to lower this number by 15 percent to 4,929. As of 2013, 4,366 individuals were diagnosed with HIV infection through injected drug use, indicating that the 2015 target has been exceeded; this progress will need to be maintained through 2015 to ensure the target is met.

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

There are two sources of data for this measure that are reported on separately. The primary source is the National Roadside Survey conducted by the National Highway Traffic Safety Administration. The second data source is the NSDUH. 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 and 2014 and found that the prevalence of nighttime weekend driving after consuming drugs or medications rose to 20.0 percent.

In addition to using data from the Roadside Survey, ONDCP references annual NSDUH data to assess whether respondents age 16 years and older drove a vehicle while under the influence of an illicit drug in the past year. The 2009 baseline estimate for this measure is 4.4 percent and

[6]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.

[7] The DAWN system was discontinued by SAMHSA in 2011; SAMHSA and CDC are currently working to implement a replacement system to provide data on drug-related ED visits.

[8] The data source for this measure has been changed from cases of incidence of drug-related HIV to diagnoses of such cases, because the estimation of the incident cases are not expected to be produced in time to be useful in assessing progress toward achieving this measure.

the 2015 target is 4.0 percent. This measure met its 2015 target in 2013, with NSDUH showing a downward trend to 4.0 percent.

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 measures to gauge progress toward achieving each of the objectives using baselines, 2015 targets, data sources, and an assessment of progress-to-date.

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

As one of the Administration's highest 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 outlines the measures, baselines, progress-to-date, targets, and assessments for this Objective.

Assessment of Progress

The following discusses the data sources, targets, progress made to date, and future action required to achieve each of the measures comprising the *Strategy's* 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 National Survey on Drug Use and Health (NSDUH). Given the data available at this time, significant progress is required to meet the 2015 target. 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 39.5 percent in 2013. Additionally, the rate of those reporting great risk in smoking marijuana once a month has declined from 30.3 percent in 2009 to 24.2 percent in 2013. Perceived risk is an important variable and has been a leading indicator of use. The sharp decline in 2013 among teens may suggest that increases in use are likely to occur in the near future.

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,

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

Objective 1 Measure	Base-line	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	2013: 39.5% 2012: 43.6%* 2011: 44.8% 2010: 47.2%	51.2%	Significant progress required to meet 2015 target
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	2013: 64.3% 2012: 65.7%* 2011: 66.2% 2010: 65.3%	68.0%	No progress-to-date, accelerated progress required to meet 2015 target
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	2013: 39.0% 2012: 39.7% 2011: 40.7% 2010: 40.4%	41.4%	No progress-to-date, accelerated progress required to meet 2015 target
Measure 1.4: Average age of initiation for all illicit drugs	17.6 years* (2009) NSDUH	2013: 19.0 2012: 18.7 2011: 18.1 2010: 19.1	19.5 years	Progress sufficient to enable meeting 2015 target
Measure 1.5: Average age of initiation for alcohol use	16.9 years* (2009) NSDUH	2013: 17.3 2012: 17.4 2011: 17.1 2010: 17.1	21.0 years[1]	Progressing, accelerated progress required to meet 2015 target
Measure 1.6: Average age of initiation for tobacco use[2]				
- Cigarettes	17.5 years (2009) NSDUH	2013: 17.8 2012: 17.8 2011: 17.2* 2010: 17.3	18.0 years	Progressing, accelerated progress required to meet 2015 target
- Cigars	20.7 years (2009) NSDUH	2013: 21.6 2012: 20.5 2011: 19.6* 2010: 20.5	18.0 years	Target met or exceeded, progress should be maintained through 2015
- Smokeless tobacco	18.9 years (2009) NSDUH	2013: 18.4 2012: 18.8 2011: 19.8* 2010: 19.3	18.0 years	Target met or exceeded, progress should be maintained through 2015

Data Sources: Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health
[1]While the age of 21 is a "stretch target" representing a challenge to achieve by 2015, the target is consistent with the standard set forth in the National Minimum Drinking Age Act of 1984. "
[2]Since NSDUH reports data according to tobacco product, the assessment is made separately for cigarettes, cigars, and smokeless tobacco.
*The difference between estimate and most recent year's estimate is statistically significant.

2012). Thus, perception of risk of cigarette use is an important indicator of youth drug use behavior. Based on data available at this time, there has been little progress toward meeting the 2015 target. According to the 2013 NSDUH, the percentage of youth aged 12 to 17 who reported

great risk in smoking one or more packs of cigarettes per day declined from 65.5 percent in 2009 to 64.3 percent in 2013.

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 crashes 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 2013 NSDUH, 39.0 percent of youth ages 12-17 perceived great risk in having 5 or more drinks of an alcoholic beverage once or twice a week. Movement toward the 2015 target of 41.4 percent has stalled, but has historically trended in the right direction. Accelerated progress is required.

Measure 1.4: Average age of initiation for all illicit drugs

According to the NSDUH, about 2.8 million persons aged 12 or older used an illicit drug for the first time in 2013, averaging about 7,800 new users per day. Over half (54.1 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 similar to the 2012 estimate of 18.7 years 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 2015 target.

