NATIONAL DRUG CONTROL STRATEGY

Performance Reporting System Report

2014

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Overview

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) was established to assess interagency progress toward the two Goals and seven Objectives of the *Strategy*, in accordance with the Office of National Drug Control Policy (ONDCP) Reauthorization Act of 2006 (P.L. 109-469).

The original PRS report[1] fully discusses the system's design and the assessment process. The PRS is essential because it 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. The PRS will assist in making adjustments to the *Strategy's* policy and program actions as required to achieve the FY 2015 *Strategy* Goals and Objectives.

This report is the first assessment of interagency progress towards the 2015 *Strategy* Goals and Objectives, showing significant progress with regard to treatment, domestic law enforcement, interdiction, and international partnerships. In the treatment area, services provided to those referred by the criminal justice system are generally as effective as those provided to the general public. However, more national research is required to assess the effectiveness of juvenile and criminal justice reform efforts. While the provision of recovery services has increased, challenges remain in the integration of substance abuse 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 into the health care system.

Significant progress was attained in domestic law enforcement and strengthening international partnerships, especially regarding the disruption or dismantlement of domestic and international drug trafficking organizations. Additionally, key source and transit countries demonstrated increased commitment to reducing drug trafficking and use through demand and supply reduction efforts. Meanwhile, more progress is needed in working with partner countries to reduce the cultivation of drugs and their production potential, especially poppy cultivation in Afghanistan, Burma, and Laos; marijuana cultivation in Mexico; and coca cultivation in Peru.

This report also discusses significant progress as well as challenges in the area of youth substance use prevention. Substantial progress has been achieved in reducing prescription drug abuse especially among 18-25 year olds, the age group showing the greatest prevalence of non-medical use of prescription-type drugs. There was considerable perception among 12-17 year olds of the great risk in binge drinking, and to a lesser extent in smoking cigarettes. Accelerated effort is needed to prevent youth marijuana use and counter youth perceptions that marijuana use is not harmful. For each of the *Strategy* Goals and Objectives, the following definitions were applied to assess progress:

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1. http://www.whitehouse.gov/sites/default/files/ondcp/prs_2012.pdf

- **Target met or exceeded, progress should be maintained through 2015** (Given the data available at this time, 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 towards 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 towards 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 towards 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 towards achieving the overall *Strategy* Goals to reduce drug use and its consequences.

Table: Summary of Interagency Progress toward the Goals of the Strategy

Status of Progress toward Strategy Goals		
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%	Progressing, accelerated progress required to meet 2015 target
	1b: Decrease the lifetime prevalence of 8th graders who have used drugs, alcohol, or tobacco by 15%	
	— Illicit Drugs	Progress sufficient to enable meeting 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%	Data not yet available
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	Significant progress required to meet 2015 target
	2c: Reduce the prevalence of drugged driving by 10%	
	— Data Source: National Roadside Survey	Data not yet available
	— 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: Summary of Interagency Progress toward the Objectives of the Strategy

Status of Progress toward Strategy Goals		
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	Progressing, accelerated progress required to meet 2015 target
	1.4: Average age of initiation for all illicit drugs	Progressing, accelerated progress required to meet 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: No progress to date, 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

Status of Progress toward Strategy Goals		
Strategy Objective	**Measures**	**Progress to Date**
Objective 2: Seek Early Intervention Opportunities in Health Care	2.1: Percent of Federally Qualified Health Center grantees providing SBIRT services	Progressing, accelerated progress required to meet 2015 target
	2.2: Percent of respondents in the past year using prescription-type drugs non-medically, age 12 - 17	Progress Sufficient to enable meeting 2015 target
	2.3: Percent of respondents in the past year using prescription-type drugs non-medically, age 18 - 25	Progressing, accelerated progress required to meet 2015 target
	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 Expand Support for Recovery	3.1: Percent of treatment plans completed	Progress sufficient to enable meeting 2015 target
	3.2: Percent of Health Center grantees providing substance abuse counseling and treatment services	No progress to date, accelerated progress required to meet 2015 target
	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	Progress sufficient to enable meeting 2015 target
	4.2: Percent of treatment plans completed by those referred by the Criminal Justice System	Target met or exceeded, progress should be maintained through 2015
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	Progressing, 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

* Of note, target is ambitious stretch target consistent with legal age for alcohol consumption.

Data Challenges and Future Steps

The greatest difficulty in having a clear understanding of drug trends is the inadequacy of data on the outcomes of drug control activities. For instance, in the absence of national data on treatment effectiveness, a proxy measure on completion rates was used. Similarly, the absence of national data on the effectiveness of juvenile and criminal justice reform efforts (beyond treatment provision) did not allow an assessment of these efforts on recidivism. Similarly, the extent of integration of substance abuse services in the Health Resources and Services Administration centers was used to represent integration in 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 to reduce use and its consequences.

The conclusions of this Report will help inform policymaking, planning, and resource allocation. When a target is not met for two or more years, a more detailed interagency assessment will be initiated by ONDCP. This assessment will examine the various factors involved in achieving the desired target levels. These assessments will be conducted as needed by existing interagency working groups (such as the demand reduction working groups or the PRS working groups) or by ad hoc groups convened as necessary. Once additional assessment cycles have been completed, ONDCP will reexamine the PRS system as a whole—concept and implementation—to consider future adjustments and enhancements.

Chapter 1: Progress Toward Strategy Goals

The *Strategy* calls for a 15-percent reduction in the rate of youth drug use over 5 years and similar reductions in chronic drug use and drug-related consequences such as drug deaths and drugged driving. A suite of seven measures has been developed to assess progress (see Table 1-1) toward 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 its baseline, FY 2015 target, data source, and assessment of progress-to-date.

Table 1-1: National Drug Control Strategy Goals & Measures, Baselines, Targets, and Progress-to-date

National Drug Control Strategy Goal/Measure	Base-line	Progress-to-date	2015 Target	Assessment
Strategy Goal 1: Curtail illicit drug consumption in America				
Strategy Measures				
1a: Decrease the 30-day prevalence of drug use among 12–17 year olds by 15%	10.1% (2009)	9.5% (2012)	8.6%	Progressing, accelerated progress required to meet 2015 target
1b: Decrease the lifetime prevalence of 8th graders who have used drugs, alcohol, or tobacco by 15%				
— Illicit Drugs	19.9% (2009)	18.5% (2012)	16.9%	Progress sufficient to enable meeting 2015 target
— Alcohol	36.6% (2009)	29.5% (2012)	31.1%	Target met or exceeded, progress should be maintained through 2015
— Tobacco*	20.1% (2009)	15.5% (2011)	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)	21.3% (2012)	19.3%	No progress to date, accelerated progress required to meet 2015 target
1d: Reduce the number of chronic drug users by 15%	NA	NA	TBD	Data not yet available
Strategy Goal 2: Improve the public health and public safety of the American people by reducing the consequences of drug use				
Strategy Measures				
2a: Reduce drug-induced deaths by 15%	39,147 (2009)	40,393 (2010)	33,275	Significant progress required to meet 2015 target
2b: Reduce drug-related morbidity by 15%				
— Emergency room visits for drug misuse and abuse	2,070,451 (2009)	2,462,948 (2011)	1,759,883	Significant progress required to meet 2015 target
— HIV infections attributable to drug use	5,300 (2009)	5,500 (2012)	4,505	Significant progress required to meet 2015 target
2c: Reduce the prevalence of drugged driving by 10%				
— Data Source: National Roadside Survey	16.3% (2007)	NA	14.7%	Data not yet available
— Data Source: National Survey on Drug Use and Health	4.4% (2009)	3.8% (2011)	4.0%	Target met or exceeded, progress should be maintained through 2015

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) What Americans Spend on Illegal Drugs; (1d) Centers for Disease Control and Prevention's (CDC) National Vital Statistics System; (2a) SAMHSA's Drug Abuse Warning Network drug-related emergency room visits; (2b) CDC's data on HIV infections attributable to drug use and National Survey on Drug Use and Health; (2c) and National Highway Traffic Safety Administration Roadside Survey.

