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NATIONAL DRUG CONTROL STRATEGY

MESSAGE

FROM

THE PRESIDENT OF THE UNITED STATES

TRANSMITTING

THE ADMINISTRATION'S 2016 NATIONAL DRUG CONTROL STRATEGY, PURSUANT TO 21 U.S.C. 1705(a); PUBLIC LAW 105–277, SEC. 706(a) (AS AMENDED BY PUBLIC LAW 109–469, SEC. 201(a)); (120 STAT. 3513)



JANUARY 12, 2017.—Message and accompanying papers referred to the Committees on the Judiciary, Energy and Commerce, Foreign Affairs, Education and the Workforce, Transportation and Infrastructure, Armed Services, Ways and Means, Oversight and Government Reform, Veterans' Affairs, Natural Resources, Agriculture, Financial Services, Homeland Security, and Intelligence (Permanent Select) and ordered to be printed

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To the Congress of the United States:

I am pleased to transmit the *2016 National Drug Control Strategy* summarizing the accomplishments of my Administration's 21st century approach to drug policy and opportunities to continue to reduce the burden of substance use in the United States. My Administration released its first *Strategy* in 2010 with a commitment to use the best available science and to consult broadly to develop a balanced and comprehensive approach to drug policy that incorporates both public health and public safety approaches to address this complex problem.

We set aggressive goals to reduce drug use by 2015 and though the results of our efforts are mixed, we have seen progress in reducing drug use and in cooperation both nationally and internationally. As a Nation we exceeded our goals for reducing alcohol and tobacco use among youth and for reducing the number of new HIV infections attributable to drug use. We have been less successful in reducing illicit drugs in youth and young adults as well as reducing the number of drug-induced deaths and driving while drugged. We also face serious challenges including an epidemic of opioid use and overdose deaths as well as growing threats from drug trafficking organizations involved in manufacturing and distributing cocaine and synthetic drugs, including novel psychoactive substances. These threats may continue to have an impact on drug use across lifespans, particularly chronic drug use and its consequences that contribute to poor academic performance, crime, underemployment, lost productivity, and health care costs, all of which threaten families and communities.

My Administration has consistently sought a broad coalition of partners to provide input into the development and enhancement of the *Strategy* during the past 7 years. We have invested in science to better understand the nature of addiction and inform the prevention and treatment of addiction and support services to help maintain recovery in the community. We have sought to use medical terms and non-stigmatizing language when discussing substance use disorders, and those who suffer from this disease. Our support for law enforcement has led to significant outcomes in taking down drug trafficking organizations and removing millions of pounds of drugs from the market. And our work with our international partners has been instrumental in our allies' increasing regulation of chemical precursors to synthetic drugs and reducing their movement across the globe. Throughout my Administration, we have used the best available evidence to balance the Nation's public health and public safety and drive collaborative efforts to create healthier, safer, and more prosperous communities.

The Nation's work in reducing drug use and its consequences is not done and there are many opportunities for advancing efforts to address ongoing and emerging challenges. I thank the Congress for

its continued support of our efforts and ask that you continue to support this vital endeavor.

BARACK OBAMA.

THE WHITE HOUSE, *January 11, 2017*.

NATIONAL DRUG CONTROL STRATEGY

2016



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President Barack Obama
The White House

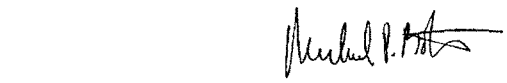
Preface from Director Botticelli

The 2016 *National Drug Control Strategy* highlights important accomplishments the Administration has made in advancing a comprehensive and balanced approach to drug policy in the United States. From the beginning, this Administration's *Strategy* has been informed by science and input from Congress, Federal agencies, state and local partners, civic and professional organizations, and hundreds of Americans who are committed to reducing the burden of substance use on friends, family members, colleagues, and communities where they live. Over the course of this Administration, there have been emerging challenges such as the opioid epidemic, new synthetic drugs, and drugged driving. President Obama's *Strategy* has provided a solid framework for public health and public safety officials and other stakeholders to collaborate and implement innovative solutions that work to prevent drug use, reduce the stigma that creates barriers to treatment, create opportunities for sustained recovery, and move support law enforcement as they work to reduce the availability of drugs across the Nation.

Perhaps the most powerful tool for reducing drug use across the Nation is the Affordable Care Act which helped to guarantee substance use services for millions of Americans through the Marketplaces and Medicaid expansion. The Administration has partnered with medical schools and medical associations to educate practitioners about substance use disorders, especially opioid use disorders, thus increasing the number of opportunities that individuals with a substance use disorder can be identified and offered treatment. Also, in 2016, a landmark report, *The Surgeon General's Report on Substance Use, Addiction, and Health,* was released.

One of the most visible challenges for the Nation has been the epidemic of opioid use and deaths resulting from opioid overdoses. As it became clear that the opioid epidemic was linked to the misuse of powerful opioid pain medications, the Administration responded with a plan designed to reduce prescription drug use. This plan was built upon the *Strategy* and works to reduce prescription drug use through education, enhanced monitoring of prescription use, creating opportunities to safely dispose of un-used prescription drugs, and providing tools for law enforcement to reduce the availability of prescription drugs in the community. Additionally, the Administration has actively supported community efforts to make the life-saving drug naltrexone widely available to reverse opioid drug overdoses and reduce the number of deaths associated with opioid use. These and other efforts reflect efforts by the Administration to integrate public health and public safety approaches to address the Nation's needs.

While we have continued to pursue the goals set forth in President Obama's *Strategy,* we and our partners have not forgotten that we are working for to improve the lives of millions of American's affected by substance use. During my tenure as Director of National Drug Control Policy, I have meet hundreds of individuals who are working towards recovery and hundreds of public health and public safety professionals who are working alongside each other to make this *Strategy* a reality. Though we have accomplished many of the tasks that the President has set for us, we as a Nation also have many more opportunities to work on reducing the burden of substance use and creating healthy communities.



Michael P. Botticelli
Director of Drug Control Policy

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Introduction

President Obama in 2010, with his inaugural *National Drug Control Strategy (Strategy)*, announced his commitment to implementing a comprehensive and balanced approach based on scientific evidence to reduce the burden of drug use on the Nation's communities. This and subsequent *Strategies* released over the past seven years fulfilled his commitment through efforts to:

- Prevent drug use before it starts;
- Train and deploy health care professionals to intervene before problematic use and substance use disorders (SUD) develop;
- Provide access to SUD treatment for the more than 22 million Americans who need care;
- Ensure the availability of services to support the recovery of those who have benefitted from treatment;
- Reduce the stigma associated with SUD by eliminating barriers that impede access to treatment, housing, employment, and other basic needs;
- Reform the Nation's criminal justice system to reduce incarceration and recidivism; Support law enforcement efforts to reduce the supply of illicit drugs in America;
- Coordinate drug control efforts among our international partners to reduce the cultivation, manufacture and trafficking of illicit drugs; and
- Enhance data collection systems and research capabilities to better support policy formulation, implementation and assessment.

The central concept behind the President's *Strategy* is the understanding that SUD is not a hopeless problem, but a brain disease that can be prevented, treated, and from which people can and do recover. Successful implementation of the *Strategy* required a balanced approach involving prevention, treatment and law enforcement.

This *Strategy*, building on advancements made over the course of the Administration, looks back over the past seven years to assess the accomplishments made in the area of drug control policy. Perhaps the single most important accomplishment in this area is the passage and implementation of the Affordable Care Act (ACA). The ACA builds on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) which requires group health plans and health insurance issuers to guarantee that financial requirements (e.g., co-pays and deductibles) and treatment limitations (e.g., visit limits) applied by most health plans and insurers to SUD and mental health disorders benefits be no more restrictive than the financial predominant requirements or treatment limitations applied to medical and surgical benefits.[1] As of March 2016, approximately 20 million individuals gained coverage via the Marketplaces and Medicaid expansion, because they were young adults who were able to stay on their parents' plans, or through other coverage provisions.[2] This translates into many more opportunities for access to screening and early intervention to help identify substance use before it becomes problematic. In addition, the Administration is working with medical schools and associations to increase the number of health care practitioners trained to provide SUD treatment especially for opioid use disorder) in primary care and other settings.

The greatest drug threat to the Nation during the Administration has been the continuing opioid epidemic, which began with the overprescribing of powerful long-acting, time-released opioid

medications originally prescribed for the relief of pain. In recent years, the epidemic was further complicated by a sharp increase in the supply and subsequent use of high purity, low cost heroin produced in Mexico and Colombia[3] and the trafficking of illicitly produced fentanyl, a powerful synthetic opioid. The response has been comprehensive and multi-faceted. Initially, the Administration formulated a plan to reduce prescription drug misuse. It contains four pillars. First, education is critical for the public and for healthcare providers to increase awareness about the dangers of prescription drug misuse, and about ways to appropriately dispense, store, and dispose of controlled substance medications. Second, enhancement and increased utilization of prescription drug monitoring programs will help to identify individuals with opioid use disorders (OUDs) and detect therapeutic duplication and drug-drug interactions. Third, the development of consumer-friendly and environmentally-responsible prescription drug disposal programs may help to limit the diversion of drugs. Fourth, by providing law enforcement agencies with the support and tools they need, their efforts to target diversion of prescription pain medication may be enhanced.

Building upon these initial efforts, the Administration encouraged state and local authorities, especially police departments and other first responders, to adopt the use of naloxone, an opioid antagonist that can reverse an opioid overdose. The Administration also encouraged wider adoption of emergency department-based programs that assist overdose victims to transition from overdose recovery to treatment. The Administration also sought to increase the use of medication-assisted therapy (MAT), including for criminal justice populations. The Food and Drug Administration (FDA) has approved three medications for the treatment of OUD: methadone, buprenorphine and naltrexone. The World Health Organization recently issued standards for the treatment of drug use disorders that includes the use of MAT to treat OUD.[4]

The Nation has seen results from these actions. The number of young adults who used prescription pain medications non-medically in the past year dropped by about one-third between 2009 and 2014.[5] In 2015, there were 16.6 million fewer prescriptions for opioid medications than the previous year—prescriptions for nearly all other categories of prescription drugs in 2015 increased over the previous year.[6] In 2012, deaths involving opioid declined for the first time since 1999 but rose again between 2013 and 2014. [7,8] In 2014, the Drug Enforcement Administration (DEA) issued its final rule implementing a regulation governing the disposal of controlled medications.[9] Patients who have such medications but who no longer have a need for them can now safely dispose of them by returning them to the pharmacy and other methods. Across the country police departments and other first responders have adopted the use of naloxone and reversed thousands of opioid overdoses and saved countless lives. In 2016, the Centers for Disease Control and Prevention (CDC) issued guidelines for prescribing opioids for chronic pain.[10]

The market for illicit opioids, including diverted opioid medications, heroin, and fentanyl, is driven by those who use these drugs frequently. Treatment is the most effective way to reduce demand for the drugs. Recognizing this reality, the President has requested $1 billion in new mandatory funding over two years to address the opioid epidemic and expand treatment for OUDs. An additional $ 90 million in new resources that was requested in the FY 2017 Budget that would continue and build on efforts at Department of Justice (DOJ) and the Department of Health and Human Services (HHS) to expand state-level prescription drug overdose prevention strategies, increase the availability of medication-assisted treatment programs, improve access to the overdose-reversal drug naloxone, and support targeted enforcement activities.

There has been substantial progress across a number of other priority areas during this Administration, including:

- Strengthening prevention efforts t through school-based education programs and continuing support for communities through the Drug-Free Communities Support program;
- Expanding screening and brief interventions into new settings to take advantage of opportunities available through the ACA and advances in intervention science;
- Integrating treatment and recovery support services into mainstream health care settings to improve access to care for individuals with SUDs;
- Training and equipping health care providers with the skills necessary to ensure SUD services are available in areas of greatest need;
- Improving access to and increasing awareness of transitional housing facilities in under-served rural areas for those in recovery;
- Improving access to services for offenders re-entering the community, including expanding MAT for offenders prior to release, and expanding alternatives to incarceration to break the vicious cycle of drug use, crime, and incarceration;
- Enhancing efforts to counter drug trafficking networks and secure the Nation's borders to reduce the flow of dangerous drugs into the United States;
- Building on successes with international partners to eradicate drug crops and reduce the supply of precursor chemicals; and
- Continuing work with Federal partners to enhance and strengthen the Federal Government's drug-related data systems.

The remainder of this chapter provides a detailed assessment of the progress the Nation has achieved in accomplishing the goals and objectives of the Strategy. The chapters that follow highlight the major drug policy issues that have been addressed by this Administration in the areas of prevention, brief intervention, treatment and recovery, criminal justice reform, law enforcement, international programs, and data collection and analysis. Chapters on two special focus areas, drugged driving and opioids, follow. For each chapter and policy issue, both the accomplishments achieved and opportunities for future progress are discussed.