Measure 1.5: Average age of initiation for alcohol use

The 2013 NSDUH shows that approximately 4.6 million persons aged 12 or older used alcohol for the first time within the past 12 months; averaging approximately 12,500 initiates per day. Most (83.5 percent) were younger than age 21 at the time of initiation, and over one half (59.1 percent) initiated use prior to age 18. The average age of first alcohol use among recent initiates aged 12 to 49 years was 17.3 years, which was similar to the 2012 estimate. There has been some progress toward achieving the target. However, based on data available at this time, accelerated progress is required to meet the 2015 target age of 21 (which was selected in the context of the legal age for alcohol use).

Measure 1.6: Average age of initiation for tobacco use

The 2013 NSDUH reported that there were approximately 2.1 million persons aged 12 or older who smoked cigarettes for the first time within the past 12 months, which was similar to the 2012 estimate (2.3 million). This averages to about 5,700 new cigarette smokers per day. Importantly, half of them (50.5 percent) began smoking before they were 18 years old. The

[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.

NSDUH provides data for specific tobacco products - cigarettes, cigars, and smokeless tobacco. Therefore, the PRS assesses progress separately for each tobacco product as follows:

Cigarettes **-** There has been no significant movement toward the target. Based on data available at this time, accelerated progress is required to meet the 2015 target age of 18 (which was selected in the context of the legal age for tobacco use). According to the 2013 NSDUH, among past-year initiates aged 12 to 49, the average age of first cigarette use was 17.5 years in 2009, which was similar to the corresponding average ages in 2012 and 2013 (17.8 years), following a drop in 2011 to 17.2 years.[10]

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 21.6 years in 2013. The 2013 NSDUH estimates that 2.8 million persons, aged 12 or older, used cigars for the first time in the past 12 months, which is similar to the 2012 estimate (2.7 million).

Smokeless Tobacco **-** The 2015 target of 18.0 years has been exceeded. According to the 2013 NSDUH, the average age of first use among 12-49 year olds was 18.4 years, similar to the 2009 (18.9 years) and 2012 (18.8 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, and 1.1 million in 2013.

Objective 2 - Seek Early Intervention Opportunities in Health Care

Full implementation of the health care reforms under the Affordable Care Act will extend access to and parity[11] for substance use disorder treatment services for an estimated 62 million Americans and help integrate treatment into mainstream health care (Berino 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 a number of tools to enable the detection and treatment of substance use disorders should be utilized, such as Screening, Brief Intervention, and Referral to Treatment (SBIRT). Furthermore, 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 Centers for Disease Control and Prevention (Centers for Disease Control and Prevention, 2011). Table 2-2 below outlines the measures, targets, and progress-to-date for this Objective.

[10]NSDUH reports that the average age of first daily smoking (e.g., smoking on each of the past 30 days) among new daily smokers aged 12 to 49, was 19.1 years in 2010 and 2011, 19.9 years in 2012, and 19.8 years in 2013. Of the new daily smokers in 2013, 33 percent were younger than age 18 when they started smoking daily. This figure averages to approximately 700 initiates of daily smoking under the age of 18 every day.

[11]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	Base-line	Progress-to-date	2015 Target	Assessment
Measure 2.1: Percent of Health Center Program grantees providing SBIRT services	10.3% (2009) UDS	2013: 16.9% 2012: 13.8% 2011: 11.3% 2010: 11.3%	15.0%	Target met or exceeded, progress should be maintained through 2015
Measure 2.2: Percent of respondents in the past year using prescription-type drugs non-medically, age 12 - 17	7.7%* (2009) NSDUH	2013: 5.8% 2012: 6.6%* 2011: 7.0%* 2010: 7.4%*	6.5%	Target met or exceeded, progress should be maintained through 2015
Measure 2.3: Percent of respondents in the past year using prescription-type drugs non-medically, age 18 - 25	15.0%* (2009) NSDUH	2013: 12.2% 2012: 13.7%* 2011: 12.7% 2010: 14.3%*	12.8%	Target met or exceeded, progress should be maintained through 2015
Measure 2.4: Percent of respondents in the past year using prescription-type drugs non-medically, age 26+	4.7% (2009) NSDUH	2013: 4.8% 2012: 5.1% 2011: 4.3% 2010: 4.8%	4.0%	No progress-to-date, accelerated progress required to meet 2015 target

Data Sources: (2.1) Health Resources and Services Administration's (HRSA) Uniform Data System (UDS); (2.2, 2.3, and 2.4) Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH)
*Difference between estimate and 2013 estimate is statistically significant.

Assessment of Progress

The following discusses the data sources, targets, progress made to date, and future action required to achieve each of the measures comprising the *Strategy's* Objective 2: Seek early intervention opportunities in health care.

Measure 2.1: Percent of Federally-Qualified Health Center grantees providing Screening, Brief Intervention, and Referral to Treatment (SBIRT) services

This measure tracks the expansion of SBIRT services among the 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 nearly 22 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, there is no national source of data 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 substance use disorder SBIRT services into primary care through the SAMHSA/HRSA Center for Integrated Health Solutions, the National

Association of Community Health Centers, and training and meetings. Based on data available at this time, the 2015 target of 15 percent of health centers providing SBIRT services has been achieved in 2013 (17 percent); this level of progress needs to be maintained.

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, because substance use at a young age increases the likelihood of a chronic substance use disorder at a later age. Given the PRS data available at this time, the 2015 target of 6.5 percent has been exceeded. The 2013 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 5.8 percent in 2013.