*Measure focuses on cigarette use.

Analysis of Progress

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's) National Survey on Drug Use and Health (NSDUH) using a 2009 baseline estimate of 10.1 percent, with a 2015 target of 8.6 percent. In 2010 and 2011 the rate remained steady at 10.1 percent and then dropped to 9.5 percent in 2012. The NSDUH data show that marijuana accounts for the majority (76 percent in 2012) of illicit drug use in this population. While marijuana use rates have not gone down in this time period, there has been a reduction in illicit drug use other than marijuana. In this same population, NSDUH shows that beginning in 2009 use rates for illicit drugs other than marijuana was 4.6 and have been trending downward with rates at 4.5 percent in 2010, 4.1 percent in 2011, and 3.7 percent in 2012.

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 data on the use of drugs, alcohol, or tobacco are not combined and are therefore 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)[2].

Sound progress has been made in all three of these areas. The most recent data show a drop in use of approximately 7.1 percent for alcohol, 4.6 percent for tobacco, and 1.4 percent for illicit drug use since 2009.

As this measure focuses on lifetime use, breaking the MTF data down further by past year use for any illicit drug and past 30 day use for alcohol and cigarettes provides further details into the progress of this measure:

> **Any Illicit Drug:** Past year use of any illicit drug among 8th graders is trending down—from 14.5 percent in 2009 to 13.4 percent in 2012.

> **Alcohol:** The 2012 estimate of lifetime alcohol use among 8th graders (29.5 percent) is already below the 2015 target (31.1 percent).

> **Cigarettes:** As with alcohol, the 2015 target for cigarette use (17.1 percent) was achieved in 2012 (15.5 percent). This decline also is seen in the rate for current cigarette use, dropping from 6.5 percent in 2009 to 4.9 percent in 2012.

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

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. As with the youth measure described above, the estimate for this measure—past month use of any illicit drug—is driven by marijuana. In 2012, the level remained steady with 21.3 percent of 18-to-25 year olds having used an illicit drug in the past month; 18.7 percent had used marijuana over the same period of time. These estimates have changed very little since 2009. However, use of drugs other than marijuana has declined among this population. The NSDUH provides an estimate for illicit drug use other than marijuana: it has declined among young adults from 8.4 percent in 2009 to 7.0 percent in 2012.

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

The data for this measure are from the report What America's User's Spend on Illicit Drugs. The purpose of the report is to estimate 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) and the amount of each drug consumed by these users. The most recent report in this series includes estimates through 2006; the report currently being finalized will extend these estimates through 2010 and include the 2009 baseline for this measure.

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 were reported to involve prescription drugs. The 2015 target is to lower the number of drug-induced deaths by 15% (33,275). In 2010, there were 40,393 drug induced deaths; 38,329 were drug poisonings, the majority (22,134) of which involved prescription drugs. Of these prescription drug-involved deaths, 75 percent involved pain relievers. In contrast, among drug poisoning deaths, only 3,038 were reported to involve heroin and 4,183 were reported to involve cocaine.[3]

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 drug misuse or abuse of illicit drugs or pharmaceuticals) from the Drug Abuse Warning Network (DAWN). 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 is to lower this number by 15% to 1,759,883. To date, this measure is moving in the wrong

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3. 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.

direction with 2,462,948 such visits in 2011. The increase 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 infected with HIV are compiled by CDC. The 2009 baseline estimate of the number of individuals infected with HIV through injected drug use (IDU) is 5,300 (including those in the transmission category of male-to-male sexual contact and IDU); the 2015 target is to lower this number by 15% to 4,505. In 2012, 5,500 individuals were infected with HIV through injected drug use, indicating that more needs to be done for this population.

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

There are two sources of data for this measure. These data are not combined into a single measure but are reported 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 most recent 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). The 2015 target is 14.7 percent. The next survey will be conducted in 2013 with results expected in 2014.

In addition to using data from the Roadside Survey, ONDCP is assessing this measure with annual data from the NSDUH on whether respondents drove a vehicle while under the influence of an illicit drug in the past year. The 2009 baseline estimate for this variable is 4.4 percent and the 2015 target is 4.0 percent. This measure met its 2015 target in 2011, with NSDUH showing a drop to an estimated 3.8 percent.

Conclusion

Sound progress has been made in reducing the lifetime prevalence of eighth graders who have used drugs, alcohol, or tobacco (cigarettes). The most recent data show a significant drop in lifetime use from 2009 to 2012 for alcohol and cigarettes while illicit drug use in this population has been trending downward since 2009.

While there has been a significant downward trend in the current (i.e., past 30 day) use of illicit drugs other than marijuana from 2009 to 2012 among 12-17 year olds, marijuana use continues to present challenges for prevention activities geared towards this age group. Among young adults (18 to 25 years of age), the current use of illicit drugs other than marijuana has declined significantly from 2009 to 2012; however, similar to youth, marijuana use remains essentially unchanged over this period. Given that marijuana use accounts for nearly 90 percent of all illicit drug use among young adults, the level of overall current illicit drug use among this population has remained unchanged since 2009.

The use of each substance differs according to age group, gender, race/ethnicity, region, and population size, suggesting which segments of each age group are making progress and areas where continued or accelerated effort is needed.

Significant progress has been achieved in reducing drugged driving. Challenges remain in reducing drug-induced deaths, emergency room visits for drug misuse and abuse, and HIV infections attributable to drug use. Accelerated progress is needed in these areas.

Chapter 2: Progress Toward 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 each of the objectives using baselines, FY 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, especially to youth. Preventing drug use before it begins, particularly among young people, is the most cost-effective way to reduce drug use and its consequences. The table below (2-1) outlines the measures, baselines, progress to date, targets, and assessments for this Objective as determined by an interagency working group.

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	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	2012: 65.7% 2011: 66.2% 2010: 65.3%	68.0%	No progress to date, accelerated progress required to meet the 2015 target.
Measure 1.3: Percentage of youths (ages 12–17) perceiving great risk in having five or more drinks of an alcoholic beverage once or twice a week	39.6% (2009) NSDUH	2012: 39.7% 2011: 40.7% 2010: 40.4%	41.4%	Progressing, accelerated progress required to meet 2015 target
Measure 1.4: Average age of initiation for all illicit drugs	17.6 years (2009) NSDUH	2012: 18.7 years 2011: 18.1 years 2010: 19.1 years	19.5 years	Progressing, accelerated progress required to meet 2015 target
Measure 1.5: Average age of initiation for alcohol use	16.9 years (2009) NSDUH	2012: 17.4 years 2011: 17.1 years 2010: 17.2 years	21.0 years[1]	Progressing, accelerated progress required to meet 2015 target

Objective 1 Measure	Base-line	Progress-to-date	2015 Target	Assessment
Measure 1.6: Average age of initiation for tobacco use[2]	17.5 years (2009) NSDUH	2012: 17.8 years 2011: 17.2 years 2010: 17.3 years	18.0 years	Cigarettes: No progress to date, 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

[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.