Progress toward Achieving the Goals of the Strategy

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

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

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

- **Target Met or Exceeded** *(Given the data available at this time, progress should be maintained.)*
- Progress Sufficient to Meet Target *(Given the data available at this time, there is a reasonable expectation that the target will be met.)*

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

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

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

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

Assessment of Progress

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

Of the 13 performance measures identified to assess progress in the *Strategy*, three met or exceeded the targets set in 2009. The first two measures include decreasing the lifetime prevalence of alcohol use and tobacco use among 8th graders by 15 percent by 2015. By 2015, alcohol use among 8th graders had dropped to 26.1 percent, and tobacco use had fallen to 17.1 percent. These numbers are16 percent and 22 percent, respectively, below the targets set in 2009. The third measure, reducing HIV infections attributable to injection drug use, exceeded the target of 4,929 newly diagnosed HIV infections attributable to drug use by 22 percent (3,852 newly diagnosed HIV infections attributable

to drug use) one year earlier than the target of 2015. One measure, 30-day prevalence of drug use by youth ages 12 to 17, shows insufficient progress toward its goal of 8.6 percent.

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

National Drug Control Strategy Goal/Measure	Baseline	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- to 17-year-olds by 15%[11]	10.1% (2009)	9.4% (2014)	8.6%	
1b: Decrease the lifetime prevalence of 8th graders who have used drugs, alcohol, or tobacco by 15%[12]				
- Illicit Drugs	19.9% (2009)	20.5% (2015)	16.9%	
- Alcohol	36.6% (2009)	26.1% (2015)	31.1%	
- Tobacco	20.1% (2009)	13.3% (2015)	17.1%	
1c: Decrease the 30-day prevalence of drug use among young adults aged 18-25 by 10%[13]	21.4% (2009)	22.0% (2014)	19.3%	
1d: Reduce the number of chronic drug users by 15%[14]				
- Cocaine	2,700,000 (2009)	2,500,000 (2010)	2,295,000	Progress cannot be assessed
- Heroin	1,500,000 (2009)	1,500,000 (2010)	1,275,000	Progress cannot be assessed
- Methamphetamine	1,800,000 (2009)	1,600,000 (2010)	1,530,000	Progress cannot be assessed
- Marijuana	16,200,000 (2009)	17,600,000 (2010)	13,770,000	Progress cannot be assessed
***Strategy* Goal 2: Improve the public health and public safety of the American people by reducing the consequences of drug use**				
2a: Reduce drug-induced deaths by 15%[15]	39,147 (2009)	55,403 (2015)	33,275	
2b: Reduce drug-related morbidity by 15%				
- Emergency room visits for drug misuse and abuse[16]	2,070,452 (2009)	2,462,948 (2011)	1,759,884	Progress cannot be assessed
- HIV infections attributable to drug use[17]	5,799 (2009)	3,852 (2014)	4,929	
2c: Reduce the prevalence of drugged driving by 10%				
- Data Source: National Roadside Survey[18]	16.3% (2009)	20.0% 2013/2014	14.7% 2014	

Two measures, the prevalence of lifetime illicit drug use by 8th graders and 30-day prevalence of drug use among young adults aged 18-25 did not meet their targets of 16.9 percent and 19.3 percent respectively. Two other measures, the prevalence of people who drive after using drugs and reducing

the number of drug-induced deaths showed no progress to date in reaching their targets of 14.7% and 33,275 respectively. Lifetime prevalence of drug use by 8th graders increased to 20.5 percent in 2015, which is 0.6 of a percentage point above the 2009 baseline and nearly 4 percentage points above the 2015 target. The most recent prevalence data available indicate that past 30-day drug use among young adults aged 18-25 has remained unchanged since 2009. This measure is driven primarily by the prevalence of marijuana use, which was unchanged over this period of time. Prevalence of drugged driving increased to 20.0, percent which is 23 percent above the 2009 baseline of 16.3 percent.[*] Below is a specific discussion of the progress for each of the measures.

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

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

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

After two years of trending toward achieving the 2015 target of 8.6 percent, estimates for past 30-day illicit drug use among 12-to-17-year-olds, increased from 8.8 percent in 2013 to 9.4 percent in 2014. This is approximately 9 percent above the 2015 target. This most recent increase appears to be driven by a 20 percent increase in illicit drug use other than marijuana (from 3.0% in 2013 to 3.6% in 2014). However, prior to 2014 the rate of use of illicit drugs other than marijuana among youth had been dropping steadily from 4.6 percent in 2009 to 3.0 percent in 2013.
As noted above, this measure is one of the two used to assess the Nation's progress toward achieving the *Strategy's* goals that is affected by the 2015 redesign of the NSDUH. In order to achieve the target, the 2015 estimate would have had to drop 0.8 of a percentage point. The 2015 NSDUH for the prevalence of marijuana use among youth, for which there is not a break in the trend, indicates there was no change from the 2014 estimate. Coupled with the trend for the rate of use of drugs other than

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

marijuana, it is possible that the Nation may have achieved this target, but due to the break in the trend resulting from the 2015 re-design, it is not possible to make a definitive statement; therefore, this measure has been rated as "insufficient progress".

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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§ 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.

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

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

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

Conclusion

Progress in implementing the President's Strategy over this next year and beyond will require a comprehensive effort that includes Federal, state, local, tribal, and territorial government agencies, international institutions and partner nations, nongovernmental organizations, academia, private industry, and American citizens from all walks of life.

Chapter 1. Strengthen Efforts to Prevent Drug Use in Our Communities

Preventing substance use before it starts is a fundamental element of the Administration's balanced approach to drug policy. Monitoring drug use trends and supporting research to inform the development and implementation of evidence-based prevention activities has been a key focus of these efforts. Research has shown that each dollar invested in proven school-based prevention programs can reduce social costs, including those related to substance use, by an average of $18.[1] When evidence-based substance use prevention programs are properly implemented by schools and communities, illicit drug use is reduced.

The Administration also has focused on streamlining Federal coordination and responding to specific drug threats, such as marijuana, synthetic drugs, and opioids; educating stakeholders about the importance of expanding evidence-based programs; building a national prevention system based on current, effective programs and activities; collaborating with state and local governments, schools, and community coalitions to enhance coordination across agencies; expanding the focus on the entire community instead of the individual; and addressing the impact of substance use on youth.

Accomplishments

The following sections describe significant accomplishments for the Nation over the past seven years and opportunities for future efforts.

Principle: A National Prevention System Must be Grounded at the Community Level

Prevention efforts are successful when they are grounded at the community level, collaborative, and involve multiple sectors of a community, including parents, schools, health and social service systems, hospitals, law enforcement, faith communities, local businesses, neighborhood organizations, and youth. Three Federal programs support the Nation's prevention infrastructure through primary prevention planning, implementation, and evaluation: the Substance Abuse and Mental Health Administration's (SAMHSA) Substance Abuse Prevention and Treatment Block Grant and the Strategic Prevention Framework Partnerships for Success grants; and ONDCP's Drug-Free Communities (DFC) Support Program. The contributions of DFC-funded community coalitions constitute a critical part of the Nation's prevention infrastructure. This investment in DFC's philosophy that 'local problems, require local solutions' has resulted in the DFC Program's success. Since 2009, DFC-funded community coalitions have consistently shown positive outcomes in the prevention and reduction of youth substance use. Based on core measures data collected by DFC grantees from 2002 to 2014, the National Evaluation found that past 30-day prevalence of use declined significantly from first to most recent observation across all substances (alcohol, tobacco, marijuana and prescription drugs) at the middle school and high school level.[2] DFC coalitions serve as a catalyst in their communities for creating sustainable local change for the specific substances affecting their youth.

With the passage of the Affordable Care Act (ACA) in 2010 came new Internal Revenue Service standards that require tax-exempt hospitals to provide a benefit to the overall health of the communities they serve.[3] These "community benefit" requirements can take many forms, including

support for local community building activities, charity care, direct funding or in-kind support, and workforce development.[4] The IRS estimates the value of the Community Benefit nationwide to be $62.4 billion.[5] ONDCP is actively involved in increasing awareness of the community benefit through conferences and webinars, and fostering on-the-ground collaborations between non-profit hospitals and community coalitions to provide resources for local substance use prevention efforts.

ONDCP has hosted a series of webinars on evidence-based prevention practices and the science of prevention for parents, care givers, and public health, state, and law enforcement officials. The agency also hosted a webinar series in April and November 2015 on New Psychoactive Substances (NPS) that examined the health consequences of NPS use, manufacturing, and strategies employed by state, local, and community entities to reduce the use and availability of NPS.

Principle: Prevention Efforts Must Encompass the Range of Settings in Which Young People Grow Up

Engaging youth in multiple settings is essential to educating them about the importance of staying healthy and above negative influences such as substance use. Young people need to hear messages about the harmful effects of drug use from multiple sources – peers, parents, teachers, mentors, faith leaders, employers, and the media, for example – and in multiple places, such as in the home, school, and the media.[6] They also need to hear these messages continuously throughout their lives.[7] While many social and cultural factors also may affect drug use trends, when young people perceive drug use as harmful, they reduce their level of use.[8]

DFC-funded community coalitions work to reduce substance use among youth and to create safer and healthier communities across the country. Between February 2014 and August 2014, 94 percent of DFC grantees distributed prevention messaging via print and electronic media. DFC grantees also utilized social media to communicate prevention messaging with youth garnering more than half a million hits. DFC-funded coalitions also directly engaged youth and adults in their communities in a broad range of settings; reached more than 740,000 people with special events; held more than 7,000 direct face-to-face information sessions and reached 130,000 adults and more than 150,000 youth; trained over 330,000 youth, parents, and other community members; recognized more than 9,000 businesses for compliance with local ordinances; and helped to pass or modify 557 laws or policies. Over 130,000 youth were specifically engaged in many activities such as Drug-free parties and alternate community events supported by the coalition, including over 38,000 young people in youth recreation programs and over 21,000 in youth organizations. Over 300,000 youth participated in activities to reduce home and social access to substances.[9] The evaluation of the program indicates that substance use among youth in DFC communities is below the national average.

The Above the Influence (ATI) campaign, originally funded by ONDCP and now transitioned to the Partnership for Drug-Free Kids (PDFK), plays a unique and important role in preventing youth drug use. In recognition of National Substance Abuse Prevention Month, Mentor Foundation USA partnered with ONDCP and the PDFK to host the 4th annual Above the Influence Day, during which over 200 students had the opportunity to interact with peers and learn strategies to stay above negative influences through the arts.

Since 2010, the Administration has been focused on educating parents and other adult influencers because they are essential to changing the way youth see and hear messaging regarding substance use. In 2011, the DEA and Department of Education (ED) collaborated to revise their most popular publication, *Growing up Drug Free: A Parent's Guide to Prevention,* a user-friendly guide geared to educate

parents on how to talk to their kids about the dangers of drugs. DEA and ED are currently working to update the guide and prepare a Spanish language edition. In 2014 and 2015, ONDCP co-hosted with the NIDA a webinar for parents and caregivers that focused on the importance of parental involvement and early intervention. The webinar, which featured parents of children lost to substance use, reached over 500 parents, caregivers, school nurses, and prevention providers, and provided tools and resources for local-level implementation of prevention strategies.

Principle: Develop and Disseminate Information on Youth Drug, Alcohol, and Tobacco Use

The Administration continues to develop information on youth drug, alcohol, and tobacco use to help prevent youth substance use. In recognition of National Substance Abuse Prevention Month in March 2015, representatives from ONDCP, ED, the Institute of Education Sciences, and the National Institutes of Health (NIH) met to foster cross-discipline data sharing in support of the Adolescent Brain Cognitive Development Study (ABCD Study).[10] The ABCD study, led by the Collaborative Research on Addiction Partnership at the NIH initiative, is the largest long-term study of brain development and child health in the United States. Data from the study will increase our understanding of the effects of drugs and alcohol on the brain and help policymakers target resources where they are most needed.

Targeting the environment of young children can positively affect subsequent behavior. In 2016, NIDA released *Principles of Substance Abuse Prevention for Early Childhood,* the first-ever research-based guide on substance use prevention in early childhood. The guide will provide principles for intervening early in childhood as well as resources for practitioners, researchers, and policymakers.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) supports research to reduce harmful and underage drinking by college students, and its consequences. In 2015, the Institute released the College Alcohol Intervention Matrix, CollegeAIM, a research-based decision tool and guide to help colleges and universities choose wisely among strategies to meet their alcohol intervention goals. CollegeAIM allows users to compare nearly 60 individual- and environmental-level strategies based on factors such as cost, effectiveness, and ease of implementation, helping them choose those interventions that best fit the needs of their campus.