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

Data from the 2013 NSDUH indicate that this age group (18-25) had the highest rate of past year non-medical use of prescription drugs (12.2 percent), as compared to the other two age groups (5.8 percent for 12-17 year olds and 4.8 percent 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 2013 rate met 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 22 years for pain relievers and stimulants[12] and 25 years for sedatives and tranquilizers. The NSDUH data highlight the need to reduce the non-medical use of pain relievers, amphetamines, sedatives, and tranquilizers by individuals who are in their early 20s.

Measure 2.4: Percent of respondents in the past year using prescription-type drugs non-medically, age 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 2013 NSDUH, opioid pain relievers were the primary type of prescription drugs that were used non-medically by those ages 26 and over. Tranquilizers were also frequently used non-medically by this group. The 2013 data available indicate that there has been no change in non-medical use of prescription drugs by those 26 and older since 2009. Of note, with a 4.8 percent rate of non-medical use of prescription drugs in 2013, this 26-and-older group amounted to nearly 9.6 million people. Of those, 3.8 million were aged 26-34 and over 5.8 million were 35 and older.

Of those aged 26-34 who used prescription drugs non-medically in 2013, 2.7 million used pain relievers and over 1.5 million used tranquilizers. Additionally, of the 5.8 million people ages 35

and older who used prescription drugs in 2013, 4.2 million of them used pain relievers and nearly 2 million used tranquilizers.

Objective 3 - Integrate Treatment for Substance Use Disorders into Health Care and Expand Support for Recovery

Addiction 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 Obama 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 are 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	Base-line	Progress-to-date	2015 Target	Assessment
Measure 3.1: Percent of treatment plans completed	45.1% (2007) TEDS-D	2011: 43.7% 2010: 44.1% 2009: 46.7% 2008: 46.6%	50.0%	Significant progress required to meet 2015 target
Measure 3.2: Percent of Health Center Program grantees providing substance use counseling and treatment services	21.6% (2009) UDS	2013: 20.0% 2012: 20.2% 2011: 22.1% 2010: 22.6%	23.0%	Significant progress required to meet 2015 target
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, progress should be maintained through 2015

Data Sources: (3.1) Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Episode Data Set – Discharge (TEDS-D); (3.2) Health Resources and Services Administration's (HRSA) Uniform Data System (UDS); (3.3) Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey of Substance Abuse Treatment Services (N-SSATS)

Assessment of Progress

The following discusses the data sources, targets, progress made to date, and future action required to achieve each of the measures comprising the *Strategy's* Objective 3: Integrate treatment for substance use disorders into health care and expand support for 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. Given the data available at this time, significant 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 downwards to 44.1 percent in 2010 and 43.7 percent in 2011.

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 nearly 22 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. An increase in the number of health center grantees offering these services would show that services for substance use disorders are more integrated and expansive; 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.

Movement toward the target is downward trending; based on the data available, significant progress is required to meet the 2015 target. According to the 2013 UDS data, the percent of grantees that provide substance use disorder counseling and treatment services has decreased by 7 percent since 2009 to a rate of 20 percent by 2013. With a 2015 target of 23 percent, significant and accelerated progress is required.

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. 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 in 2011; this level of progress needs to be maintained.

Objective 4—Break the Cycle of Drug Use, Crime, Delinquency, and Incarceration

At the end of 2013, about 6.9 million people—about 2.8 percent of the total adult population - were under some form of adult correctional supervision (Glaze and Herberman 2013). 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 and Karberg, 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, but most 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 and Karberg, 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	Base-line	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	2012: 45.3% 2010: 40.5%**	42.7%	Target met or exceeded, progress should be maintained through 2015
Measure 4.2: Percent of treatment plans completed by those referred by the Criminal Justice System	48.8% (2007) TEDS-D	2011: 47.5% 2010: 47.9% 2009: 49.6% 2008: 48.4%	51.0%	Progressing, accelerated progress required to meet 2015 target

Data Sources: (4.1) Office of Juvenile Justice and Delinquency Prevention's (OJJDP) Juvenile Residential Facility Census (JRFC); (4.2) Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Episode Data Set – Discharge (TEDS-D)

* Biennial census

** Recalculated to reflect TEDS-D data for prior years which is subject to revision by states.

Assessment of Progress

The following discusses the data sources, targets, progress made to date, and future action required to achieve each of the measures comprising the *Strategy's* Objective 4: Break the Cycle of Drug Use, Crime, Delinquency, and Incarceration.

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, 85 percent of all residential juvenile facilities offered treatment for substance use disorder services in 2006 were selected as the baseline because it was the latest year for which data from the JRFC were available. The base year for the PRS is 2009 except in cases where 2009 data were not yet available. For this measure 2006 data were used. 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. Using the same degree of change, an increase of 5 percent, as reported in the PRS design report with the revised baseline value of 38.8 percent, the 2015 target was also revised to 42.7 percent.

In 2012, the data showed that 900 out of 1,985 (45.3 percent) juvenile facilities reported providing treatment for a substance use disorder. Of the facilities in the juvenile justice system offering treatment for substance use disorders, 44 percent were public residential facilities and 46.7 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 1,985 in 2012 and a similar reduction in the number of facilities providing treatment services from 950 in 2008 to 900 in 2012. A complete breakout of past availability of facilities providing treatment for substance use disorders by facility type can be found at Table 2-4a below.