Analysis of Progress

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

The data for this measure are from SAMHSA's NSDUH. The NSDUH provides annual data on a range of populations (household members ages 12 and older) and substances of abuse, including ages of initiation for each substance. The survey includes college students in dormitories, people living in homeless shelters, and civilians living on military bases. 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 declined (from 49.3 percent in 2009 to 43.6 percent in 2012) as did those reporting great risk in smoking marijuana once a month (from 30.3 percent in 2009 to 26.5 percent in 2012).[4] Perceived risk is an important variable and has been a leading indicator of use. The sharp decline in 2012 among teens may suggest that increases in use are likely to occur in the 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 is associated with increased risk in illicit substance use. Hence, 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 no progress to meet the 2015 target. According to the 2012 NSDUH, the percentage of youths aged 12 to 17, who reported great risk in smoking one or more packs of cigarettes per day, went from 65.5 percent in 2009 to 65.7 percent in 2012.

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4. NSDUH, 2012 and 2011

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 accidents and fatalities, risky behavior, violent behavior, and an increased risk of alcohol dependence. In NSDUH, binge drinking is defined as having five or more drinks on the same occasion on at least one 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 five or more days in the past 30 days.[5] According to the 2012 NSDUH, 39.7 percent of youth (ages 12-17) perceived great risk in having five or more drinks of an alcoholic beverage once or twice a week. Movement is progressing in the right direction, but accelerated progress is needed to achieve the 2015 target of 41.4 percent.

Measure 1.4: Average age of initiation for all illicit drugs

According to the 2012 NSDUH, about 2.9 million persons (aged 12 or older) used an illicit drug for the first time, averaging to about 7,900 new users per day. Over half of those aged 12 to 49 who reported first time illicit drug use (55.1 percent) were younger than age 18. The average age of initiation was 18.7 years, which was similar to the 2011 estimate of 18.1 years. Movement towards the target of 19.5 years is in the right direction. Nonetheless, given the data available at this time, accelerated progress will be required to meet the 2015 target.

Measure 1.5: Average age of initiation for alcohol use

The 2012 NSDUH shows that approximately 4.6 million persons aged 12 or older used alcohol for the first time within the past 12 months; averaging to approximately 12,600 initiates per day. Most (81.4 percent) of those were younger than age 21 at the time of initiation. The average age at first alcohol use among recent initiates (between 12 to 49 years old) was 17.4 years, which was similar to the 2011 estimate. There has been some progress towards 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.) Most (82.9 percent) of the 4.7 million past year alcohol initiates were younger than 21 at the time of initiation. Over one half (61.2 percent) initiated use prior to age 18.

Measure 1.6: Average age of initiation for tobacco use

The 2012 NSDUH reported that there were approximately 2.3 million persons (aged 12 or older) who smoked cigarettes for the first time within the past 12 months, which was similar to the 2011 estimate (2.5 million). This averages to about 6,400 new cigarette smokers per day. Importantly, about half of them (51.4 percent) began smoking before they were 18 years old. The 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 towards 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 2012 NSDUH, among

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5. 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.

past -year initiates aged 12 to 49; the average age of first cigarette use was 17.5 years in 2009, which was higher than the corresponding average age in 2011 (17.2 years)[6]

Cigars: The 2015 target has been exceeded. Among past year cigar initiates aged 12 to 49; the average age at first use was 19.6 years in 2011 and 20.5 years in 2012. The 2012 NSDUH estimates that 2.7 million persons, aged 12 or older, used cigars for the first time in the past 12 months, which is similar to the 2011 estimate (2.8 million).

Smokeless Tobacco: The 2015 target has been exceeded. According to the 2012 NSDUH, recent initiates aged 12-49 first started using smokeless tobacco at 18.8 years on average, similar to the 2010 (19.3 years) and 2011 (19.8 percent) averages. The numbers of persons who initiated the use of smokeless tobacco in the past year were estimated at 1.5 million in 2010, 1.3 million in 2011, and 1.0 million in 2012.

Conclusion

While sound progress has been made with regard to use of cigars and smokeless tobacco, more work is required to bolster prevention in the areas of underage alcohol use, underage cigarette use, and illicit drug use. In particular, youth use rates for marijuana are high, and MTF findings indicate that the highest initiation rates are among the youngest respondents. In addition, the perception of risk of youth marijuana use is trending downward, which is a sign of possible future increases in use.

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[7] for substance use disorder treatment services for an estimated 62 million Americans and help integrate treatment into mainstream health care.[8] 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 towards this Objective concentrates on the availability of SBIRT and the effectiveness of treatment for prescription drug abuse, which has reached epidemic proportions according to the Centers for Disease Control and Prevention. The table below (2-2) outlines the measures, targets, and progress-to-date for this Objective.

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6. NSDUH reports that the average age of first daily smoking among new daily smokers aged 12 or older, was 19.1 years in 2010 and 2011, and 19.9 years in 2012. Of the new daily smokers in 2011, 38 percent were younger than age 18 when they started smoking daily. This figure averages to approximately 916 initiates of daily smoking under the age of 18 every day.

7. 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 medical and surgical care.

8. Berino, K., Rosa, P., Skopec, L. & Glied, S. (2013). Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans. *Research Brief*. Assistant Secretary for Planning and Evaluation (ASPE). Washington, DC (Citation: Abstract of the Brief found at http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm)

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 Federally Qualified Health Center grantees providing SBIRT services	10% (2009) Uniform Data System	2011: 11% 2010: 11.0%	15.0%	Progressing, accelerated progress required to meet 2015 target.
Measure 2.2: Percent of respondents in the past year using prescription-type drugs non-medically, age 12–17	7.7% (2009) NSDUH	2012: 6.6% 2011: 7.0% 2010: 7.4%	6.5%	Progress sufficient to enable meeting the 2015 target
Measure 2.3: Percent of respondents in the past year using prescription-type drugs non-medically, age 18–25	15% (2009) NSDUH	2012: 13.7% 2011: 12.7% 2010: 14.3%	12.8%	Progressing, accelerated progress required to meet 2015 target.
Measure 2.4: Percent of respondents in the past year using prescription-type drugs non-medically, age 26+	4.7% (2009) NSDUH	2012: 5.1% 2011: 4.3% 2010: 4.8%	4.0%	No progress to date, accelerated progress required to meet 2015 target.

Analysis of Progress

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

This measure centers on Federally-Qualified Health Center (FQHC) grantees providing SBIRT services. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those at risk of developing disorders. The Health Resources and Services Administration's (HRSA) FQHC grantees provide services to nearly twenty million people in traditionally underserved areas and report data on the services they provide. However, HRSA collects data only on its grantees and not on all health centers. In the absence of data on the aggregate performance of all health care providers and facilities nationwide, the HRSA measure is used as a proxy for the expansion of screening services. Data on the percent of FQHC grantees providing SBIRT services are drawn from HRSA's Uniform Data System (UDS) and are collected annually from HRSA grantees.

Movement towards the 2015 target is progressing in the right direction. However, based on the data available at this time, accelerated progress is required to meet the 2015 target. HRSA is working with health centers to integrate substance abuse SBIRT services into primary care through the SAMHSA/HRSA Center for Integrated Health Solutions, the National Association of Community Health Centers, and through training and meetings. More HRSA grantees must provide SBIRT services in order to achieve the 15 percent performance target by 2015.