In 2016, ED made available free of charge their School Climate Surveys, new high-quality, adaptable surveys and associated web-based platform that allow States, local districts, and schools to collect and act on reliable, nationally-validated school climate data (including substance use indicators) in real time. The platform processes data and provides user-friendly reports in real-time. Education agencies administering the survey can store the data locally on their own data systems. ED will not have access to the data. In 2017, ED will survey a nationally-representative sample of schools to create school climate benchmark scores. These benchmark scores will be added to the platform's reporting functionality to enable comparisons between local and national scores.

In 2011, the Department of Defense Education Agency distributed a parent-teacher resource guide to 194 schools, reaching 85,000 students worldwide. In 2014, ONDCP successfully collaborated with ED's Office of Elementary and Secondary Education to provide drug prevention messaging and materials to more than 10,000 21st Century Community Learning Center grantees through the You for Youth (Y4Y) portal, an online professional development and technical-assistance tool. Also in 2014, ONDCP and ED hosted an academic forum for educators, researchers, and prevention specialists to examine the nexus between substance use and academic achievement among youth. Forum panelists

shared their research findings and strategies to implement evidence-based prevention interventions in school settings.

Principle: Criminal Justice Agencies and Prevention Organizations Must Collaborate

The Administration has made a concerted effort to foster public health and public safety collaboration and share information on effective prevention strategies with law enforcement. An ONDCP-sponsored webinar entitled "The Science of Prevention: Evidence-Based Strategies to Reduce Drug Use" was held on August 4, 2015, with the goal of expanding an understanding of effective prevention strategies within the High Intensity Drug Trafficking Areas (HIDTA) program. HIDTAs provide assistance to Federal, state, local, and tribal law enforcement agencies that operate in areas determined to be critical drug-trafficking regions of the United States.

Currently, 22 regional HIDTA programs, including those in Southwest border (SWB) regions, support prevention activities. Forces United, a program funded by the SWB HIDTA/San Diego Region, supports efforts by the four California HIDTA regions' Opioid Prevention Committees and serves as an example of public health and public safety working together to address common challenges. The program also helps coordinate the Committees' efforts regarding naloxone guidelines; educating patients, parents, and law enforcement; prescription drug monitoring programs; prescription drug take-back programs; and implementation of a grant to support recovery from SUDs.

In 2012, DEA updated two of its drug websites: GetSmartAboutDrugs.com, which is geared toward parents, and the teen-focused JustThinkTwice.com. Both sites continue to educate millions of youth about the impact of substance use and offer links to resources for support.

In 2016, U.S. Surgeon General Dr. Vivek Murthy released the first-ever Surgeon General's Report on Substance Use, Addiction, and Health. This landmark project will bring national attention to the enormous public health problems posed by substance use and the role all of us can play to prevent and reduce substance use and its consequences.

Opportunities for the Future

SUDs are preventable, and there are many opportunities to expand the prevention infrastructure with evidence-based programs. If the Nation is to decrease drug use, communities across the country should intensify and expand the implementation of evidence-based practices for youth substance use prevention in schools, among law enforcement, local hospitals, and other community partners. Prevention in school settings is particularly important, as it helps ensure youth are receiving appropriate and positive messaging to make them more resilient to pressures that can increase the likelihood of drug use. The new Student Support and Academic Enrichment formula grant program, authorized by the Every Student Succeeds Act, would provide funds that local school districts can use for drug prevention activities.

Fostering change at the local level and sustaining long-term outcomes require that the latest research findings and evidence-based programs reach communities. Continued coordination among Federal agencies can ensure that prevention resources are not fragmented, but properly utilized to maximize the benefit to communities.

Addressing the prescription opioid and heroin epidemic will continue to be a priority for the Nation. Tools are available that have been proven to be effective in preventing and reducing drug use and reversing opioid overdoses. These tools can continue to be used and the Nation can expand its efforts to address issues related to the epidemic, such as infectious disease prevention and control and suicide prevention

Chapter 2: Seek Early Intervention Opportunities in Health Care

In 2015, 21.7 million Americans 12 and older needed specialty SUD treatment, and of these individuals, 19.3 million did not receive it in the past year. The majority of these individuals (95 percent) who did not received specialty treatment did not perceive the need for it[1] Routine and universal screening by health care providers can be an important tool for detecting substance use and other risky patterns that may be more amenable to brief interventions or referral to more definitive treatment when necessary. In individuals with co-occurring chronic conditions, untreated SUDs have been linked to poor health outcomes and an increased likelihood and frequency of hospital readmissions and emergency department encounters.[2] Failure to screen for substance use in primary care and general medical settings represents a major missed opportunity to enhance quality of care and reduce these readmissions and emergency department encounters.

General screening for substance use in primary care and other settings is important for monitoring possible drug-drug interactions, determining the need for a range of evidence-based treatments, and, where necessary, making referrals to specialty treatment settings. Specialty treatment may be warranted when substance use is severe or has progressed to a chronic disorder. As with other health conditions, there is a range of interventions for preventing and treating the continuum of SUDs, but their deployment rests upon initial screening, case identification, and early intervention.

Screening and early intervention are supported through the largest expansion of mental health and substance use disorder (MH/SUD) coverage in a generation. The ACA requires coverage for MH/SUD services by most individual and small employer health insurance plans, including all medical plans offered through the Marketplaces. These plans are also required to cover rehabilitative and habilitative services, which can provide support to individuals with MH/SUDs. These new protections build on provisions in the MHPAEA, that and expanded MH/SUD benefits and Federal parity protections to insured Americans.

Accomplishments

Implementation of services within primary care and other settings seeking to improve early identification and intervention targeting risky substance use should be based on science. Much work has been done to help train practitioners in evidence-based screening and early intervention and to help service systems adopt these protocols. The following sections describe accomplishments in this important area of population health intervention.

Principle: Identifying Substance Use Disorders Early Saves Lives and Money

Beginning with the inaugural *Strategy* in 2010, the Administration sought to expand strategies such as Screening, Brief Intervention, and Referral to Treatment (SBIRT) that help increase access to services in mainstream health care settings. SBIRT is an intervention that can be integrated across a range of health care settings to help identify risky and problematic substance use that may be responsive to brief office-based services. It also can help detect when use has advanced to the point where a referral to specialty care is required. The policy since 2010 has been that screening is an essential part of health

care and can support health care providers in engaging in important conversations with their patients in primary care settings. This approach can be less stigmatizing and anxiety-producing than being directly referred to a specialty care program for SUDs. Over the past seven years, ONDCP has worked with its Federal partners to develop programs to increase the adoption of evidence-based interventions that can be offered in primary care settings, enhance provider training, develop financing strategies to support early interventions, and support research to improve the quality of these important services.

Increasing adoption of screening and early intervention

An important catalyst for integrating substance use services in primary care settings across the Nation was funding by SAMHSA of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) Demonstration Program. SBIRT is an evidence-based practice used to identify, reduce, and prevent problematic use of and dependence on alcohol and illicit drugs. Between 2009 and 2013, SAMHSA's program funded more than 150 grants, and a number of grants are active through 2016. Funding allowed grantees to develop and implement SBIRT approaches for different populations in different settings and to provide training and technical assistance on SBIRT to thousands of health professionals across the Nation, from clinical social workers to nurses, nurse practitioners, physicians' assistants, and physicians. SAMHSA awarded 33 state SBIRT grants (four states funded twice); 12 College SBIRT grants; 17 Medical Residency SBIRT training grants; and 88 health care student training grants. Among the 17 medical residency grants, 6,600 physicians were trained, and 14 of these grants funding the training of 11,800 allied health professionals. In 2014, SAMHSA continued to support ongoing SBIRT program efforts to train allied health professionals and awarded Medical Professional Training Grants to an additional 11 institutions.

Since 2010, a number of technical grants expanded adoption of SBIRT, including:

- Dissemination of an SBIRT training curriculum for health care providers in primary care settings through a collaboration between the Center for Substance Abuse Treatment/SAMHSA and Health Resources and Services Administration (HRSA).
- In 2013, SAMHSA funded an Addiction Technology Transfer Center (ATTC) for SBIRT. This ATTC, which works to accelerate the adoption and implementation of SBIRT and other promising evidence-based SUD treatment and recovery services, continues to conduct webinars, disseminate an SBIRT newsletter on the Web, provide training curriculums online and via CD, support learning community websites, and offer free training to the public on numerous aspects of SBIRT implementation and integration with primary care.
- An SBIRT training offered to all Military Service primary care providers in TRICARE, a program of the Department of Defense (DoD) Military Health System that provides civilian health benefits for military personnel, military retirees, and their dependents, including some members of the Reserve Component. Provided through the Office of Health Affairs in the DoD, the training is an opportunity for the early identification of SUDs, allowing for timely intervention with TRICARE beneficiaries.
- SAMHSA and HRSA jointly fund the Center for Integrated Health Solutions (CIHS), which supports a resource page for SBIRT information, tools, and resources. The CIHS supports the adoption of SBIRT through technical assistance strategies, including a clearinghouse that promotes the development of integrated primary and behavioral health services to better address the needs of individuals with MH/SUDs, whether seen in specialty behavioral health or primary care provider settings.

In 2011, the NIAAA released Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide, which provides information to help medical practitioners identify alcohol use and alcohol use disorder (AUD) in youth ages 9-18, and to identify risk for alcohol use, especially for younger children. NIAAA is supporting five studies to evaluate the youth alcohol screening guide as a predictor of alcohol risk, alcohol use, and AUD, and as an initial screen for other behavioral health problems in various settings including primary care, emergency department, juvenile justice, and academic settings

Also in 2011, the American Congress of Obstetricians and Gynecologists, in collaboration with the CDC, developed the Women and Alcohol website offering resources for women's health care providers to identify women with risky alcohol use and provide brief educational counseling to reduce or eliminate alcohol use.

In 2014, SAMHSA funded state SBIRT programs with a focus on health information technology (HIT) development. Up to 30 percent of the grant funds can be used for HIT development, improvement and integration of electronic health record (EHR) adoption, health information exchange capability, telehealth, and web portals, etc. Each of the state SBIRT program grantees developed state-specific strategic plans in coordination with SAMHSA's Center for Substance Abuse Treatment (CSAT). SAMHSA's HIT team provided technical guidance and oversight in this effort. States are at varying stages of implementation, as progress is closely tied to the level of HIT infrastructure within each state and their respective health care organizations. SBIRT state grantees include Ohio, Vermont, New York, South Carolina, New Mexico, and Maryland.

More recently, in March 2016, HRSA awarded $94 million to support the expansion of SUD services within 271 health centers in 45 States, the District of Columbia, and Puerto Rico. Funding will allow these centers to improve and expand the delivery of SUD services with a focus on providing medication-assisted treatment (MAT) for OUD. HRSA also provided funding to establish an estimated 266 new health center sites in 2015. These efforts were in addition to efforts in 2014 and 2015 that provided $166 million in funding to expand the capacity of behavioral health services in health centers nationwide.

Improving Access to Quality Treatment

In July 2014, the Centers for Medicare and Medicaid Services (CMS) announced an urgent need to improve how health care is delivered, measured, and experienced in the substance use field. Through its Medicaid Innovation Accelerator Program (IAP) for Addressing Reducing Substance Use Disorders, CMS is providing states with technical support designed to accelerate the development and testing of SUD service delivery innovations. Strategies under consideration include payment and health care delivery models; data analytics; quality measurement; rapid cycle learning; and state-to-state learning involving sharing lessons and interventions used by other states. Several states have been successful in implementing interventions that reduce drug and alcohol use, thereby reducing health care costs and improving patient health. To date, 6 states[3] participated in the High Intensity Learning Collaborative (HILC). Participating states included: Kentucky, Louisiana, Michigan, Pennsylvania, Texas, and Washington. The HILC offered states technical support to tailor solutions to their own needs and to develop relevant policy, program, and delivery system reforms. The types of technical support included assistance with resources regarding care transitions and treatment engagement following withdrawal management; model SUD health home and managed care contract language; and administrative claims and managed care organization encounter data standardization. In addition to the HILC, 48 states and Washington, DC participated in 15 Targeted Learning Opportunities

(TLOs) webinars. These TLOs webinars connected states to content experts and leading practices across the country on a number of topics within SUD delivery system reform, such as encouraging SUD provider participation in Medicaid and the integration of primary care and SUD services. The IAP is also providing strategic design support to a number of states to assist with their section 1115 SUD demonstration proposals, under a new section 1115 demonstration opportunity to develop a full continuum of care for individuals with SUD, including coverage for short-term residential treatment services not otherwise covered by Medicaid. This new opportunity supports states undertaking broad and deep SUD system transformation efforts, enabling them to provide a full continuum of care by introducing service, payment and delivery system reforms to improve the care for individuals with SUD.[4]

The Department of Veterans Affairs (VA) and DoD established a joint workgroup comprising research and treatment SUD experts to review and revise current guidelines for promotion of evidence-based practices for SUD treatment and prevention. The workgroup reviewed the evidence for management of opioid disorders and renewed the recommendations of MAT as recommended evidence-based treatment for OUD. The workgroup published the most recent Clinical Practice Guidelines (CPG) for SUD treatment in December 2015.