Table 2-4a: 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
Total number of facilities	3,047	2,955	2,799	2,649	2,450	2,111	1,985
N facilities providing treatment	1,147	1,252	1,149	1,071	950	854	900
% of total	37.6%	42.4%	41.1%	40.4%	38.8%	40.5%	45.3%

Availability of substance use disorder treatment by facility operation

Facility operation	**2000**	**2002**	**2004**	**2006**	**2008**	**2010**	**2012**
Public							
Total facilities	1,200	1,182	1,187	1,166	1,150	1,074	1,007
% providing service	40.7%	45.3%	42.7%	45.4%	42.3%	42.5%	44.0%
Private							
Total facilities	1,847	1,773	1,612	1,483	1,300	1,037	978
% providing service	35.7%	40.4%	39.8%	36.5%	35.6%	38.4%	46.7%

Measure 4.2: Percent of treatment plans completed by those referred by the criminal justice system[13]

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 since 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[14], length of stay in treatment, substance use disorder characteristics, and client demographics. Given the data available at this time, this measure needs accelerated progress to meet the target of 49 percent for 2015. According to the latest 2011 TEDS-D, the data showed that 47.5 percent (278,519 of 586,901) criminal justice referrals completed their drug use treatment plans.

[13] 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.

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

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 the Table 2-5 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 are 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[15] 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.

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

Objective 5 Measure	Base-line	Progress-to-date	2015 Target	Assessment
Measure 5.1: Number of domestic CPOT*-linked organizations disrupted or dismantled	296 (2009) PTARRS	2013: 473 2012: 450 2011: 477 2010: 425	380	Target met or exceeded, progress should be maintained through 2015
Measure 5.2: Number of RPOT**-linked organizations disrupted or dismantled	119 (2009) MIS	2014: 153 2013: 170 2012: 156 2011: 164 2010: 116	120	Target met or exceeded, progress should be maintained through 2015
Measure 5.3 Methamphetamine lab activity (as measured by number of methamphetamine lab seizure incidents)	12,852 (2009) NSS	2013: 11,329 2012: 12,754 2011: 13,405 2010: 15,207	9,639	Progressing, accelerated progress required to meet 2015 target

Data Sources: (5.1) Department of Justice's (DOJ's) Performance and Accountability Report (PAR); (5.2) Organized Crime and Drug Enforcement Task Forces (OCDETF) Management Information System (MIS); (5.3) El Paso Intelligence Center's (EPIC) National Seizure System (NSS) extracted March 5, 2014. Includes DEA Hazardous Waste Disposal System (HWDS) data merged in the summer 2012

*CPOT - Consolidated Priority Organization Targets

**RPOT - Regional Priority Organization Targets

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

Assessment of Progress

The following discusses the data sources, targets, progress made to date, and future action required to achieve each of the measures comprising the *Strategy's* Objective 5: Disrupt Domestic Drug Trafficking and Production.

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

US law enforcement agencies and their partners, focus on the CPOTs 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) which captures domestic and international CPOT-linked PTO organizations disruptions/dismantlements from the DEA. In 2009, 296 domestic CPOT-linked organizations were disrupted or dismantled; this increased to 473 in Fiscal Year (FY) 2013. In FY 2011, DEA started reporting Domestic Field Division and Diversion Control separately in its budget and performance submissions. However, it continues to report its Domestic Field Division and Diversion Control PTO Dispositions as a consolidated Domestic performance measure. This is due in part to the small number of CPOT-linked PTOs disrupted or dismantled by the Diversion Control Program. In 2009, only 3 of the CPOT-linked organizations disrupted or dismantled involved the diversion of chemicals. The number of Diversion Control disruptions and dismantlements were 4 in 2010, 11 in 2011, 5 in 2012, and 3 in 2013. The number of CPOT-linked organizations disrupted or dismantled from FY 2009 through FY 2013 reported in the table indicates that the required target of 380 CPOT-linked organizations disrupted or dismantled has been met.

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

Similar to CPOT-linked organizations, Regional Priority Organization Targets (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 FY 2015 target was set at 90 RPOT-linked organizations disrupted or dismantled with a FY 2009 baseline of 119. The original FY 2015 target of 90 was set in FY 2010 and based on actual fiscal year data available at the time, input from the OCDETF regions, and factoring in the impact of the reduction in the number of RPOT targets beginning in FY 2011 from 200 to 150, a 25 percent reduction. The reason for this reduction in RPOT targets is to ensure that the OCDETF regions are identifying and targeting the major drug traffickers operating throughout the region so that the limited resources available are used to disrupt and dismantle the most significant drug trafficking organizations in the region. Therefore, the estimated targets set in FY 2010 for the number of RPOT-linked organizations disrupted or dismantled from FY 2011 through FY 2015 showed a slight downward trend because of the reduced number of RPOTs targeted.

However, since the initial target for FY 2015 was set in FY 2010, OCDETF realized much higher numbers than originally estimated by achieving great success over the past several years in disrupting and dismantling RPOT-linked drug trafficking organizations. Because OCDETF emphasizes the importance of priority targeting, the OCDETF regions, task forces, and strike forces have increasingly been focusing attention and resources on identifying drug trafficking organizations linked to these priority targets, and the cases identified have become significantly more complex and resulted in the disruption and dismantlement of a higher number of linked drug trafficking organizations.