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

Surveys and studies highlight the non-medical use of prescription drugs, especially among young adults and adolescents. The availability of such drugs and the long-term consequences of such misuse necessitate a focus on the 12–17 age group. Given the PRS data available at this time, there is reasonable expectation that the 2015 target will be met. The 2012 NSDUH reported that the percentage of

youths aged 12–17 who used prescription drugs non-medically in the past year was 7.7 percent in 2009, declining to 6.6 percent in 2012.

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

NSDUH 2012 data indicate that this age group (18-25) had the highest rate of prescription drug abuse (13.7 percent), as compared to the other two age groups (6.6 percent for 12-17 year olds and 5.1 percent for those aged 26 and over). Prescription drug misuse ranked second only to marijuana use in the 18-25 age group. While the data indicates progress towards the 2015 target, accelerated progress is required. Of note, 18-25 years is the primary age group for all new misusers of prescription drugs except sedatives. Among 12-49 year olds, the average ages of those initiating psychotherapeutic misuse were 22 years for pain relievers and stimulants[9] and 25 years for tranquilizers. (The average age of initiation of sedatives is 26, just outside this age group.) The NSDUH data highlight the need to reduce the misuse of pain relievers, amphetamines, 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.

Addictive prescription drugs fall into three categories: opioids, central nervous system depressants, and stimulants. According to the 2012 NSDUH, pain relievers were the primary type of prescription drugs that were misused by those ages 26 and over. Tranquilizers were also highly misused by this group. Given the data available at this time, there has been no progress to date in reducing prescription drug misuse by those aged 26 and over. Of note, with a 5.1 percent rate of prescription drug misuse in 2012, this 26 and older group amounted to nearly 10.3 million people. Of those, almost 3.8 million were aged 26-34 and over 6.5 million were 35 and older.

Of those aged 26-34 who misused prescription drugs in 2012, 2.7 million misused pain relievers and over 1.5 million misused tranquilizers. Additionally, of the 6.5 million people of ages 35 and older who misused prescription drugs in 2012, nearly 4.9 million of them misused pain relievers and nearly 2.3 million misused tranquilizers.

Conclusion

Although efforts to date in support of early intervention are promising, accelerated progress is necessary to meet several of the 2015 targets. To achieve greater success in preventing substance abuse and addiction, screening and early intervention should continue to expand.

The Federal Government, in close coordination with states and communities, has developed an assertive multi-pronged approach to reduce prescription drug abuse including: educating parents, youth, patients, and healthcare providers; tracking, monitoring, and preventing the diversion and abuse of prescription drugs; encouraging the proper disposal of prescription drugs; and taking enforcement actions against clinics and prescribers that are not prescribing within the usual course of practice for legitimate medical purposes.

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9. The average age of new methamphetamine users was 18 years, a younger age than in 2009.

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 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.

The following 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	2009: 47.0% 2008: 46.6%	50.0%	Progress sufficient to enable meeting 2015 target.
Measure 3.2: Percent of Health Center grantees providing substance abuse counseling and treatment services	23.0% (2009) UDS	2011: 22.0% 2010: 22.0%	23.0%	No progress to date, accelerated 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	2011: 39.0% 2010: 36.0%	39.0%	Target met or exceeded, progress should be maintained through 2015

TEDS-D: Treatment Episode Data Set – Discharge

UDS: Uniform Data System

N-SSATS: National Survey of Substance Abuse Treatment Services

Analysis of Progress

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 completing 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 (SSAs). Given the data available at this time, there is reasonable expectation that the 2015 target will be met, as the baseline was set for 45.1% using 2007 data when the PRS was initially established. In 2008 46.6% treatment plans were completed; this increased to 47% in 2009.

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

This measure focuses on the integration of substance abuse counseling and treatment into mainstream health care. Since there are no national records on available health care services, this measure focuses on HRSA's Federally Qualified Health Center grantees and the 20 million individuals they serve. This measure is a proxy for assessing the extent of substance abuse counseling and treatment services provided in primary care settings. An increase in the number of health center facilities offering these services would show that substance abuse services are more integrated and expansive, a reasonable conclusion because HRSA Health Center Program grantees are major providers of primary care for the poor and underserved. Data for this measure are drawn from HRSA's UDS and are collected annually from HRSA grantees.

Movement towards the target is stalled; based on the data available, accelerated progress is required to meet the 2015 target. According to the 2011 UDS data, the percent of HRSA facilities that provide substance abuse counseling and treatment services has not changed (22 percent) since 2010. Since the 2015 target is 23 percent, 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 abuse 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 4 of the standard spectrum of recovery services has been achieved in 2011; this level of progress needs to be maintained.

Conclusion

While the overall effectiveness of treatment is progressing and the availability of recovery support services in treatment facilities has increased, challenges remain regarding the integration of substance use disorder services into mainstream health care. The implementation of the Affordable Care Act will provide more opportunities to provide greater access to treatment for substance use disorders by efficiently integrating such treatment into health care services and locations. Moreover, Health Information Technologies such as Electronic Health Records promise uniform mandatory collection of data on services provided and outcomes obtained. Electronic Health Records will enable the documentation of client records and services provided, with features that enable individual privacy while enabling the analysis of aggregate data that will inform comprehensive performance assessment and policy guidance.

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

At the end of 2011, about 6.98 million people—about 2.9 percent of the total adult population - were under some form of adult correctional supervision.[10] Recent studies have examined the amount of illicit drug use and dependence among this special population. According to the most recent information available (2004), 45 percent of Federal prisoners met the criteria for drug dependence or abuse.[11] Nearly three-quarters of state prison inmates are in need of some substance abuse intervention with over 31 percent of men in prison and over 52 percent of female inmates requiring intensive treatment services including residential treatment programming. 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.[12] Several surveys of 'correctional agencies' (defined as any form of criminal justice supervision) in NIDA's Criminal Justice Drug Abuse Studies indicated that only 10 percent of adult males in the justice system and approximately a quarter of all juveniles participated in some form of alcohol and drug program.

Over the past few years, the Administration has sought to reform the criminal justice system to more effectively address individuals with 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 abuse.

The following table (2-4) outlines the measures, targets, and progress-to-date for this Objective.

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	2010: 40.5%**	42.7%	Progress sufficient to enable meeting 2015 target
Measure 4.2: Percent of treatment plans completed by those referred by the criminal justice system	46.8% (2007) TEDS-D	2009: 49.6% 2008: 48.8%	49.0%	Target met or exceeded, progress should be maintained through 2015

RFC: Juvenile Residential Facility Census
TEDS-D: Treatment Episode Data Set – Discharge
* Recalculated to correct computation error of initial baseline.
** Biennial census

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10. BJS report, *Correctional Populations in the United States, 2011*
11. Bureau of Justice Statistics Special Report: Drug Use and Dependence, State and Federal Prisoners, 2004. Revised January 19, 2007.
12. Belenko and J. Peugh, Estimating drug treatment needs among state prison inmates, Drug and Alcohol Dependency, 2005.

Analysis of Progress

Measure 4.1: Percent of residential facilities in the Juvenile Justice System offering substance abuse treatment

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 abuse treatment.