Enhancing Provider Education

A majority of physicians and other health care providers have not been trained and do not feel adequately prepared to provide care for SUDs.[5] This lack of knowledge was an impediment to provider adoption of SBIRT. To address this educational and training deficit, HHS agencies collaborated to provide training in SBIRT to health care providers throughout the country, particularly in the Indian Health Service (IHS) and in Community Health Centers. SAMHSA supported this effort by developing a Physician Clinical Support System (PCSS) to increase health care providers' knowledge of SUDs and evidence-based treatment for SUDs. PCSS continues in 2016, focused on safe opioid prescribing, proper prescribing of medication-assisted treatment for OUDs, and the nexus of pain and opioid misuse.

Along with increasing the specialization of providers in behavioral health, it is important that doctors have a baseline understanding of the disease of addiction. In 2010, ONDCP collaborated with the National Board of Medical Examiners to identify areas for improved SUD content in the United States Medical Licensing Examination (USMLE). As a result, the USMLE includes a broader range of questions on SUDs and their relationship with other health conditions. Inclusion of these questions signals the importance of this knowledge to the practice of medicine. It suggests the need for students to master this material and underscores the need for schools to include it in their curricula.

Work across the Federal Government began in 2010 to address the growing demand for an expanded workforce. In particular, HRSA and SAMHSA established a technical assistance and training center to train health care providers on behavioral health care services, including SUD services, with the goal of increasing the number of trained health care professionals.

In addition, the Department of Labor (DOL) administers the Trade Adjustment Assistance Community College and Career Training (TAACCCT) Grant Program that provides grant awards to community colleges nationwide. TAACCCT provides community colleges and other eligible institutions of higher education with funds to expand and improve their ability to deliver education and career training programs. TAACCCT grantees have programs than span multiple industries

including healthcare. Some programs with a healthcare focus include curricula or certifications for counseling people with SUDs. NIDA's Centers of Excellence for Physician Information developed curriculum resources on SUDs to be integrated into existing curricula to enhance medical student/resident physician education. These curriculum resources address pressing issues facing physicians today, particularly recognizing risk factors and identifying prescription drug misuse in their patients. Finally, the NIDAMED Coalition, a partnership established between NIDA and the American Academy of Pediatrics, the California Academy of Family Physicians, the American Osteopathic Association, the American Academy of Physician Assistants, and the American Association of Nurse Practitioners, together with leading experts and other medical associations, has created a CME/CE that provides clinicians with research-based information and clinical strategies to help them prevent and address SUD and prescription pain medication misuse in their adolescent patients. After final review by NIDA, this web-based CME/CE is expected to launch before January, 2017.

To provide additional training and education for Military Health System medical providers who prescribe potentially addictive medications, an interactive video training entitled "Do No Harm" was developed by the Uniformed Services University of the Health Sciences to illustrate the most important points about prescription pain medication misuse. The interactive video training addresses the incidence of medication misuse; risk factors and risk stratification of patients for medication misuse; steps to mitigate medication misuse; and indications for referral to subspecialty providers. This training was disseminated to medical providers in 2013 and was updated in 2016 to meet the requirements in the 2015 Presidential Memorandum and will continue to be required for all credentialed and privileged prescribing providers.

Opportunities for the Future

Much has been accomplished to educate health care practitioners about how to identify and treat SUDs, progress can be made in other areas including:

- Revisiting reimbursement rates for interventions to ensure they are competitive with reimbursement rates for comparable physical medical approaches and are compliant with Federal law.
- Consider expanding reimbursement for interventions conducted by health professionals beyond the physician, to include other health care specialists such as social workers, nurses, and other allied professionals in primary care and other health care environments.
- Expand research to identify strategies to expand the adoption of screening and intervention across health care and social service settings.

Chapter 3: Increasing Access to Treatment and Supporting Long-Term Recovery

From the outset of this Administration, treatment was understood to be a critical and even life-saving resource for millions of Americans with SUDs. For this reason, ONDCP has been working with Federal partners and stakeholders to increase access to high-quality treatment services. The importance of these efforts is underscored by neuroscience research, which has enhanced our understanding of SUD as a brain disease.[1] We know that although it is possible to treat some early stage SUDs with brief interventions and referrals to community-based services and supports,[2] this approach may not be effective once SUDs have become severe and chronic. The revolutionary advances made by science, combined with the courage of individuals and family members who chose to speak out about SUDs and the hope of recovery, and have helped the Nation understand that a comprehensive public health approach is required to make progress against this disease.

Over the past seven years, the Nation has changed how it views SUDs, treatment, and recovery. Yet, there has been little progress in the number of Americans accessing treatment. Data from the 2009 NSDUH found that 11.2 percent of Americans who needed treatment for a SUD received treatment at a specialty facility.[3] By 2014, this estimate remained unchanged; 11.6 percent of Americans 12 years and older in 2014 who needed specialty treatment for an SUD received treatment at a specialty facility.[4] The provision of key treatment services, such as medication-assisted treatment (MAT), which utilizes FDA-approved medications, remains somewhat limited.[5] Despite a public health crisis brought on by the misuse of medications and heroin use, only 9 percent of SUD treatment facilities support provision of methadone, buprenorphine, or extended release naltrexone delivered by programs certified by SAMSHA.[6]

Thirty-one percent of individuals who felt they needed treatment for a drug or alcohol use problem indicated they did not enter treatment because they had no health coverage or could not afford the cost of treatment.[7] For those who are not ready to stop using, early intervention in a doctor's office may create the environment to seek help. For those who do not enter treatment because of inadequate resources, which may include many who say they are not ready to stop using, the ACA's benefit requirements for individual and small employer plans provide the potential to access treatment to address their SUDs and begin the process toward recovery. Additionally, innovations in the financing and delivery of care models that support the integration of primary care, treatment for SUDs, and recovery services have created opportunities for building bridges among providers and patients to provide quality treatment for those in need.

Accomplishments

With the implementation of the Administration's first *Strategy* in 2010, there has been an emphasis on moving from an acute care model to one that acknowledges the chronic nature of SUDs. Three principles guide this effort. The first is an expanded emphasis on access to integrated models of care, particularly within mainstream health care settings where individuals may have more opportunities for screening and identification of SUDs. The second principle clarifies the importance of providing high-quality care to those who access treatment services. Finally, people can and do recover from this

chronic illness, and celebrating those in recovery and seeking to enter recovery can help counter the stigma that many experience as they address this disorder. The accomplishments below highlight the progress that has been made in recent years, but remaining challenges require continued, determined effort.

Principle: SUD Treatment Must be an Integrated, Accessible Part of Mainstream Health Care

The current system of care has been structured historically to provide episodic, acute care to individuals with SUDs through encounters with emergency departments and detoxification units that often discharge individuals to the community without linkages to long-term, stable treatment. As this model does not address the chronic nature of SUDs, many of those who seek recovery experience repeating cycles of abstinence, return to use, and treatment that often extend many years before they achieve stable recovery, become permanently disabled, or die.[8]

The ACA provided the potential for access to MH/SUD services for almost 62 million people. Signed into law in 2010, the ACA requires non-grandfathered individual and small group health insurance plans in the individual and small employer health insurance plans markets to cover treatment for MH/SUDs as essential health benefits, and was a catalyst for extensive and complementary actions from SAMHSA, HRSA, and the CMS.

The ACA served as a catalyst to action for Federal agencies, as well as for the SUD treatment and medical fields. Efforts focus on increasing access to SUD services in varied mainstream health settings, improving the quality and availability of medications, modernizing health information technology, and addressing workforce issues.

Expanding Coverage and Access to Services

In 2010, Federal data indicated that the majority of uninsured individuals with an SUD also had incomes less than 200 percent of the Federal poverty line. SAMHSA provided states with information on how to enroll these uninsured Americans in the Medicaid program, which would expand access to treatment for eligible adolescents and adults. Through its "financing academies" (a technical assistance initiative that builds relationships among State substance abuse agencies, insurance commissioners, and Medicaid directors) and its public statements, SAMHSA made State SUD treatment providers aware of the opportunities that Medicaid can offer.

To expand resources for treatment in the private sector, the Administration wrote regulations to implement the parity requirements of the MHPAEA. The final rule, released in 2013, made clear that health plans and issuers subject to MHPAEA offering coverage for SUDs may not impose benefits with requirements and limitations on those benefits that are more restrictive than the predominant requirement or limitation imposed for medical/surgical benefits. This includes financial requirements such as co-pays and treatment limits (e.g., visit limits) on MH/SUD services. The ACA further impacts MHPAEA by expanding those requirements to group health plans sponsored by small employers and to individual insurance policies (including Marketplace coverage) and ensuring such plans cover services for individuals with SUDs. Throughout 2014, SAMHSA and CMS led a variety of educational efforts with both public (Department of Labor - DOL, Internal Revenue Service - IRS) and private partners (National Association of Insurance Commissioners and a multitude of others) to provide technical information to States, health insurance plans, consumers, and other stakeholders

about the content and implications of the final regulations as they relate to private employer-sponsored group health plans.

In 2016, CMS issued a regulation applying the parity standards in explaining how MHPAEA applies to Medicaid managed care organizations, Medicaid alternative benefit plans, and the Children's Health Insurance Program (CHIP) benefits. This regulation ensures that beneficiaries who receive services through managed care organizations, alternative benefit plans, or CHIP will have access to mental health and SUD services at parity with similar medical-surgical services, regardless of whether services are provided through the managed care organization or another service delivery system.[9] Finally, CMS finalized regulations that provide that states may make a capitation payment to managed care organizations for enrollees with a short-term stay in an Institution for Mental Diseases.[10] [11]

HRSA committed to increase the ability of CHCs to address SUDs and related mental health conditions, both through training of existing staff and through hiring of new staff with specializations in SUDs. SAMHSA, which has long partnered with HRSA to improve behavioral health care quality in rural CHCs, delivered technical assistance to this new expansion initiative. In March 2016, HRSA provided $94 million to integrate SUD treatment services with primary care services in 271 community health centers across the Nation, expanding access to treatment and MAT services. SBIRT services are provided at 406 HRSA-funded health centers, and in 2015 health centers delivered SUD services to approximately 400,000 patients

In 2013, DoD expedited changes to the TRICARE policy manuals to allow the provision of medication-assisted treatment (MAT) in TRICARE-authorized Substance Use Disorder Treatment Facilities. (TRICARE is the program that provides health coverage for members of the armed forces.) In 2016, DoD revised its regulation to eliminate administrative barriers to care and expand the range of SUD treatment services covered under TRICARE. Coverage now includes intensive outpatient services, MAT for opioid disorders and treatment of SUDs by individual professional mental health providers. Additionally, requirements to authorize MH/SUD service institutional providers to become TRICARE providers are now streamlined, and reimbursement methodologies for newly recognized providers are established.

In 2008, VA included SUD treatment in the VHA *Handbook on the Uniform Mental Health Services in VA Medical Centers and Clinics*, which detailed the benefits available to all Veterans enrolled in the VA Healthcare System. Each facility must offer at least two evidence-based psychosocial interventions for SUD and MAT as indicated. By policy, MAT with FDA-approved opioid agonists must be available to Veterans for whom it is indicated. VA has created several initiatives to disseminate these policy requirements. Two are highlighted here. In 2012, VA implemented a comprehensive online resource center that provides access to screening and assessment tools, VA and DoD clinical practice guidelines, and information on accessing VA treatment services. To ensure that screening and assessment services were known to veterans and their families, VA developed and implemented a national outreach campaign, *Make the Connection*. This public awareness and outreach campaign connects Veterans, their friends, and family members with information, resources, and solutions related to issues affecting their health, well-being, and relationships.

VA continues to expand the availability of MAT for veterans with OUDs. In FY2015, MAT, including office-based treatment with buprenorphine, was provided in over 90%percent of VA medical centers. More than 300 sites of service provided at least some buprenorphine, including Community-Based Outpatient Clinics, which are separate from the medical centers. In 2015, VA expanded its pharmacy

benefit plan to include extended-release naltrexone, another FDA-approved medication for treating OUDs.

In 2009, the Administration signed into law an end to the longstanding ban on most Federal funding for needle exchange programs. In partnership with the White House Office of National AIDS Policy, ONDCP issued policy guidance to States, tribes, and communities on how to implement needle exchange programs in the context of comprehensive, recovery-oriented public health systems that also offer people who use intravenous drugs treatment for SUDs, other medical care, and testing for HIV and hepatitis B and C. Congress reinstated the ban in 2012 but later removed the ban on using Federal funds for services, other than the purchase of syringes, following an outbreak of HIV and hepatitis C related to injecting drug use in Indiana in 2015. This policy reversal was instrumental in responding successfully to the outbreak.