Therefore, because of the much higher than initially expected recent yearly totals, in 2014 OCDETF adjusted its FY 2015 target estimate upward to 156 from 90. The adjusted target of 156 takes into account the higher numbers OCDETF achieved from FY 2011 through FY 2013, and is a projection based upon an average of trend analysis and forecasting of actual data from 2005 to 2014.[16]

Measure 5.3: Methamphetamine Lab Activity

An actual measure of methamphetamine lab activity (similar to many other covert aspects of drug trafficking) is unknown. A proxy for methamphetamine lab activity is the number of methamphetamine lab seizures: as lab activity increases, more labs are seized; as lab activity decreases, the number of lab seizures decreases (assuming law enforcement resources and priorities are stable). For example, in 2005, with the enactment of the Combat Methamphetamine Epidemic Act, precursor chemicals for domestic labs were restricted and the number of methamphetamine lab seizures declined dramatically[17].

This measure assesses progress in reducing methamphetamine lab seizure activity and associated consequences, such as methamphetamine lab and dumpsite clean-up costs. Methamphetamine lab seizure incident data are compiled by the National Seizure System (NSS) at the El Paso Intelligence Center (EPIC).

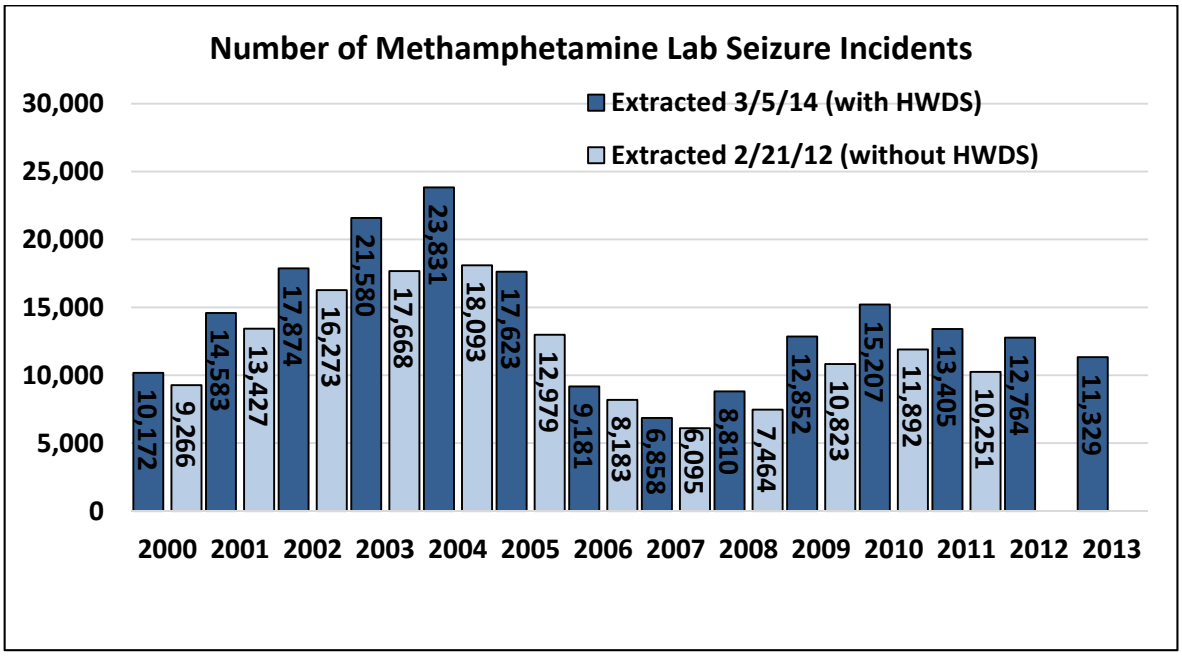
In 2011, EPIC discovered that some methamphetamine lab seizure incidents tabulated in the Hazardous Waste Disposal System (HWDS), which was used to account for methamphetamine clean-ups, were omitted from the National Seizure System (NSS). The HWDS incidents missing from NSS were integrated into the NSS for all previous years. Subsequent methamphetamine lab clean-up incident reporting was tabulated in the NSS to avoid future NSS under-reporting. Since the initial PRS report, the number of methamphetamine lab incidents, as measured by the NSS at EPIC, increased for all years when data from the HWDS was integrated into the existing NSS.

[16] The FY2015 Target was calculated using actual regional data available from FY2005-FY2014 for which the national totals were 56; 70; 91; 104; 119; 106; 161; 156; 170; 153; respectively.

[17] For clarity, lab seizures can be categorized as pre-labs (equipment and glassware seized), operating labs, or post-operation labs (dumpsites). Different state reporting may define each of these categories differently, therefore a sum of all three types is used as the measure of seizures and is called: “methamphetamine lab seizure incidents”.

Figure 2-5 below 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 12,852 and has seen downward trends since FY 2010 with 15,205 seizures to 13,405 in FY 2011, 12,754 in FY 2012 and 11,329 in FY 2013. Using the same 25 percent reduction for the 2015 target, the target has also been revised to 9,639.

Figure 2-5: Number of methamphetamine lab seizure incidents before and after inclusion of HWDS incidents



Progress in Reducing Methamphetamine Production

While the number of methamphetamine labs has remained stable since 2009, progress has been made in reducing the overall domestic production amounts. A key reason for this shift is the increase in methamphetamine/amphetamine labs operated by local user/distributors with no apparent ties to organized crime groups, coupled with a smaller overall production capability than the super labs[18]. While the downward shift in production capacity is a positive sign, small-scale domestic labs are estimated to account for only a small portion of U.S. methamphetamine supply. For example, 80 percent of the methamphetamine labs seized in the United States are of the smallest capacity category, i.e., less than 2 ounces (U.S. Department of Justice, 2013b). The bulk of U.S. methamphetamine supply is linked to production in Mexico (U.S. Department of Justice, 2013b).