In the initial PRS design, 2006 was selected as the baseline because it was the latest year for which data from this biennial census was available. In 2006, 85 percent of all residential juvenile facilities offered substance abuse treatment services. Since then, the data has been corrected on the number of juvenile facilities that provided substance abuse "screening" rather than substance abuse "treatment." As a result, the baseline has been recalculated to reflect the rate of juvenile facilities that provided substance abuse treatment. The corrected value for 2006 is 40.4 percent. With 2008 data available, the baseline year becomes 2008 with a value of 38.8 percent. Using the same degree of change as reported in the PRS design report with the new baseline value of 38.8 percent, the new 2015 target becomes 42.7 percent.

The 2010 data showed that overall 40.5 percent of facilities in the juvenile justice system offered substance abuse treatment with 42 percent of public residential facilities and 38 percent of private facilities providing substance abuse services, either on-site or off-site. Given the data available at this time,[13] there is reasonable expectation that the 2015 target will be met.

Measure 4.2: Percent of treatment plans completed by those referred by the criminal justice system[14]

Research indicates that increased completion of treatment plans is correlated with improved treatment outcomes and is also a predictor of reduced drug use.[15] This measure is a proxy since there are no nationwide data on the outcomes of treatment effectiveness in the criminal justice population. The TEDS-D data set covers areas such as treatment completion[16], length of stay in treatment, substance abuse characteristics, and client demographics. Given the data available at this time, the target has been met or exceeded. This level of progress needs to be maintained. According to 2009 TEDS-D, 49.6 percent of criminal justice referrals completed their treatment plans.

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13. 2009 is the base year for the Strategy and the PRS except in cases where 2009 data are not yet available; 2008 is the baseline year for this measure.

14. TEDS-D definition of Court/criminal justice referral/DUI/DWI - 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. It also includes clients on

15. Principles of Drug Addiction Treatment: A Research Based Guide. National Institute on Drug Abuse. Second Edition, April 2009.

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

Conclusion

Overall, those in the juvenile justice system who need substance abuse treatment services are receiving them, and the target for treatment plan completion has been met. A major obstacle to assessing treatment access and effectiveness in the juvenile and criminal justice systems is the lack of national data on the subpopulations involved and their progress and outcomes. National data is also lacking with regard to the types of criminal justice supervision and services provided at each stage of the criminal justice system and after the completion of community supervision or release from incarceration.

The criminal justice system includes Federal, state, local, and tribal law enforcement agencies, court systems, and correctional agencies, making it challenging to gain a national perspective of the overall effectiveness of reform efforts underway at every level. However, capturing the extent and effectiveness of treatment within the criminal justice system could improve with the expansion of Health Information Technology (HIT), including electronic health record (EHR) systems and health information exchanges (HIEs), and enhanced data collection and wider dissemination. The expansion of Medicaid eligibility under the Affordable Care Act further magnifies the advantages of data sharing across systems that serve justice-involved populations.

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 below (2-5) are intended to collectively assess the progress for Chapter 5 of the *Strategy* toward limiting to the availability of illicit drugs by targeting the organizations that produce and distribute them.

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 Domestic Field Division/ 3 Diversion Control (2009) PTARRS**	2012: 450/5 2011: 477/11 2010: 425/4	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	2012: 156 2011: 164 2010: 116	90	Target met or exceeded, progress should be maintained through 2015
Measure 5.3: Number of methamphetamine lab incidents	10,823 (2009) NSS	2011: 10,251*** 2010: 11,892	7,293	Progressing, accelerated progress required to meet 2015 target.

CPOT—Consolidated Priority Organization Targets

PTARRS—Priority Target Activity and Resource Reporting System

RPOT—Regional Priority Organization Targets

MIS—OCDETF's Management Information System

NSS—National Seizure System, El Paso Intelligence Center, extracted February 21, 2012

*Consistent with OMB guidance, in FY 2011 overall Domestic PTO performance was reported separately by program: Domestic Operations (S&E) and Diversion Control Program (DCFA). Data in the table above reflect that reporting modification; respectively.

**The number of domestic CPOT-linked organizations disrupted or dismantled comes from DEA's Priority Targeting Organization (PTOs) PTARRs database. In FY 2011, DEA started reporting Domestic Field Division and Diversion Control separately.

***Between February 23, 2011 and October 1, 2011, there were no DEA funds available for clean-up, resulting in probable under-reporting of lab incidents.

Analysis of Progress

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

The Consolidated Priority Organization Targets (CPOTs) are heads of narcotic and/or money laundering organizations, poly-drug traffickers, clandestine manufacturers and producers, and major drug transporters, all of whom are believed to be primarily responsible for the illicit drug supply. Law enforcement agencies focus on these 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 disruptions/dismantlements from the DEA. Data from 2009 through 2012 indicate sufficient progress to enable the achievement of the FY 2015 target of 380 domestic CPOT-linked organizations disrupted or dismantled. In 2009, 296 domestic CPOT-linked organizations were disrupted or dismantled; this increased to 425 in FY 2010, 477 in FY 2011 and 450 in FY 2012.

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

Regional Priority Organization Targets (RPOTs) are those individuals and organizations whose drug trafficking and/or money laundering activities have a significant impact in the nine designated OCDETF regions[17] as determined by the U.S. Department of Justice and its partner agencies. OCDETF's Management Information System is used to collect the number of RPOT-linked disruptions and dismantlements. The target was initially set in FY 2011, when OCDETF reduced the number of possible RPOTs from 200 to a maximum of 150. At the beginning of FY 2013, there were 136 identified RPOTs for the OCDETF regions. The reason for this reduction was 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. The number of RPOT-linked organizations disrupted or dismantled from FY 2011 through FY 2015 was expected to show a slight downward trend because of the reduced number of RPOTs identified. Data from 2009 through 2012 indicate sufficient progress to enable the achievement of the FY 2015 target of 90 domestic RPOT-linked organizations disrupted or dismantled. In FY 2009 and FY 2010, 117 and 116 RPOT-linked organizations, respectively, were reported as disrupted or dismantled; this increased to 164 in FY 2011. In FY 2012, there were 156 RPOT-linked organizations reported as disrupted or dismantled. The reason for the number of RPOTs exceeding the target in FY 2012 was that a large number of prosecuted cases were closed by one of the OCDETF regions in FY 2011 and a much larger number than estimated reported for the Southwest Region in FY 2012. Also, a significant number of the RPOT organizations reported as dismantled or disrupted in FY 2012 were identified prior to the reduction in the number of RPOT targets. RPOT-linked OCDETF investigations have declined approximately 4 percent since additional limits on the number of targets were implemented, of which this trend is expected to continue.

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

Measure 5.3: Number of Methamphetamine Lab Incidents

This measure assesses progress since 2009 in reducing the number of methamphetamine labs in the United States and associated consequences, such as methamphetamine lab clean ups and dumpsites that are left behind. An aggressive target of 7,293 was set for 2015—a 25 percent decrease from the 2009 level. Methamphetamine lab incident data are collected by fiscal year from the National Seizure System (NSS) at the El Paso Intelligence Center (EPIC). The data do not reflect merely the number of labs seized, but also information regarding dumpsites, chemicals, glass, and other relevant equipment used in the production of methamphetamine. This distinction is important because the data reflect not only illegal activity but also any adaptations in methods of production. In 2012, the number of methamphetamine lab incidents, as measured by the NSS at EPIC, increased for all years when data from the Hazardous Waste Disposal System (HWDS) was integrated into the existing NSS. This report provides information on the original baseline and target using the original source data without the HWDS. The number of methamphetamine lab incidents has remained stable with 10,823 methamphetamine lab incidents in 2009,[18] compared to 10,251 in 2011. While the number of methamphetamine labs has remained stable since 2009, progress has been made to reduce the overall production amounts. A key reason for this shift is the increase in methamphetamine/ amphetamine labs operated by local user/distributors with no apparent organizational ties to organized crime organizations, coupled with a smaller overall production capability than the super labs[19]. While the downward shift in production capacity is a positive sign, small-scale domestic labs are assessed to account for only a small portion of U.S. methamphetamine consumption. Moreover, 80 percent of the methamphetamine labs seized in the U.S. are of the smallest capacity category, i.e., less than 2 ounces[20].