New Financing Models, Integrating Primary Care and SUD Services

As of 2016, 11 states have approved Medicaid State Plan Amendments that include plans for screening for substance use and referral to treatment, and 19 states are targeting their Medicaid health home efforts at beneficiaries with SUD or serious mental illness (SMI). Health homes are an optional benefit available to states that allow for expanded coordination of care for individuals who have a chronic condition, such as SUD and are at risk for developing a second chronic condition or who have two or more chronic conditions. As most individuals who have an SUD also have other chronic health conditions, such as high blood pressure or severe mental illness, health homes provide an important framework for comprehensively addressing the needs of this population. To help implement the health home model under the ACA, SAMHSA and CMS developed a consultation plan for states submitting proposals for State Plan Amendments to develop health home programs.

ONDCP in collaboration with NIDA, SAMHSA, NIAAA, and HRSA hosted a workforce conference in 2010 entitled *Integrating Substance Use Services into Primary Care.* The meeting showcased models of integrated care in different health care settings, demonstrating that movement had begun for the SUD field. It served as a catalyst for addressing credentialing and licensing issues and the development of a career ladder for SUD counselors by SAMHSA, and it offered a closer look at workforce and workplace issues such as the adoption of business approaches, HIT, and insurance reimbursement.

In addition to the $105 million in 2014 and 2015 for mental health and SUD services in community health centers, HRSA made 271 awards totaling $94 million to support SUD services in 2016. MAT was a key focus of this effort.

In 2010, ONDCP co-sponsored a Family Treatment Forum during which experts from HHS, Education, and DOJ participated in panel discussions and answered questions from primary care and family physicians. The forum resulted in a new partnership between the HRSA's Federally Qualified Health Centers (FQHCs) and primary care and family practitioners. Through FQHCs, which offer basic medical services to underserved populations, family treatment providers will now be able to create partnerships and refer their clients to medical services. Often people who are being treated for SUD require additional medical treatment. In 2011, ONDCP continued to facilitate this new connection to ensure access to medical care for women and children taking part in family treatment programs.

Improving Coordination of Care while Protecting Privacy

To safeguard key privacy rights while increasing opportunities for information sharing to improve the coordination and quality of care, SAMHSA published a Notice of Proposed Rulemaking (NPRM) in early 2016 to update and modernize the substance use confidentiality regulations in 42 CFR Part II, the rule that protects the confidentiality of SUD treatment records. An interagency team collaborated from 2011 through 2015 and submitted two sets of recommendations to the Office of the National Coordinator for Health IT (ONC) for SUD and related behavioral health measures for inclusion in the Meaningful Use program. The measures are on the list for inclusion in planned updates to the set of approved measures.

In its 2015 Certification Final Rule, the ONC included a technical standard on Data Segmentation for Privacy (DS4P) that helps health care providers comply with the laws applicable to them by allowing providers to tag data as sensitive and express re-disclosure restrictions and other obligations in an electronic form. DS4P enables sensitive health information to be exchanged electronically. The ONC strongly encourages health information technology developers to include DS4P functionality and pursue certification of their products to help support their users' compliance with relevant state and Federal privacy laws that protect sensitive health information.

Principle: Patients with SUDs and Their Families Must Receive High-Quality Care

Medication-Assisted Treatment in Primary Care

In 2013, DoD removed the ban on medication-assisted treatment (MAT) for OUDs. Since that time, DoD has collaborated with VA, SAMHSA, the military services, and Walter Reed National Military Medical Center to offer training on prescribing MAT to DoD and VA providers, leading to the required DEA waiver to prescribe buprenorphine. Approximately 100 providers have completed the required training, and DoD has increased the number of providers holding a current DEA waiver by 15 percent.

In 2014, VA and DoD established a joint workgroup composed of research and treatment SUD experts to review and revise current guidelines related to the promotion of evidence-based practices for SUD treatment and prevention. The workgroup reviewed the evidence for management of opioid disorders and renewed the recommendations of MAT as recommended treatment for OUD. The workgroup finalized the most recent Clinical Practice Guidelines (CPG) for SUDs, published in December 2015.

In 2013, the Bureau of Prisons (BOP) launched a reentry program field trial in which extended-release, injectable naltrexone, an opioid antagonist approved by the FDA for the treatment of OUDs, was administered to people as they transitioned to community custody. Under the pilot, participants received their first two doses of the medication during the last two months of their incarceration and six doses (one per month) while in community treatment at the Residential Reentry Center (RRC) or on home confinement.

In 2015, SAMHSA awarded grants to 11 states with high per-capita rates of treatment admissions for OUDs to expand access to clinically appropriate services for SUDs. Awarded directly to the single state agencies with authority over the Substance Abuse Prevention and Treatment Block Grant, these grants required that medication-assisted treatment be part of the continuum of services funded.

Establishing National Quality Standards for the Treatment of Substance Use Disorders

In 2012, SAMHSA published the *National Behavioral Health Quality Framework* to provide a mechanism to examine and prioritize quality prevention, treatment, and recovery elements at the purchaser, provider, and population levels. Aligned with the National Quality Strategy, SAMHSA promulgated a series of quality measures to help guide efforts to identify and implement behavioral strategies and interventions leading to better and more affordable care and healthier people and communities. In addition, ONDCP, HHS, and partner agencies have been involved in the development and implementation of behavioral health-related quality measures.

Medications Development

The Administration has actively supported research to develop new medications. For example, NIDA research is supporting the development of vaccines for cocaine, opioids, nicotine, and methamphetamine. The vaccines work by stimulating the body's own immune system to produce antibodies that target and bind the drug's molecules in the bloodstream and prevent them from reaching the brain. The cocaine and nicotine vaccines have had promising results in human trials, effectively reducing drug use in those patients who are able to achieve high antibody levels as a result of vaccination.

To garner more pharmaceutical involvement, NIDA is "de-risking" compounds in the early stages of discovery – awarding large grants up-front for shorter durations to encourage quicker results among closely monitored grantees or to allow a change in direction as needed. This more nimble strategic approach was prompted in part by the successful clinical trial of an alternative to transmucosal buprenorphine, supported by 2-year American Recovery and Reinvestment Act funding. The new drug formulation of buprenorphine, probuphine, is appropriate for patients who are currently stable on low dose buprenorphine. It can be implanted under the skin and allows continuous delivery of the medication for six months after a single treatment, potentially eliminating the need for a daily dose, potentially improving patient compliance, and reducing the potential for diversion and misuse. The drug was approved by the FDA in May 2016.

Workforce Development

The IHS Scholarship program has been awarding funds since 1978 to qualified Native American and Alaskan Native health professions students. The program allows health scholars to study clinical psychology, pre-clinical psychology, social work, pre-social work, and SUD counseling. Since 2010, the program has given awards to 187 American Indian/Alaskan Native health scholars to expand their studies in behavioral health.

Each agency agreed to continue funding research projects on the role of SUD, post-traumatic stress disorder (PTSD), and traumatic brain injury on the well-being of former (VA) and current (DoD) military personnel and their families. Also in 2010, through its Centers for Excellence in Substance Abuse Treatment and Education, VA committed to provide ongoing consultation to HRSA and IHS as they improve the integration of care for SUDs into the health care systems they oversee.

In June 2015, ONDCP co-hosted a White House Symposium with the American Board of Addiction Medicine Foundation and key Federal partners, including NIDA, NIAAA, SAMHSA, HRSA, and the National Cancer Institute (NCI). During the symposium, several groups made

commitments to promote advances in addiction medicine. The American Board of Addiction Medicine Foundation (now the Addiction Medicine Foundation) committed to establishing an Addiction Medicine Fellowship in every medical school in the country. At the time of the meeting, there were a total of 27 established Addiction Medicine Fellowships. Since the 2015 symposium, 14 additional institutions have established fellowships that are accredited by The Addiction Medicine Foundation, bringing the total number of fellowships to 41. The American Association of Medical Colleges committed to assisting in the establishment of fellowship programs and to infusing addiction medicine into all physicians' training from day one. The American Board of Family Medicine committed to designating addiction medicine as a core competency and to incorporating the topic into its certification requirements. Since the symposium, the certification requirements have been disseminated by the American Board of Medical Specialties (ABMS), after formally recognizing Addiction Medicine as a subspecialty in October of 2015 and publicly announcing the recognition in March 2016. The ABMS is tentatively scheduling the first exam featuring Addiction Medicine in 2017. The Accreditation Council for Graduate Medical Education (ACGME) participated in the 2015 symposium, and announced in June 2016 that the field of Addiction Medicine would be accredited by the ACGME. Other boards represented at the symposium, Internal Medicine, Family Medicine, Pediatrics, Emergency Medicine, Preventative Medicine and Obstetrics and Gynecology, also have recognized addiction medicine as a subspecialty. These boards function as independent groups and are not directly influenced by any other boards or organizations.

Technology Innovations and HIT

Showcasing innovations for the SUD field, ONDCP convened scientists, researchers, and developers at the White House in 2013 to highlight technologies to improve SUD treatment, wellness, and mental and behavioral health. Supported by SAMHSA, ONC, and the Office of Science and Technology Policy (OSTP), conference panelists presented on a range of innovative health technologies, from smartphone apps that help people maintain their sobriety to biosensors that can detect human emotions that may put individuals at risk for relapse.

ONDCP and HHS worked with Federal partners to develop consensus recommendations for 14 behavioral health-related clinical quality measures. Each measure supports one or more of the Institute of Medicine domains of health care quality, promoting effective, safe, efficient, patient-centered, equitable, and timely care. These treatment measures are included in the Centers for Medicare & Medicaid Services' (CMS) Electronic Health Records Meaningful Use Incentive Program.

Principle: Celebrate and Support Recovery

Successful recovery from SUDs and other chronic conditions requires changing deeply imbedded behaviors and maintaining those changes over time. Relapse is a common, though not inevitable, part of this process. The likelihood of recovery can be affected by stress, unresolved trauma, the availability of drugs, continued involvement in drug-using social circles, safe housing, a supportive social network, engagement in continuing care, receipt of recovery support services, and participation in mutual aid groups. Some of these factors also can affect the likelihood that people will initiate drug use.[12]

In the 2010 *Strategy*, the Administration broke new ground by supporting recovery as a national drug policy priority and by creating an expert team to coordinate the implementation of related *Strategy* goals, objectives, and action items. The 2010 *Strategy* called for actions that would "celebrate and

support recovery from SUDs." This was significant because it marked the first time that demand reduction policy was broadened to take account not only education, prevention, and treatment activities, but the broader processes of SUDs and recovery and the increasingly important role the organized SUD recovery community plays as educators, recovery support services providers, and advocates.

ONDCP has been engaged in ongoing activities to celebrate recovery and educate and inform the public and policymakers about SUDs and recovery. The Administration's drug policy reform efforts emphasize the importance of balanced, comprehensive multi-sector efforts to address both the public health and public safety challenges associated with drug use. The recognition that SUD is a disease and that people can and do recover is foundational to this policy framework. Celebrating recovery and educating the public about recovery are key strategies for supporting its promotion.

While ONDCP works to celebrate, educate, and inform throughout the year, each September provides a special opportunity during *National Alcohol and Drug Addiction Recovery Month* (Recovery Month). By virtue of Presidential Proclamation, and thanks to the efforts of SAMHSA; state, local, and tribal governments; and the recovery community, Recovery Month is celebrated across the Nation through special events and rallies.

Reviewing Laws & Regulations that Impede Recovery from Substance Use Disorders

Over the course of the Administration, significant steps have been taken to reduce barriers to recovery created by laws, regulations, policies, and practices. The Federal Interagency Reentry Council, which is described in Chapter 4, has made significant strides in addressing legal and regulatory barriers affecting many people in recovery from SUDs. Accomplishments include:

- Modification to the Free Application for Federal Student Aid (FAFSA) electronic form. First-time applicants are no longer asked about past convictions for drug offenses if they have never received student aid;
- Development of *FAFSA Facts*, a document that clarifies when and how drug convictions affect eligibility for Federal student aid and steps one can take to have eligibility reinstated;
- Dissemination of a letter from the Department of Housing and Urban Development encouraging public housing authorities and subsidized housing owners to use the discretion available to them under law to house people with past felony convictions;
- Dissemination of a 2011 joint letter from the Secretary of the ED and ONDCP reminding higher education officials of the need to comply with Federal regulations requiring colleges and universities to provide drug education and prevention programming. One of these requirements is that colleges and universities annually notify students of any drug or alcohol counseling, treatment, rehabilitation, and reentry programs available to them.; and
- Distribution of a letter from DOJ to State Attorneys General urging them to review laws in their states that create collateral consequences to conviction and to consider eliminating collateral consequences that do not respond to a public safety need. Additionally, ONDCP has developed preliminary recommendations to increase Federal employment opportunities for people in recovery from SUDs.