[18] The term "superlab" refers to a laboratory that generates 10 pounds or more of methamphetamine per production cycle.

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

Disrupting and dismantling violent criminal enterprises that traffic illicit drugs into the United States in partnership with foreign nations 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. There is also 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 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. The effort also 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 the supply or demand of drugs. This objective's measures listed in the Table 2-6 below collectively assess the progress of the *Strategy* in strengthening international partnerships and reducing the availability of foreign-produced drugs in the United States.

Assessment of Progress

The following discusses the data sources, targets, progress made to date, and future action required to achieve each of the measures comprising the *Strategy's* Objective 6: Strengthen International Partnerships and 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 their 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. It was decided that a pilot period for data would be needed to refine the data collection process. During the pilot it was determined that data for Bolivia, Guatemala, Pakistan and the Dominican Republic were more difficult to collect on a systematic and yearly basis at this time. Since then 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 will be used for the purposes of this report.

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

Objective 6 Measure	Base-line/Source	Progress-to-date	2015 Target	Assessment
Measure 6.1: Percent of selected countries* that increased their commitment to supply reduction	2009 or earliest available State Department	100% (progress to date**)	100%	Target met or exceeded, progress should be maintained through 2015
Measure 6.2: Percent of selected countries* that increased their commitment to demand reduction	2009 State Department	100% (progress to date**)	100%	Target met or exceeded, progress should be maintained through 2015
Measure 6.3: Percent of selected countries*** showing progress since 2009 in reducing either cultivation or drug production potential	2009 ONDCP	29% (progress to date**)	100%	No Progress to Date, accelerated progress required to meet 2015 target.
Measure 6.4: Number of international CPOT-linked organizations disrupted or dismantled	65 (2009) PTARRS	2014: 72 2013: 77 2012: 69 2011: 52 2010: 74	60	Target met or exceeded, progress should be maintained through 2015

Data Sources: (6.1 and 6.2) Department of State; (6.3) Office of National Drug Control Policy; (6.4) Drug Enforcement Administration's (DEA) Priority Target Activity and Resource Reporting System (PTARRS)
* The countries selected for this measure are: Afghanistan, Mexico, Colombia and Peru.
** The most available data available varies among countries.
*** The countries selected for this measure are: Afghanistan, Burma, Laos, Mexico, Bolivia, Colombia, and Peru.

The political will to sustain counternarcotics efforts with host nation resources has continued. The selected countries' supply reduction budgets have all increased from 2009 through 2013, which makes the 2015 target on track for achieving this outcome (i.e. 100% of the selected countries have increased their commitment to supply reduction through their budgets or their achievements. The progress for each country is described separately below:

Afghanistan's Ministry of Counternarcotics (MCN) has increased its capacity to plan and implement programs as a growing amount of donor support is being placed "on budget," under full MCN control rather than control by the United Nations Office on Drugs and Crime or a donor nation. The 2013 MCN budget increased 38 percent from 2011's $12.0 million to $16.6 million. Afghanistan is working to increase its capacity to counter the illicit economy and sustain broad, multi-faceted programs that address narcotics cultivation, production, trafficking, and use, enhance public information campaigns, and develop regional and international cooperation networks. The U.S.-mentored Afghan counternarcotics police-vetted units now initiate, plan,

coordinate, and execute – without any significant non-Afghan tactical support – large-scale interdiction operations.

Colombia's budget from 2009 to 2014 shows significant increases in the drug policy programs of the Justice and Interior Ministries and an increase 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 $4.5 million in 2014. In 2011, the functions for drug policy in the Ministry of Justice and Interior were separated. The Defense budget for drug policy programs was $12.5 million in 2009 and $15.3 million in 2013. As of September 2014, the Ministry of Defense spent $10.4 million. Colombia has also taken fiscal responsibility for the helicopter safety program and absorbed the direct cost of the herbicide used in aerial eradication operations. On January 20, 2014, President Santos signed a comprehensive Asset Forfeiture law (no. 1708) aimed at countering money laundering. Colombia has also increased its commitment to state presence in and around coca growing areas through increases to its Public Security Forces from 429,793 in 2009 to 470,000 in 2014. Also of note was Colombia's role in assuming greater responsibility in the region by taking over control of the Air Bridge Denial program, which is aimed at interdicting drugs.

Mexico's budget from 2009 to 2014 shows a steady increase in funding for drug supply reduction and security efforts, from $8 billion in 2009 to over $10.4 billion in 2014 (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 2014 shows an increase in overall drug supply reduction spending from $42.5 million in 2009 to $157.7 million in 2014. 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, combating money laundering, etc. In 2014 Peru eradicated a record high of over 31,200 hectares (ha) of coca and the target for 2015 is 35,000 ha. In 2014, DEVIDA created nearly 25,000 new jobs and assisted over 34,258 families on over 52,000 ha of alternative crops, 13,722 of which were newly planted. Projected spending for supply reduction efforts is expected to increase further to $177.6 million in 2015 (U.S. Department of State, 2014b).