Conclusion

The production and trafficking of illicit drugs by criminal organizations in the United States is a complex phenomenon. Progress is being made toward reducing the trafficking and production of drugs through disrupting and dismantling drug trafficking organizations. While the number of methamphetamine lab incidents remains stable, data on the amount of methamphetamine production indicate lower levels than in previous years because 80 percent of the methamphetamine labs now seized in the United States are of the smallest capacity category, i.e., less than 2 ounces.[21] 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, coupled with a smaller overall production capability than super labs.[22] While the downward shift in production capacity is a positive sign, small-scale domestic labs are assessed to account for only a small portion of U.S. methamphetamine consumption.

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18. NSS, EPIC, extracted February 21, 2012
19. The term "superlab" refers to a laboratory that generates 10 pounds or more of methamphetamine per production cycle.
20. NSS, EPIC, extracted January 28, 2013
21. NSS, EPIC, extracted January 28, 2013
22. 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 a 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 of crime. 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. The measures listed in the table below (2-6) are intended to collectively assess the progress of the *Strategy* in strengthening international partnerships and reducing the availability of foreign-produced drugs in the United States.

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

Objective 6 Measure	Base-line	Progress-to-date	2015 Target	Assessment
Measure 6.1: Percent of selected countries on the Majors list* that increased their commitment to supply reduction	2009 State Dept	100%	100%	Target met or exceeded, progress should be maintained through 2015
Measure 6.2: Percent of selected countries on the Majors list* that increased their commitment to *demand* reduction	2009 State Dept	100%	100%	Target met or exceeded, progress should be maintained through 2015
Measure 6.3: Percent of selected Majors list countries showing progress since 2009 in reducing either cultivation or drug production potential	2009 ONDCP	43%	100%	Progressing, accelerated progress required to meet 2015 target.
Measure 6.4: Number of International CPOT-linked organizations disrupted or dismantled	65 (2009) PTARRS	2012: 69 2011: 52 2010: 74	60	Target met or exceeded, progress should be maintained through 2015

* Majors list—"Major" countries are countries that are classified as major drug transit or drug producing countries for the purpose of the Foreign Assistance Act of 1961.

PTARRS—Priority Target Activity and Resource Reporting System

Analysis of Progress

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

This measure is intended to assess progress of selected countries in aggregate and does not compare countries' efforts to each other in curbing the supply of drugs. A particular country's commitment to addressing their unique supply reduction challenges is based on the data available from that country and can include information on budget, programs, and policies. Supply reduction efforts would include international partner support, including financial resources, for drug crop eradication, drug interdiction, judicial and law enforcement programs and institutional strengthening focused on drug trafficking. The countries selected from the Majors list during the PRS design process were: Afghanistan, Bolivia, Colombia, Guatemala, Mexico, Pakistan, Peru and the Dominican Republic. During the design phase it was determined that while assessing aggregate progress would be helpful, there were no data sources available that could inform such an indicator. It was determined that the State Department would explore options for obtaining relevant data; baselines and targets would be established once data were available. It was also decided that a pilot period for data collection would be needed to refine the data collection process. For the pilot, data collection was included from Afghanistan, Mexico, Colombia and Peru. These countries are key countries that the United States collaborates with in reducing the supply of illicit drugs.

The political will to sustain counternarcotics efforts with host nation resources has become increasingly apparent. The selected countries' supply reduction budgets have all increased from 2009 through 2012, which makes the FY 2015 target on track for achieving this outcome.   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 as opposed to control by the United Nations Office on Drugs and Crime (UNODC) or a donor nation. The 2012 MCN budget increased 19 percent from 2011's $12.0 million (658.2 million Afs) to $15.0 million (804.0 million Afs). Included in this budget is the funding for Counternarcotics Public Information programs, the Good Performers Initiative, Governor Led Eradication reimbursement, the Counternarcotics Police of Afghanistan's Technical Investigative Unit, the National Interdiction Unit, and the Sensitive Investigative Unit and Afghan Counternarcotics Tribunal and Criminal Justice Task Force.

Colombia's budget from 2009-2012 shows stability in the Justice Ministry's supply reduction programs and an increase in its Defense spending for supply reduction. Justice Ministry spending on supply reduction was $0.8 million in 2009 and $0.7 million in 2010. The Defense budget for these programs was $12.5 million in 2009 and $15.3 million in 2013. Since 2009, Colombia has also taken fiscal responsibility for the helicopter safety program and absorbed the direct cost of the herbicide used in aerial eradication operations. The first chamber legislative body in Colombia also passed a more comprehensive Asset Forfeiture law in 2013 as a consequence for money laundering. Colombia has also increased its commitment to supply reduction through increases to its Public Security Forces from 429,793 in 2009 to 448,000 in 2012. Also of note was Colombia's role in assuming greater responsibility in the region by taking over

the control of the Air Bridge Denial program, which is aimed at interdicting drugs. Finally, for every $1 USD spent on alternative development programs, $8 is leveraged from outside funding sources.[23]

Mexico's budget from 2009-2012 shows a steady increase in funding for drug supply reduction and security efforts, from 103.8 billion Mexican pesos (roughly $8 billion) in 2009 to over 125 billion Mexican pesos ($10 billion) in 2012. Resources are being directed to support organized crime control efforts, crime prevention, interagency coordination, the creation of a single police force, the justice system, and strengthening the social fabric. Mexico's counternarcotics efforts have caused significant disruptions in the operations of drug trafficking organizations based in Mexico. Since December 2009, 61 high-profile drug traffickers were arrested or killed. In comparison, only one high-profile DTO member was arrested from 2003 to November 2009.

Peru's public budget from 2009-2013 shows an increase in overall drug supply reduction spending from $52.7 million in 2009 to $99.5 million in 2013.[24] Included in the total budget is the drug supply reduction funding for the Peruvian National Police Antidrug Directorate (DIRANDRO), National Customs and Tax Administration Agency (SUNAT), Peruvian Ports and Coast Guard General Directorate (DICAPI), Peruvian Air Force (FAP), and the National Commission for Development and Life without Drugs DEVIDA.[25] 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. The Humala Administration more than tripled seizures of precursor chemicals, increasing from 107 metric tons of seized illicit drugs in 2011 to nearly 384 metric tons in 2012.

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

This measure is intended to assess the progress of selected countries in aggregate and does not compare countries to one other regarding efforts to curb drug use and its consequences internally. The countries were selected in the same manner as Measure 6.1 to explore options to refine the data collection process. Budgets for demand reduction efforts, as well as other demand reduction efforts taken on by Afghanistan, Mexico, Colombia, and Peru were examined. In lieu of specific budget related information, demand reduction indicators would include international partner support, including financial resources for drug prevention and treatment programs.