Fostering the Expansion of Community-Based Recovery Support Programs, Including Recovery Schools, Peer-led Programs, Mutual Aid Groups, and Recovery Community Organizations

Over the course of the Administration, SAMHSA has initiated or sustained a range of grant programs to support peer recovery support services and the development of recovery-oriented systems and services. These include:

- Recovery Community Services Program (RCSP), which supports the development and enhancement of recovery community organizations (RCOs);
- Targeted Capacity Expansion Peer-to-Peer program, which replaced RCSP;
- Recovery Community Services Program Statewide Networks grants (RCSP SN), which support the development of statewide RCO networks;
- Statewide Peer Networks for Recovery and Resiliency, which support similar networks for mental health consumer organizations, RCOs, and organizations that serve both the mental health consumer and SUD recovery communities; and
- Targeted Capacity Expansion, Local Recovery-Oriented Systems of Care grants, which help local governments and organizations develop systems and services that emphasize long-term recovery outcomes.

The first four of these programs accounted for more than $38 million in funding through 65 grants to a wide range of community-based organizations. In addition, over $13 million in new grants was awarded to 11 local governments and community-based organizations under the Targeted Capacity Expansion (TCE) grant program.

Increasing Transitional Housing Options in Rural Communities

In August 2016, Secretary of Agriculture Tom Vilsack, announced an initiative to use USDA's rural development resources to help fill the need for transitional housing for people recovering from opioid and other SUDs. The four-pronged initiative is the result of a conversation Secretary Vilsack had in May 2015 in New Hampshire at the Hillsborough County Superior Court, where individuals involved with the State's drug court program told him that a lack of access to affordable housing made it challenging for participants to successfully complete their recovery from SUDs.

Using USDA Community Facilities Financing for Transitional Housing Projects

USDA Rural Development's Rural Housing Service (RHS) instructed its field staff that Community Facilities (CF) program financing may be used for the construction, expansion and improvement of transitional housing facilities. The CF program provides affordable funding to develop essential community facilities in rural areas, such as hospitals and schools. Additionally, the CF program can be used as a financing tool for non-profit organizations considering the purchase of existing properties for the purpose of transitional housing. In order to be eligible, transitional housing facilities must provide supportive services to rural residents to help them recover and prepare them to live independently within two years.

Partnering with Non-profits to Transform Vacant USDA Properties into Transitional Housing

Rural Development has also launched an initiative to encourage its state offices to sell single-family homes and multi-family properties that are exiting USDA's Real Estate Owned (REO) housing program to qualified non-profit organizations that would convert them into transitional housing facilities. REO properties are houses owned by USDA as a result of foreclosure. The single-family REO initiative is effective in the 22 States where the REOs are managed by that State's Rural Development office.

USDA also developed a "Contract for Deed" pilot in the Single Family Housing program that would make USDA-held REOs available for purchase at below-market-rate cost by qualified non-profits providing housing for homeless individuals recovering from SUDs. The non-profit would have two years to complete the purchase transaction, and would be able to utilize available RHS financing for the purchase. During that time, the non-profit would take over the management of the property for the benefit of the individual and community, pay the related taxes, make needed repairs and handle other responsibilities. This two-year window would allow them to gain experience managing the property and coordinate essential treatment services for the tenant, while also securing the funding needed to purchase the property. The pilot is currently operating in four states – New Hampshire, Missouri, Nevada, and Vermont – and can include up to fifteen total REO properties.

Making Vacant Multifamily Units Available to Tenants Participating in Treatment Programs

USDA also developed a pilot project to incentivize owners of USDA multi-family rental housing properties in New Hampshire, Vermont, Nevada and Missouri.to rent to those in recovery by making hard-to-fill vacant units that are currently unsubsidized eligible for rental assistance if they are occupied by a current participant of a drug court program. Drug court programs have been proven to successfully reduce substance use and criminal recidivism because they require participants to fulfill court mandated treatment and recovery requirements.

Using Data to Target Resources

Finally, USDA is harnessing the power of open data in order to most effectively target our resources and to allow individuals in recovery to better locate USDA assistance. USDA's Rural Housing Service has released data on its portfolio of Community Facilities loans, guarantees, and grants across the country, which include hospitals, health clinics, group homes, and mental and behavioral health treatment facilities, to Data.gov and policymap.com, an online data mapping platform, where it can be visually overlaid with other indicators on substance use and recovery services. This new data supplements existing multi-family property and single-family housing data that the Agency recently released publicly. For example, the public can now map USDA multi-family and single-family housing properties and locate nearby Drug and Alcohol Treatment Centers using the latest SAMHSA data. Users can further determine which centers provide OUD treatment and use telemedicine, among many other attributes.

Opportunities for the Future

There is strong evidence that medication-assisted treatment (MAT) can help stabilize individuals in treatment for OUDs and move them toward long-term recovery. However, there continue to be significant barriers to accessing MAT, especially for individuals involved in the criminal justice system. Educating community and correctional officials and other stakeholders about MAT and its role in reducing recidivism, supporting recovery, and saving lives, and fostering the adoption of practices to support successful reentry and recovery are important goals for the field.

Consistent with the expansion of MAT in community and correctional settings, training and support may be expanded to physicians and other prescribers to accelerate the integration of SUD treatment into mainstream health care systems. More physicians in primary and specialty care settings and other health care professionals should become familiar with Federal and state treatment regulations, FDA labeling, standards, guidelines and research on the use of FDA-approved pharmacological treatments for OUD; seek the training and registration required to prescribe buprenorphine; and become familiar with the full array of SUD treatment resources in their community, including MAT. Limited Medicaid coverage may contribute to the significant gap between treatment need and capacity at the state and national levels. Some research estimates that there are somewhere between 1.3 and 1.4 million individuals aged 12 and older who have an OUD but do not receive MAT.[13] However, not all Medicaid beneficiaries have access to SUD services. A 2013report by the American Society for Addiction Medicine noted that 31 state Medicaid FFS programs were found to cover methadone maintenance in outpatient narcotic treatment programs. This report also indicated that every state Medicaid agency covers buprenorphine/naloxone, either in branded or generic formulation or both, and 42 states have some coverage of injectable sustained release naltrexone.[14] In 2014, the Center for Medicaid and Children's Health Insurance Program (CMCS) issued a bulletin highlighting the use of MAT to help persons with SUDs recover in a safe and cost-effective manner. The bulletin provides background information about MAT, examples of state-based initiatives, and useful resources to help ensure proper delivery of these services.[15]

Finally, in addition to being imprecise and inconsistent, the terminology adopted for both scientific and casual discussions of substance use and SUDs can be stigmatizing, often implying that SUDs are the result of a personal or family failing.[16] There is growing recognition of the need to adopt language that is reflective of the DSM-V and of scientific research.

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

From the beginning, the Obama Administration embraced the notion that our Nation cannot arrest its way out of the drug problem, and the 2010 *Strategy* identified issues that had long plagued the criminal justice system. These included "one-size-fits-all" processes, overcrowded jails and prisons, release of incarcerated people back into communities unprepared to help them, and reliance on the justice system as the primary safety net for people with SUDs and mental illnesses.

To remedy these issues, ONDCP has called upon law enforcement and public health officials to collaborate on effective strategies to address SUDs, encourage partnerships between law enforcement and community organizations; support diversion and alternatives to incarceration; address substance use issues among individuals in corrections facilities or under community supervision; promote treatment and accountability among justice-involved individuals; and support people reentering their communities from incarceration. In addition to promoting and maintaining the safety of communities while treating SUDs, the Administration has made it a priority to identify and expand promising, evidence-based practices that increase public safety, promote public health, and correct injustice.

Law enforcement agencies are increasingly using public health strategies which reflect a growing awareness of how the needs of people with SUDs and mental illness should be addressed. Law enforcement agencies are increasingly establishing or improving existing crisis intervention teams with protocols to engage people with mental illness or who are under the influence of substances. First responders, especially, have been helping public health providers address the opioid epidemic more effectively. Around the Nation, many police officers and sheriffs' deputies are now equipped with the overdose- reversing drug naloxone and are creating best practices around this life-saving intervention.

Jurisdictions also are taking advantage of research regarding appropriate levels of supervision for individuals to reduce the risk of committing additional crimes and treatment assignment based on one's health needs. Many judicial and correctional systems are actively looking for opportunities to divert individuals with an SUD away from the system and the cycle of crime, incarceration, and release and focusing on c community-based diversion programs. In some instances, jurisdictions are looking at the point of arrest or arraignment to properly assess the needs of an individual and match those needs with appropriate interventions and services, rather than incarceration, which can both reduce costs and improve outcomes overall

The Administration also has been addressing legal and regulatory barriers to successful reentry and funding programs that provide supportive services to returning citizens. Efforts to support the returning citizens include efforts to support all individuals with a criminal record, as a record even without incarceration may be just as damaging to a person's chances of success as any lack of services upon leaving jail or prison.

Accomplishments

Today, law enforcement agencies, corrections facilities, courts, and community programs are much more likely to seek out and implement policies and practices that integrate public health and public safety. Such an approach has led to increased use of overdose-reversal drugs and crisis intervention by first responder law enforcement officers; diversion of offenders with drug problems to services rather than the traditional practice of catch and release; and efforts to reduce legal and regulatory barriers that can impede successful re-entry into the community. Discussed below are recent major accomplishments as well as remaining opportunities.

Principle: Help Communities Build the Capacity to Prevent Drug-Related Crime

Partnerships among public health and public safety practitioners have proliferated as law enforcement, prosecutors, judges, and corrections professionals recognize the significant role they play in ensuring the well-being of people in their care. Sheriffs and prison wardens have sought opportunities to provide treatment to people in their facilities, recognizing incarceration as an opportunity to help people with SUDs receive the care they need. More jails and prisons also are seeking ways to connect people with treatment when they leave custody, and some jurisdictions are taking the critical step of supplying naloxone to people at risk for opioid overdose.

The President convened a Task Force on 21st Century Policing to provide meaningful solutions to help law enforcement agencies and communities strengthen trust and collaboration. The Task Force Report was released in 2015 and identified ways to improve police-community relations and offered best practice recommendations. The Justice Department will continue to explore these issues and dedicate resources to promote safety for the public and for police officers.

Building capacity in communities includes giving communities the tools to reduce violence and promote academic and career success. Over the past 7 years, the Administration has made violence prevention a priority. In 2010, the Departments of Justice and Education launched the National Forum on Youth Violence Prevention. By 2015, there were 17 Forum cities, and these were complemented by the Community-Based Violence Prevention program operating in 16 cities nationwide. Together with law enforcement, service providers, community residents, and community- and faith-based organizations, the Forums are realizing reductions in the violence, particularly gun violence, that contribute to environments where drug use and related behaviors can flourish. Another collaborative initiative established by the Administration is My Brother's Keeper, established to help communities reach out to young persons, providing support through educational and employment opportunities, and diverting them away from criminal activities.

Principle: Develop Infrastructure to Promote Alternatives to Incarceration When Appropriate

The expansion of Medicaid to more adult men (who comprise the majority of the justice-involved population) has provided participating states, counties, and cities with resources to offer treatment for these conditions that was not previously available, although Medicaid coverage options for individuals during periods of incarceration may be limited. The Office of the Assistant Secretary for Planning and Evaluation HHS estimates that, among non-elderly adult men aged 18 to 64, the uninsured rate dropped by nearly 38.3 percent as a result of the ACA; this translates into more than eight million adult men who have gained insurance coverage.[1]

For system-wide changes, the Justice Reinvestment Initiative has captured the attention of conservative and liberal legislators alike, offering data-driven solutions to complicated and costly criminal justice challenges, such as over-incarceration and recidivism often attributed to untreated SUDs. In states like West Virginia and Georgia, State legislators and Governors have worked together to identify and address the triggering factors for growing justice system costs. In West Virginia, for example, legislation established risk/need assessment* requirements at pretrial, in correctional settings, and for people under community supervision. They also used legislation to integrate SUD services more fully into the justice system which can lead to reductions in crime and lower rates of incarceration.[2] The West Virginia Governor's Office reported that anticipated prison spending would instead be diverted to creating treatment services for individuals with SUDs.