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 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. The selected countries' demand reduction budgets and activities have all increased from 2009 through 2013, which makes the FY 2015 target on track for achieving this outcome. The progress for each country is described separately 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 in the Afghan cultural context. The Ministry of Public Health (MoPH) 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 MCN will assume the responsibility for strategic development of drug demand reduction policy, while MoPH has the programmatic lead in service delivery. This transition plan will create uniformity amongst the treatment centers nationwide and will help incorporate existing Afghan treatment professionals within the country's government civil service structure. Since FY2009, three Afghani nationals have been awarded NIDA Hubert H. Humphrey Drug Abuse Research Fellowships. The NIDA-supported component of the broader State Department fellowship program combines academic courses at a leading U.S. university and a professional affiliation with an Institute grantee to teach fellows about NIDA-supported substance use disorder research and the application of research to the development of science-based government policy and prevention and treatment programs.

Colombia's national budget for Drug Demand Prevention, Mitigation, and Treatment increased from $6.0 million in 2009 to $7.2 million in 2013 (U.S. Department of State, 2014a). Colombia has shown success in beginning to lead demand reduction efforts in the region. From June 27-29, 2012, Colombia hosted a Regional Grant Writing and Scientific Peer Review Workshop in Bogotá, Colombia. NIDA also continues to support a domestic grant to a U.S. principal investigator working with partners in Colombia on Risk Factors for Adolescent Drug Use in the United States and Colombia.

Mexico's 2012 budget for Demand Reduction was $84 million, increasing to $95.8 million in 2013; 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 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 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 has also 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 2014 shows an increase in its overall demand reduction budget from nearly $1 million in 2009 to $7.9 million in 2014. 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 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 the 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, which was held June 13-16, 2014 in Puerto Rico (U.S. Department of State, 2014b).

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

Reducing the cultivation or drug production[19] potential of selected countries represents a 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 U.S. data (ONDCP, 2011) 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 is that 100 percent of the selected countries should show progress in reducing drug cultivation or production from their individual baseline figures in 2009 by 2015.

Accelerated progress is needed to meet the 100 percent target of all selected countries showing improvement since 2009, with only two countries (Bolivia and Colombia) reducing either illicit drug cultivation or production since 2009. The progress of each country is described separately below:

Afghanistan experienced an increase in poppy cultivation and a concomitant increase in potential opium production. Poppy cultivation totaled 131,000 hectares in 2009 and increased to an estimated 211,000 hectares in 2014. Potential opium production similarly increased from 5,300 metric tons in 2009 to 6,300 metric tons in 2014.

Bolivia experienced a reduction in coca cultivation and in the potential pure cocaine production. Coca cultivation totaled 29,000 hectares in 2009 and decreased to 25,000 in 2012. According to

[19] Potential production estimates are calculated from potential cultivation estimates by applying several conversion factors, such as plant yields and chemical processing efficiency. These conversion factors are different for each drug and growing area and are calculated by US Government agencies.

the most current estimates, potential pure cocaine production decreased from 150 metric tons in 2009 to 145 metric tons in 2012.

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 hectares in 2010 to 57,600 hectares in 2014). Potential opium production also rose from 530 metric tons in 2010 to 670 metric tons in 2014. If the entire opium harvest were processed into pure heroin it would have produced 29 metric tons in 2009 and 76 metric tons in 2013.

Colombia experienced a reduction in coca cultivation and production. Coca cultivation totaled 116,000 hectares in 2009 and decreased to 112,000 in 2014. Potential pure cocaine decreased from 265 metric tons in 2009 to 245 metric tons in 2014.

Laos experienced substantial increases in production and cultivation of poppy. Poppy cultivation estimates increased from 2009 to 2014 from nearly 940 hectares grown in the region of Phongsaly in 2009 to 6,200 hectares 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.

Mexico experienced an increase in opium poppy cultivation and a moderate increase in marijuana cultivation. Poppy cultivation areas totaled 10,500 in 2012 and increased to 17,000 hectares in 2014, while marijuana totaled 11,500 in 2012 and 13,000 hectares in 2013. A change in the estimate methodology in 2011 precludes a direct comparison with prior cultivation estimates. If the fields used in this analysis were processed into pure heroin, they would have produced 26 metric tons of pure heroin in 2013. There is no marijuana production estimate due to a lack of yield data for Mexico.

Peru experienced a significant increase in coca cultivation and potential cocaine production from 2009 to 2013. Coca cultivation increased from 40,000 hectares in 2009 to 59,500 hectares in 2013. Potential pure cocaine production increased from 225 metric tons of cocaine in 2009 to 305 metric tons in 2013.

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 the DEA, and the Department of Homeland Security in disrupting and dismantling foreign CPOT-linked organizations. The data source maintained by DOJ for this measure, the Priority Target Activity

and Resource Reporting System (PTARRS), captures domestic and international CPOT-linked disruptions/dismantlements from Federal law enforcement.

In FY 2009, PTARRS recorded that 65 international CPOT-linked organizations were disrupted or dismantled. Due to the number of CPOT-linked disruptions and dismantlements decreasing to 52 in FY 2011, the target of 60 international CPOT-linked organizations disrupted or dismantled through FY 2015 was established. In FY 2012, FY 2013 and FY 2014, DEA reported 69, 77 and 72 CPOT-linked disruptions and dismantlements, respectively. DEA is confident that the slight decrease in the number of international CPOT-linked dispositions reported in FY 2014 is not unusual; instead it is indicative of the natural, yet temporal, fluctuations that occur when reporting investigative or enforcement-based outcomes. The number of international CPOT-linked organizations disrupted or dismantled from FY 2009 through FY 2014 demonstrates that DEA, with support from the State Department and other agencies, has met the required target of 60 international CPOT-linked organizations disrupted or dismantled by 2015, and anticipates meeting the target for FY 2015.