100 percent of the selected countries' demand reduction budgets and other demand reduction indicators have increased from their individual 2009 baselines, indicating sufficient progress to enable the achievement of the FY 2015 target of 100 percent of selected countries increasing their budgets for demand reduction efforts. Each country is described separately below:

Afghanistan's MCN's capacity has increased the amount of donor support being placed on budget for Afghan Government Financing for Drug Demand Reduction (DDR) programs from zero in 2009 to $3.0 million in 2012. These funds support Ministry of Public Health treatment centers providing residential, outpatient, and home-based assistance. Afghanistan's treatment system has matured over

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23. INCSR 2012.
24. Ministry of Economy and Finance Economic Transparency Website
25. Integrated and Effective Management Program for Drug Supply Control in Peru

several years. The MCN and the Ministry of Public Health (MoPH) are currently developing a transition plan, which allows for continued cooperation between the two ministries and increases the capacities of staff as U.S. foreign assistance on DDR decreases over time. 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 Afghan government civil service structure.

Colombia's national budget for Drug Demand Prevention, Mitigation, and Treatment decreased from $6.0 million in 2009 to $3.2 million in 2012.[26] Colombia's budget does not include the budget that the departments spend in prevention and treatment. While their budget for demand reduction efforts has been decreasing, 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.[27] NIDA also awarded 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 budget for Demand Reduction increased from $29.2 million (380.3 million pesos) in 2009 to $122.7 million (1,594.4 million pesos)[28] in 2012. Mexico's El Instituto para la Atención y Prevención de las Adicciones en la Ciudad de México (IAPA) hosted a September 2012 international meeting in Mexico City focusing on inhalant abuse, which featured presentations by members of the NIDA International Program Inhalant Working Group (IWG). The U.S. -Mexico Drug Abuse Prevention Research Fellowship also reflects Mexico's support of increasing 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.[29] Mexico has also hosted Demand Reduction conferences focused on research[30]. From 2009 to 2012, NIDA awarded 15 grants for various projects—most of which were focused on drug-related HIV—to U.S. Principal Investigators working with partners in Mexico.

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26. Ministry of Health
27. http://international.drugabuse.gov/about-us/news/2012/09/nida-supports-latin-american-scientists-grants-workshop
28. Exchange rate: $1USD = 13 Mexican Pesos.
29. A binational comparison of HIV provider attitudes towards the use of complementary and alternative medicine among HIV-positive Latino patients receiving care in the US-Mexico border region. Muñoz FA, Servin AE, Kozo J, Lam M, Zúñiga ML. *AIDS Care*. 2012, October 23. [E-published ahead of print.] Choosing Sides: HIV Health Care Practices among Shared Populations of HIV-Positive Latinos Living near the US-Mexico Border. Servin AE, Muñoz FA, Strathdee SA, Kozo J, Zúñiga ML. *Journal of the International Association of Physicians in AIDS Car*e. 2012, November-December, 11(6):348-55. doi: 10.1177/1545109712453854. E-published 2012, August 27.Dr. Strathdee's AIDS International Training and Research Program (AITRP) grant (D43TW008633-03). Research will explore intergenerational drug use and sex work in the Mexico–U.S. border region.
30. Basic Parent Management Training in the Oregon (PMTO) Model, in Mexico City; November 23–27, 2010; http://international.drugabuse.gov/about-us/news/2011/01/researchers-attend-meeting-basic-parent-management-training-oregon-model

Peru's allocation of funds from 2009-2012 shows an increase in its overall demand reduction budget from $37.5 million in 2009 to a forecasted $57.1 million for 2013.[31] Included in the total budget is the drug demand reduction funding for DEVIDA, Peru's Counternarcotics Strategy for prevention, treatment, and rehabilitation, as well as for Peru's Ministry of Health. NIDA awarded 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.

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

Reducing the cultivation or drug production potential of a Majors List country represents a success in the international effort to reduce the flow of illicit drugs. The Majors List 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[32] 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.

More progress is needed to meet the 100 percent target of all selected countries showing improvement since 2009, with over half of the countries reducing either illicit drug cultivation or production since 2009. 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 198,000 hectares in 2013. Potential opium production similarly increased from 5,300 metric tons in 2009 to 5,500 metric tons in 2013. If the entire opium harvest were processed into pure heroin, it would have produced 630 metric tons in 2009 and 656 metric tons in 2013.

Bolivia experienced reductions in the cultivation of coca and in the potential production of pure cocaine. Coca cultivation totaled 29,000 hectares in 2009 and decreased to 25,000 in 2012. Potential pure cocaine production decreased from 165 metric tons in 2009 to 155 metric tons in 2012.

Burma experienced a significant increase in poppy cultivation and opium production. Poppy cultivation increased from 19,000 hectares in 2009 to 36,500 hectares in 2011 (poor weather stunted cultivation in 2009). Potential opium production also rose from 305 metric tons in 2009 to 451 metric tons in 2011. If the entire opium harvest were processed into pure heroin it would have produced 29 metric tons in 2009 and 43 metric tons in 2011.

Colombia experienced a reduction in coca cultivation and production. Coca cultivation totaled 116,000 hectares in 2009 and decreased to 78,000 in 2012. Potential pure cocaine decreased from 280 metric tons in 2009 to 175 metric tons in 2012.

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31. DEVIDA's Counternarcotics National Strategy 2012-2016, and Ministry of Economy and Finance
32. ONDCP March 2011 Cultivation and Production Estimates, 2005-2009 and updates from other unpublished U.S. data.

Laos did not experience reductions in either production or cultivation of poppy. Poppy cultivation estimates increased from 2009 to 2011 from nearly 1,000 hectares grown in Phongsaly in 2009 to 4,400 hectares grown in three primary growing areas in 2011. Potential opium production for Phongsaly totaled 11.5 metric tons in 2009 and the three primary growing areas surveyed in 2012 potentially produced 57 metric tons of opium. If the entire opium harvest were processed into pure heroin, it would have produced approximately 1 metric ton in 2009 and 5.5 metric tons in 2011.

Mexico experienced a modest reduction in opium poppy cultivation and an increase in marijuana cultivation.[33] Poppy cultivation areas totaled 10,500 hectares in 2012, while marijuana in totaled 11,500 in 2012. A change in the estimate methodology in 2011 precludes a direct comparison with cultivation estimates from 2009, but marijuana cultivation has trended upward while poppy cultivation dipped slightly. If the fields used in this analysis were processed into pure heroin, they would have produced 26 metric tons of pure heroin in 2012. There is no marijuana production estimate due to a lack of yield data for Mexico.

Peru showed no reduction in either coca cultivation or potential cocaine production from 2009 to 2012. Coca cultivation increased from 40,000 hectares in 2009 to 50,500 hectares in 2012. Potential pure cocaine production increased from 225 metric tons of cocaine in 2009 to 290 metric tons in 2012.

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

The Department of Justice's (DOJ) 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 has great impact on the Nation's illicit drug supply and the flow of foreign-produced drugs into the United States.

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 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 and FY 2010, 65 and 74 international CPOT-linked organizations were disrupted or dismantled, respectively. With forseable declining resources and 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, DEA reported 69 CPOT-linked disruptions and dismantlements. The number of international CPOT-linked organizations disrupted or dismantled from FY 2009 through FY 2012 indicates 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.

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33.   The methodology used to produce cultivation estimates for Mexico was modified beginning with the 2011 estimate. Full country revisions to estimates prior to 2011 are not possible, but a back-cast of two primary cultivation areas for each crop allow for comparison.