Principle: Use Community Corrections Programs to Monitor and Support Justice-Involved Persons with Substance Use Disorders

The conversation has shifted from cracking down on people who use drugs to diverting people away from traditional justice processes and toward more supportive services. The number of problem-solving courts, such as adult drug courts, Veterans Treatment Courts, and DWI courts, has increased over the course of the Administration, bolstered by partnerships at the Federal level. The Departments of Health and Human Services, Justice, and Veterans Affairs have all committed resources to expanding and improving this model for combining treatment and accountability. In addition, the DOJ's Smart on Crime suite of programs has expanded to include Smart Supervision and Smart Pretrial, drawing on available evidence to establish effective alternatives for people with varying levels of need. Further, the Departments of Health and Human Services and Justice have added language to their drug court grant requests for applications to promote the effective and appropriate use of medication-assisted treatment in drug court settings. Judges presiding over federally-funded drug courts cannot prevent a client from using medication-assisted treatment as a condition of successful participation in the drug court program.

In 2016 ONDCP and the Bureau of Justice Assistance (BJA) collaborated on the development of an on-line video and two webinars presenting examples of State and local programs. ONDCP also convened corrections leadership to provide local examples and foster dialogue on Medication Assisted Treatment (MAT) for Justice-Involved Populations at a meeting in June 2016.

Principle: Create Supportive Communities to Sustain Recovery for the Reentry Population

By coordinating Federal agencies, the Federal Interagency Reentry Council is changing Federal policies and regulations relating to people with criminal records and has encouraged similar changes in states, counties, and cities. This coordination amongst the Departments of Justice, Labor, Health and Human Services, Education, and the Small Business Administration has increased possibilities for people with criminal records, creating pathways to employment, education, housing, and health care.

For example, more than 600 Second Chance Act grants, first funded in 2009, have been awarded in 49 states and are being used to promote comprehensive programs. Many of these awards have been used to assist drug-involved offenders reenter the community. . Resources are used to help individuals

* Risk/needs assessments are generally interview instruments that collect data on behaviors and attitudes that may help determine an individual's *risk* of committing further criminal acts and *need* for rehabilitative or supportive services, including treatment for an SUD. Decisions about appropriate placement in supportive programming, level of supervision, and intensity of treatment can then be made based on this information.

re-entering the community with housing, transportation, job readiness, health care, and treatment for SUD. Further, the Department of Labor Employment and Training Administration's Reentry Employment Opportunities program provides grants to organizations to help people prepare for and reenter the workforce. The focus of this program is on individuals with high need for services. . Recipients of these awards must work with SUD treatment providers to ensure the SUD treatment needs of their participants are met.

Principle: Improve Treatment for Youth in the Juvenile Justice System`

The Administration has committed to improving outcomes among youth. The Administration's My Brother's Keeper, Generation Indigenous, and Children of Incarcerated Parents initiatives have drawn attention to the challenges facing young people in communities of color and American Indian and Alaska Native communities, and young people whose parents are involved in the justice system. Partnerships between the Federal government and private sector companies, tribal leadership, and public media have helped draw attention to these issues and identify available resources to promote well-being and success among at-risk youth.

The Administration has put great effort into disrupting the school-to-prison pipeline, initiating investigations and litigation to protect young people's civil rights in school discipline, in interactions with law enforcement, and in juvenile courts. In addition, the Administration has put into place the Supportive School Discipline Initiative to help educators and administrators address discipline issues without resorting to justice system involvement. The Departments of Justice, Health and Human Services, and Education have provided guidance, funds, and technical support to educators and administrators, helping to guide school systems toward less punitive measures for behavior that is merely disruptive to school settings. Grants like the Office of Juvenile Justice and Delinquency Prevention's School Justice Collaboration Program allow jurisdictions to help identify student needs, like treatment for mental illness or SUD, and encourage partnerships between school systems and justice systems that allow for developmentally-appropriate resolutions to discipline issues. Rather than keeping a child out of school and involved with the justice system, better prevention, intervention, and reentry efforts can help retain more students through graduation. Preventing entry into the justice system, whether as a juvenile or adults, can have long-term implications for the future. These alternatives can help someone avoid a criminal record that will affect his or her ability to secure employment or housing for years after an offense.

Opportunities for the Future

Looking ahead, there is a need to sustain efforts to develop, evaluate, and implement effective interventions for SUDs that can be integrated in the justice service system. The Federal Government and its state, local, and tribal partners should continue to look to jurisdictions that have achieved successes in reducing recidivism, decreasing jail and prison populations while maintaining public safety and helping more justice-involved individuals lead healthy and productive lives in recovery from a SUD. Executive agencies should continue to encourage innovations in justice practices and work with Congress to reform laws that impede fairness and efficiency in the justice system.

Work is needed to help justice-involved youth with an SUD and those at risk of developing an SUD. This includes supporting research to develop and identify effective, developmentally appropriate treatment models and institutional structures that meet the unique needs of young people; implementing case management systems that incorporate important stakeholders – families, schools,

community leaders, and law enforcement; and expanding prevention services that address substance use and other risky behaviors.

There continues to be a gap between what is available and what is needed in terms of services for people reentering their communities following incarceration. Immediate needs like housing, health care, and transportation as well as the provision of services that promote long-term success through education, employment, family reunification, and peer recovery support are not always readily available. To make reentry programs and services more successful, Federal and private-sector efforts should look at eliminating the collateral consequences of a criminal record. Further, resources and practices might be identified to incentivize collaboration and co-location among service providers. Special attention could be paid to reaching out to rural and tribal populations with limited or no access to local service providers.

The development of better practices to address substance use and justice system involvement – identifying people with SUDs as early as possible and connecting them to treatment – could have positive implications for the health care and justice systems.

In all instances, public safety practitioners and public health care providers should continue to find ways to better integrate the services provided to the community. Access to treatment and recovery depend upon these partnerships, as do effective prevention and diversion. The justice system is the linchpin in balancing public health and public safety approaches to drug policy, and in the years to come, it will build upon successes and look for opportunities to improve.

Chapter 5: Disrupt Domestic Drug Trafficking and Production

The 2010 *Strategy* identified three policy objectives with regard to domestic drug trafficking and production. The *Strategy* called for ONDCP and its interagency partners to focus on coordinating Federal drug enforcement initiatives with state, local, and tribal entities; securing U.S. borders; and addressing specific drug problems as they arise. Progress has been made in all three policy areas. Intelligence and information sharing among drug enforcement and investigative task forces has been strengthened, implementation of the three border strategies by the interagency partners is helping to secure the borders, and agencies have been flexible in addressing new drug problems as they arise. While milestones have been met for many of the action items, the efforts need to continue at or above their current level. Drug Trafficking Organizations (DTOs) are flexible and constantly changing their tactics. The law enforcement response should be just as flexible and responsive. Following is a summary of the accomplishments to date and those areas where coordinated work might continue.

Accomplishments

To address the challenges of domestic drug trafficking and production, the Administration established a number of principles to enhance public safety while reducing overlap between agencies and departments. These include increasing coordination and collaboration. Multi-jurisdictional task force teams that implement strategies to pool resources and share information are the backbone of counterdrug enforcement efforts. De-confliction and information sharing – the process of determining when law enforcement personnel are conducting simultaneous actions in close proximity to one another – remain priorities for law enforcement agencies. Support to tribal law enforcement will continue. A second principle emphasizes secure borders. Securing the land, air, and maritime avenues of approach into the United States and controlling the illegal flow of drugs, bulk cash, and weapons into and out of the country has been a top priority for the Administration. Finally, work that identifies new trends in drug and illicit contraband has helped disrupt domestic drug trafficking and production. A number of Federal agencies are actively working to identify and address new threats through robust inter-agency efforts, training, and information sharing.

Principle: Federal Enforcement Initiatives Must be Coordinated with State, Local, and Tribal Partners

The Obama Administration has made coordination and information-sharing among State, local, and tribal law enforcement agency partners a priority. This effort has been central to the work of multi-jurisdictional task forces engaged in disrupting and dismantling Drug Trafficking Organizations (DTO) through Organized Crime Drug Enforcement Task Forces' (OCDETF) investigations and Strike Forces as well as DHS' Border Enforcement Security Task Forces (BEST).

<u>De-confliction</u>

The OCDETF Program operates through its prosecutor-led, intelligence-driven, multi-agency task force structure and is the centerpiece of the DOJ's counter-drug enforcement efforts. De-confliction is inherent in the OCDETF structure and process. Every investigation proposed for OCDETF designation is reviewed by local and regional representatives of OCDETF's seven member

investigative agencies – Bureau of Alcohol, Tobacco, and Firearms (ATF), DEA, Federal Bureau of Investigation (FBI), ICE/Homeland Security Investigations (HIS), IRS, United States Marshals Service (USMS), and United States Coast Guard (USCG) – as well as the federal prosecutor's office that will be handling the prosecution of the case. Further, all OCDETF investigations involve active participation by at least two of the OCDETF agencies throughout the duration of the investigation. Almost 90 percent of OCDETF investigations also involve participation by other Federal agencies as well as state, local, or tribal law enforcement agencies. Finally, a prerequisite of OCDETF designation for every case is submission of all target names to the multi-agency OCDETF Fusion Center (OFC,) resulting in an extensive de-confliction intelligence product provided to all agencies with information in the OFC related to any of the targets. In sum, every OCDETF case begins with extensive de-confliction and continues with operational de-confliction throughout the course of the investigation.

The HIDTA program is a Federal grant program administered by ONDCP that provides assistance to Federal, state, local, and tribal agencies operating in areas determined to be critical drug-trafficking regions of the United States.* HIDTAs provide an umbrella to coordinate Federal, state, local, and tribal drug law enforcement agencies and act as neutral centers to manage, de-conflict, analyze, and report on drug enforcement activities in their respective regions. Event coordination ensures law enforcement agencies working in close proximity of one another are immediately notified when enforcement actions are planned in a manner that threatens or compromises other enforcement operations. Notifications of such conflicts enhance officer safety and promote the coordination of operations in a multi-agency environment. Similarly, target coordination alerts investigators when there is an investigatory cross-over by enforcement agencies. To ensure coordination, every HIDTA requires its task force and strongly encourages non-participating agency task forces to coordinate targets and subjects under investigation. Three different - de-confliction systems (Case Explorer, RISSAFE, and SAFETNet) are used by HIDTAs to accomplish this task. Each system can de-conflict events, cases, subjects, and targets. After several years of analysis and technical work, these systems achieved interoperability in May 2015. All 28 HIDTAs are now fully integrated and capable of interoperability.

Information Sharing and Task Forces

Since the release of the *Strategy* in 2010, Federal agencies have made great strides in information sharing with state, local, and tribal law enforcement partners. On December 7, 2012, the Jaime Zapata Border Enforcement Security Task Force Act (Zapata Act) was signed into law. The Zapata Act established the BEST program to enhance border security through collaborative efforts among Federal, state, local, tribal, and foreign law enforcement agencies. By sharing information and coordinating activities, law enforcement officials are able to better protect U.S. communities from crime, violence, and the trafficking of arms, drugs, and people.

Participation in OCDETF investigations helps ensure the success of a multi-jurisdictional drug task force. Since 2010, state and local law enforcement agencies have participated in at least 90 percent of OCDETF investigations each year. Sharing intelligence and information products also is key to successful investigations. Investigator and Intelligence Analyst demand for OFC products continues to rise. In 2015, the OFC received a 33 percent increase in product requests, a 21 percent increase in the number of targets referenced in their products, and had a 27 percent increase in the number of

* For additional information, please see https://www.whitehouse.gov/ondcp/high-intensity-drug-trafficking-areas-program.

disseminations. Additionally, The DEA's De-Confliction & Information Coordination Endeavor (DICE) increased the number officers using its system by 15 percent.

Tribal Law Enforcement Support

Supporting tribal law enforcement agencies remains a policy priority for the Administration. U.S. Immigration and Customs Enforcement (ICE) continues its joint efforts with tribal law enforcement agencies on the Southwest and Northern borders. In the Southwest, they are working with the Shadow Wolves, an ICE tactical patrol unit located on the Native American Tohono O'odham Nation in southern Arizona. From October 2006 through 2015, this 9-member unit has been responsible for the seizure of over 113,000 pounds of marijuana, over 86 criminal arrests of smugglers, and the seizure of 106 vehicles.[1] In the summer of 2013, the Native American Targeted Investigation of Violent Enterprises (NATIVE) Task Force was created as a new HIDTA Initiative for the SWB-Arizona HIDTA. NATIVE is a cooperative Federal and tribal task force targeting smuggling operations of individuals and organizations throughout the Tohono O'odham Nation. NATIVE includes law enforcement personnel from the Tohono O'odham Police Department, Homeland Security Investigations (HSI), and the Bureau of Indian Affairs (BIA) Drug Enforcement Division.

Law Enforcement

In 2014, HIDTA-funded initiatives disrupted or dismantled 2,877 drug trafficking organizations, removing significant quantities of drugs from the market and seizing over $1.1 billion in cash and non-cash assets from drug traffickers.[†] In addition, law enforcement has made strides against Consolidated Priority Organization Target (CPOT) organizations. In Fiscal Years 2014 and 2015, OCDETF member agencies initiated 1,979 OCDETF investigations, and they dismantled 233 and disrupted 438 CPOT-linked drug trafficking organizations.