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. There is a range of data 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 (e.g., illicit drug crop cultivation and production estimates and illicit drug seizure statistics).

Table 2-7 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 discusses the data sources, targets, progress made to date, and future action required to achieve each of the measures comprising the *Strategy's* Objective 7: Improve Information Systems for Analysis, Assessments, and Local Management.

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

Objective 7 Measure	Base-line	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)	2011: 23.5 2010: 19.5	16 months	Significant progress required to meet 2015 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: 937,643 2012: 356,782	220,000 web hits/ year	Target met or exceeded, progress should be maintained through 2015
National Survey on Drug Use and Health (NSDUH) (Journal articles referencing NSDUH)	37 per year	2014: 113 2012: 148	41 per year	Target met or exceeded, progress should be maintained through 2016
Measure 7.3: Increase Federal data sets that establish feedback mechanisms to measure usefulness (surveys, focus groups, etc.)				
SAMHSA Funded Data Sets[b]	0	1 (progress to date)	1	Target met or exceeded, progress should be maintained through 2015

Data Sources: (7.1) Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Episode Data Set Admissions (TEDS-A); (7.2) Substance Abuse and Mental Health Services Administration's (SAMHSA) Substance Abuse and Mental Health Data Archive (SAMHDA) and National Survey on Drug Use and Health (NSDUH) (Journal articles referencing NSDUH); (7.3) Substance Abuse and Mental Health Services Administration's (SAMHSA) sponsored a conference for the users of SAMHSA's data sets; conference generated recommendations

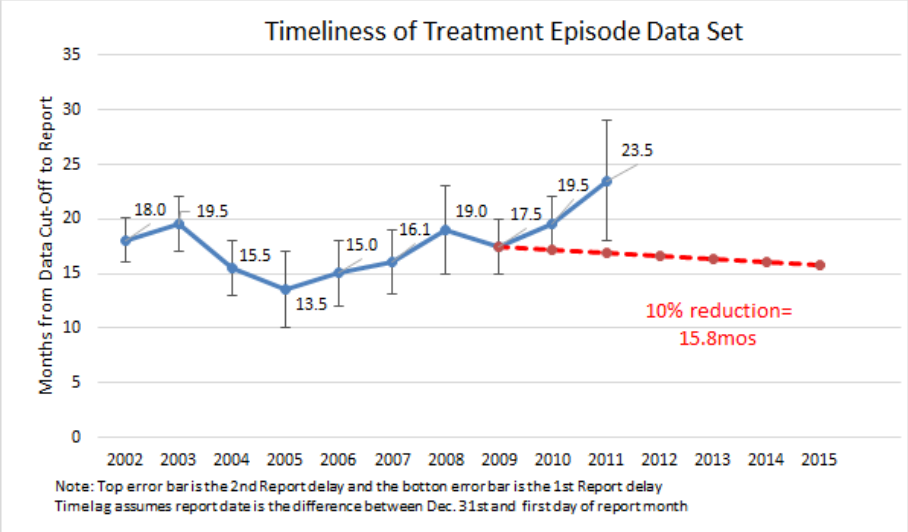
Measure 7.1: Increase timeliness (year-end to date-of-release) of select Federal data sets above their baseline by 10%

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 was highlights, and the second one was a final report. From CY2008 forward, the first report was national measures, and the second report was state measures. The table below shows the document dates for each TEDS-A report. This measure was calculated each year by averaging the time lag for the two reports. Figure 2-7 shows the trend in TEDS-A report timeliness. 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. Accelerated progress is needed to meet the 2015 target.

Table 2-7a: Document dates for each TEDS-A report

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
1st	May-04	Jun-05	Feb-06	Nov-06	Jan-08	Feb-09	Apr-10	Apr-11	Jun-12	Jul-13	Jul-14
2nd	Sep-04	Nov-05	Jul-06	Jun-07	Jul-08	Aug-09	Dec-10	Sep-11	Nov-12	Jun-14	---

Figure 2-7: Timeliness of TEDS-A reports, 2002-2015



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. Two key sources of data are the Substance Abuse and Mental Health Data Archive (SAMHDA) which housed the NSDUH, the Behavioral Health Services Information Systems (TEDS-A and TEDS-D, the N-SSATS, and the MHSS), 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. Both data sets have exceeded their targets.

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.

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 including, 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 estimates of emerging drug problems, especially the non-medical use of prescription drugs. 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 taken 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, including more accurately, rapidly, and transparently estimating the cultivation and yield of marijuana, opium, and coca globally.

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 both 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. Finally, expanding understanding of patterns and risks associated with drugged driving will support better public safety efforts. ONDCP has partnered with National Highway Traffic Safety Administration and the National Institute on Drug Abuse to support driver simulator research to examine driving impairment as a result of marijuana and combined marijuana and alcohol use and correlate it with the results of oral fluid testing to identify behavioral indicators of impairment.

Appendix A: Glossary of 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 Organization Priority (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
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 Targeting 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.

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