Conclusion

Some key source and transit countries demonstrated increased commitment to reducing drug trafficking and use through demand and supply reduction efforts. With regard to the amount of illicit production and cultivation, more than half of the key countries selected are making gains in reducing cultivation or production. While accelerated progress is needed to meet the 2015 target of 100 percent of countries showing reductions since 2009 in either cultivation or production, the advances are encouraging. Significant progress has also been made regarding the disruption or dismantlement of domestic and international drug trafficking organizations that constitute the greatest drug trafficking threats to the United States.

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).

The table below (2-7) 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.

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]	15 Months	2010 - 18 Months 2009 - 15 Months	13 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	356,782 web hits/year	300,000 web hits/year	Target met or exceeded, progress should be maintained through 2015
National Survey of Drug Use and Health (NSDUH) (Journal articles referencing NSDUH)	37 per year	148 journal articles in 2012	50 per year	Target met or exceeded, progress should be maintained through 2015
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	1	Target met or exceeded, progress should be maintained through 2015

a The 3-year moving average timeliness of the initial TEDS report over the period 2002-2008 was used to estimate the 3-year average timeliness in 2010 (for the 2008 report).

b SAMHSA sponsored a conference for the users of SAMHSA's data sets; conference generated recommendations.

Analysis of Measures

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 (TEDS) was identified as an important data source and good candidate for improving lag times between collection and reporting. Given year-to-year variation in reporting times, targets for this measure were developed based on the historical 3-year moving average of timeliness. The baseline for release of TEDS data from the completion of data collection to release is 15 months, with a target of 13 months. Data regarding the publishing timeline for the 2010 TEDS report showed a period from data collection to release of 18 months. Accelerated progress is needed to meet the 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

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) and the NSDUH. SAMHDA promotes the access and use of the Nation's preeminent substance abuse and mental health research data by assuring accurate public use data files and documentation. 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 300,000 web hits per year by 2015. The baseline for NSDUH is based on current information and sets a 2015 target of 50 journal articles/ year referencing NSDUH data. 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 exceeded 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 prescription drug abuse, particular emphasis will be placed on this area.

For the NSDUH, a re-design is planned for 2015 to incorporate updates to the methodology and to improve its ability to provide estimates of emerging drug problems, especially prescription drug abuse. The Drug and Alcohol 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.

Information on the criminal justice population is also important for informing policies and programs. Efforts are underway to strengthen drug information systems focused on arrestees and incarcerated Individuals. 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 (FDSS) to the National Seizure System (NSS) and the transitioning of DAWN to the SAMHSA Emergency Department Surveillance System to monitor drug-related emergency department visits. 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. And 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.

Conclusion

There has been sound progress in improving timeliness, utilization, and feedback regarding drug-related data, but more needs to be done. There continues to be a pressing need for more complete and timely reporting of drug-involved deaths. In addition to mortality data, there is also a need to have enhanced morbidity data collections systems.

The approaches articulated by the President's *Strategy* include sustaining and enhancing existing systems, developing new data systems and analytical methods, and improving community-level data. These approaches are also consistent with the Office of Management and Budget's guidance to make better use of existing administrative data and innovative approaches to assess progress in a cost-effective manner.

Addendum: Glossary of Acronyms, Abbreviations, Definitions and Performance Terms

Acronyms

AA   Alcoholics Anonymous

ADAM   Arrestee Drug Abuse Monitoring Program, U.S. Department of Justice

AI/AN   American Indian and Alaskan Native

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

CATS   Consolidated Asset Tracking System

CBHSQ   Center for Behavioral Health Statistics and Quality, SAMHSA

CBP   Customs and Border Protection, U.S. Department of Homeland Security

CMEA   Combat Methamphetamine Epidemic Act

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.

CSAT   Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration

DAWN   Drug Abuse Warning Network, U.S. Department of Health and Human Services

DEA   Drug Enforcement Administration, U.S. Department of Justice

DCP   DEA's Diversion Control Program

DHS   U.S. Department of Homeland Security

DDs   Disruptions and Dismantlements

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.

DVA   U.S. Department of Veterans Affairs

EPIC   El Paso Intelligence Center, U.S. Department of Justice

FAA   Foreign Assistance Act of 1961

FBI   Federal Bureau of Investigation

FQHC   Federally Qualified Health Center grantees of the Health Resources and Services Administration

GPRA   Government Performance and Results Act

GPRMA   GPRA Modernization Act of 2010

HWDS   Hazardous Waste Disposal System

HIDTA   High Intensity Drug Trafficking Areas, Office of National Drug Control Policy

HHS   U.S. Department of Health and Human Services

HRSA   Health Resources and Services Administration, U.S. Department of Health and Human Services

ICE   Immigration and Customs Enforcement, U.S. Department of Homeland Security

IHS   Indian Health Service

IRS CI   Internal Revenue Service Criminal Investigation

INCSR   International Narcotics Control Strategy Report, U.S. Department of State

JRFC   Office of Juvenile Justice and Delinquency Prevention's Juvenile Residential Facility Census, U.S. Department of Justice

LSD   Lysergic acid diethylamide, known colloquially as acid, is a semisynthetic psychedelic drug of the ergoline family

MDMA   (3, 4-methylenedioxy-N-methylamphetamine) is an empathogenic drug of the phenethylamine and amphetamine classes of drugs. MDMA has become widely known as "ecstasy."

MH   Mental Health

MHS   Military Health System (U.S. Department of Defense)

MIS   OCDETF's Management Information System

MLO   Money Laundering Organization

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.

MTFs   Military Treatment Facilities (U.S. Department of Defense)

MORE   My Ongoing Recovery Experience (U.S. Department of Defense)

NA   Narcotics Anonymous

NIDA   National Institute on Drug Abuse

NIJ   National Institute of Justice

NSS   National Seizure System

N-SSATS   National Survey of Substance Abuse Treatment Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

NSDUH   National Household Survey on Drug Use and Health, 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

PTO   Priority Targeting Organization

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).

RDAP   Residential Drug Abuse Treatment Program (U.S. Department of Justice)

RSAT   Residential Substance Abuse Treatment (U.S. Department of Justice)

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

SAPTBG   The Substance Abuse Treatment Block Grant

SARP   Substance Abuse Rehabilitation Program (U.S. Department of Defense)

SBA   Small Business Administration

SBIRT   Screening, Brief Intervention, and Referral to Treatment, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

SSAs   Single State Agencies

STRIDE   The System to Retrieve Information from Drug Evidence

SUDRFs   Substance Use Disorder Rehabilitation Facilities

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

UCR   Uniform Crime Report, Federal Bureau of Investigation, U.S. Department of Justice

USCG   United States Coast Guard, U.S. Department of Homeland Security

VHA   Veterans Health Administration

YRBS   Youth Risk Behavior Survey. This is an American biannual survey of adolescent health risk and health protective behaviors such as smoking, drinking, drug use, diet, and physical activity conducted by the Centers for Disease Control and Prevention.

Definitions

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.

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.

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 State Department criteria for illicit drug production or transit: Afghanistan, the Bahamas, Bolivia, Brazil, Burma, Colombia, the Dominican Republic, Ecuador, Guatemala, Haiti, India, Jamaica, Laos, Mexico, Nigeria, Pakistan, Panama, Paraguay, Peru, and Venezuela.

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 Working Groups.

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.

Performance Terms

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.

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.

PRS Process
Collaboration of drug control agencies to identify performance outcome measures and targets, and an interagency assessment of progress towards the Strategy's Objectives.

Performance Target
Desired level of performance to be achieved during a specified fiscal year for that measure.

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.