Principle: The United States Must Continue to Secure Its Borders

Protecting America's borders requires a close partnership among Federal, state, local, and tribal authorities. Drug-trafficking organizations, operating throughout the United States, collect and move thousands of packages of illicit drugs, currency, and weapons through America's local communities.

Domestic Highway Enforcement

Identifying the interior corridors of drug movement and denying traffickers use of America's highways has been a focus of this Administration's *Strategy* since 2010. ONDCP started the Domestic Highway Enforcement (DHE) program in December 2005 to assist the HIDTAs with market disruption through a coordinated nationwide highway enforcement strategy. The DHE strategy is based on collaborative, intelligence-led policing to enhance coordinated, multi-jurisdictional operational law enforcement efforts to counter the transportation of illegal drugs on interstate highways specifically identified as drug trafficking corridors. A coordinated nationwide highway enforcement strategy contributes significantly to reducing criminal activity and enhancing public safety on the Nation's major transportation corridors. From 2010 to 2015, the DHE program confiscated $2.2 billion worth of drugs, and disrupted or dismantled 353 drug trafficking organizations. The El Paso Intelligence Center (EPIC) supports the DHE program through its National Seizure System (NSS), the Tactical

† HIDTA Performance Management Process Database extract January 2016.

Incident Notification System (TINS), a Predictive Intelligence Unit, and an online DHE community website. Users can access the DHE community of interest section through the DHS Homeland Security Information Network (HSIN). The website portal allows DHE informational reports and current trends associated with drug trafficking to be accessed by law enforcement officers across the Nation.

Southwest Border

ONDCP developed the first *Southwest Border Counternarcotics Strategy* in 2010 and updates the document on a biennial basis. The 2016 *National Southwest Border Counternarcotics Strategy* builds upon and expands the successful Supporting Actions of previous iterations of the *Strategy*. By using lessons learned, statistical data, agency annual reports, situational bulletins, and input from the field, the multi-agency developers of the 2016 *Strategy* have produced a document that addresses the current, as well as emerging, challenges posed by trans-national criminal activity associated with drug trafficking along the border. The SWB strategy also encompasses demand reduction as highlighted in the Declaration of Demand Reduction Cooperation that acknowledged "the need to intensify prevention and treatment efforts on both sides of the border." The work is ongoing, and it includes measures to strengthen families and communities and promote healthy lifestyles and attitudes for at-risk youth and other vulnerable populations.

Federal agencies have made impressive gains in their efforts to secure the Southwest border (SWB). Efforts such as the Southern Border and Approaches Campaign provide for three DHS Joint Task Forces (East, West, and Investigations) to coordinate and integrate efforts to secure the border and its approaches. Specifically, the Joint Task Force-West (JTF-West), with its four corridors along the border (California, Arizona, West Texas, and South Texas), provides a forum for border security partners at the Federal, state, local, tribal, and bi-national level to share information, integrate resources, and coordinate operations. The JTF-West efforts continue to advance DHS's mission of identifying, disrupting, and degrading Transnational Criminal Organizations. The Alliance to Combat Transnational Threats (ACTT) is a multi-agency operation initiated in September 2009 in the Sonora-Arizona Corridor involving over 50 Federal, tribal, state, and local law enforcement and public safety organizations. ICE and U.S. Customs and Border Protection (CBP) have begun using the concept of tailoring the ACTT approach to the El Paso-Ciudad Juárez Corridor.

The DHS Science &Technology directorate continues to work closely with CBP, the U.S. Coast Guard (USCG), and ICE to identify and develop technologies to improve surveillance and detection capabilities along land and maritime borders which directly support the *National Drug Control Strategy*. This includes investments in tunnel detection and tunnel activity monitoring technology, low-flying aircraft detection and tracking systems, maritime data collection/integration/data sharing capabilities, supply chain cargo security, and improved border surveillance tools. For example, in 2011, CBP and DoD shared test results regarding technology deployments, such as the Border Tunnel Activity Detection System, to determine capabilities of certain technologies and requirements.

Targeting the southbound interdiction of currency and weapons has been the focus of several Federal agencies from 2010 to the present. Cross-border gun trafficking prosecutions in the Southwest have been enhanced by increasing information sharing among and between Southwest Border USAOs, partner investigative agencies, and vetted Government of Mexico entities, and by expanding gun trafficking training. The Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF), CBP, DEA,

the Federal Bureau of Investigation (FBI), ICE, and USMS continue to) participate in multi-agency initiatives, such as BESTs as well as OCDETF investigations and Strike Forces.

The 2016 *National Southwest Border Counternarcotics Strategy* builds upon and expands the successful supporting actions of previous iterations of the document, and builds on lessons learned to better address emerging challenges caused by trans-national criminal activity including the ongoing opioid and heroin crisis.

Northern Border

The *National Northern Border Counternarcotics Strategy,* first published in 2012 and updated in 2014, recognizes that transnational criminal organizations operating on both sides of the U.S.–Canada border exploit the international boundary to smuggle proceeds from illegal drugs sold in the United States and Canada and to transport drugs such as marijuana, MDMA (ecstasy), methamphetamine, and cocaine between the two countries. The Northern Border Strategy has led to a unique level of cooperation between the United States and Canada. For example, the Akwesasne Mohawk Indian Reservation, which falls under the jurisdiction of the U.S. and Canada, has been an integral partner in northern border security. The tribal police participate in the BEST unit that borders Canada and the reservation, and they also participate in an Integrated Border Enforcement Team, a U.S.-Canada intelligence-driven enforcement team that includes core members ICE, CBP, USCG, the Royal Canadian Mounted Police (RCMP), and the Canada Border Services Agency (CBSA). The cooperative initiative targets organized crime and other criminal activity between ports of entry.

Since the release of the 2014 *National Northern Border Counternarcotics Strategy*, information sharing between U.S. and Canadian law enforcement has improved, and substantial opportunities for further improvement have been identified. For example, CBP, the Canada Border Services Agency (CBSA), and the Royal Canadian Mounted Police (RCMP) regularly exchange information about drug seizures made at the border, helping to identify trafficking trends, routes, and organizations. Additionally, U.S. and Canadian law enforcement share information about drugs coming from other countries, particularly those that arrive from overseas in mail and express consignment packages. Customs laboratories in Canada and the U.S. frequently exchange technical information about emerging trends, such as synthetic opioids and designer drugs. To assist in implementation of the Northern Border Strategy, the Science and Technology Directorate at DHS developed the Coastal Surveillance System (CSS) to enhance awareness of maritime smuggling activity and increase the availability of actionable law enforcement information to CBP, USCG, and other Federal, state, local, tribal, international, and private partner law enforcement agencies. CSS is currently piloted at CBP's Air and Marine Operations Center (AMOC) and includes Canadian partner participation. Additionally, Canadian law enforcement officers, including officers from the CBSA, RCMP, and several provisional and local law enforcement agencies, fully participate in BESTs.

Caribbean Border

Released in January 2015, The *Caribbean Border Counternarcotics Strategy (CBCS)* set forth the Administration's plan to prevent illegal trafficking of drugs in and around the United States Caribbean border (including Puerto Rico, the U.S. Virgin Islands, and the islets and cays surrounding those main islands). The goal of the *CBCS* is to substantially reduce the threat posed by drug trafficking, transnational organized crime, and associated violence to Puerto Rico and the U.S. Virgin Islands. The *CBCS* presents the combined efforts of the National Drug Control Program agencies in the Caribbean

border in the following areas: intelligence collection and information sharing; interdiction in the air and maritime domains, and the ports of entry; investigations and prosecutions; disrupting and dismantling drug trafficking organizations with a focus on the threat posed by drug-related violence; and increased demand reduction efforts in affected communities. The *CBCS* was developed in close consultation with Federal agencies and officials representing Puerto Rico and the United States Virgin Islands. Due to the limited interior landmass and unique nature of the Puerto Rico/U.S. Virgin Islands maritime borders, Federal collaboration with state, local, and territorial law enforcement agencies is one of the *CBCS*'s major areas of emphasis.

One strategic objective of the *CBCS* was to strengthen communities and reduce the demand for drugs. ONDCP used the highly effective DFC Support Program to increase the number of community-based coalitions in Puerto Rico. DFC is a Federal grant program that provides funding to community-based coalitions that organize to prevent youth substance use. To help Puerto Rican communities apply for the program in 2015, ONDCP staff presented two onsite technical assistance sessions to prospective coalitions from Puerto Rico. After these workshops, the number of applicants increased from two in 2014 to eight in 2015. Ultimately, four new DFC grantees received awards in 2015, for a total of five DFCs in Puerto Rico.

Principle: Focus National Efforts on Specific Drug Problems

The United States continues to be challenged by emerging trends in illicit drug use, synthetic substances such as methamphetamine and new psychoactive substances. ONDCP continues to work with law enforcement to build collaborative and comprehensive strategies to track ongoing threats and identify new threats and respond with coordinated policy approaches that address enforcement, prevention, treatment, and recovery.

Methamphetamine

The Administration remains committed to reducing the use, production, and trafficking of methamphetamine. Price and purity data and increased methamphetamine seizures across the Southwest border indicate rising domestic availability, most of which is the result of high levels of methamphetamine production in Mexico. While the majority of methamphetamine available in the United States is produced in Mexico[2] with precursor chemicals from China, the presence in the United States of small-capacity production laboratories (SCPLs) and methamphetamine hydrochloride ("ice") conversion laboratories poses a serious threat.

Through the HIDTA program, ONDCP manages the National Emerging Threats Initiative (NETI), formerly known as the National Methamphetamine and Pharmaceuticals Initiative. The NETI assists the HIDTAs with coordination, information sharing, and training for prosecutors, investigators, intelligence analysts, and chemists to: enhance the identification of criminal targets; increase the number of chemical/pharmaceutical drug crime-related investigations and prosecutions; and curtail foreign chemical and precursor sources that are used by domestic illicit drug manufacturers. The NETI also facilitates the planning and coordination of regional prescription drug summits where policy makers, law enforcement, public health officials, and others gather to share information and develop strategic approaches to countering the threat posed by the diversion and misuse of prescription drugs. In addition, 437 OCDETF cases (43 percent of all OCDETF cases initiated that year) involved methamphetamine in FY 2014. In FY 2015, 419 cases (44 percent of the total) involved

methamphetamine. For all active cases in FY 2015, OCDETF member agencies reported seizing approximately 37,000 kilograms of methamphetamine.

Marijuana

Illegal marijuana cultivation on public land not only provides a supply of the drug to communities in the United States, it is harmful to the environment. It negatively affects wildlife, vegetation, water, soil, and other natural resources through the use of chemicals, fertilizers, and terracing and from poaching. ONDCP works with its Federal, state, local, and tribal partners to address ecological threats posed by marijuana cultivation on public and tribal lands. ONDCP convenes the Public Lands Drug Control Committee, a Federal interagency group that coordinates programs to support marijuana eradication operations, investigations, and related intelligence and information sharing.

The Campaign Against Marijuana Planting (CAMP) is a significant initiative focused on eradication of marijuana grow sites. The California Department of Justice Bureau of Investigation and the U.S. Department of Agriculture Forest Service lead CAMP with the primary objective of reducing the amount of marijuana available to the illegal drug market. More than 110 local, state, tribal, and Federal agencies have participated in CAMP, making it one of the largest and longest-running law enforcement task forces in the United States. Most recently, in operations that culminated in September 2015, CAMP conducted marijuana enforcement operations in 28 counties covered by all four California HIDTAs. Operating mostly on public lands, CAMP's four regional teams raided 408 illegal marijuana cultivation sites, eradicating 956,898 marijuana plants and seizing 5.34 tons of processed marijuana. Its multi-jurisdictional model successfully leverages the resources of diverse law enforcement agencies to confront illegal marijuana cultivation on a statewide scale. CAMP headquarters is co-located with the Central Valley HIDTA program office in Sacramento.

The start of FY 2014 and through 2015, Marijuana was involved in 248 of the open OCDETF cases, and OCDETF member agencies reported seizing approximately 44,063 kilograms of marijuana in that same time period.

Diverted Prescription Drugs

The National Institute of Justice (NIJ) furthers the Administration's crime prevention and law enforcement goals by supporting research on drug-related crime to promote effective responses to illegal drug markets (including diversion of legal drugs) and criminal behavior related to drug use. Under its Controlled Substances and Forensic Toxicology Program, NIJ's Office of Investigative and Forensic Sciences funds research to improve narcotics enforcement, forensic science, and medicolegal death investigations. In FY2012, NIJ funded research on illegal prescription drug market interventions in collaboration with ONDCP to examine:

- Strategies and resources for HIDTAs;[3]
- The North Carolina Controlled Substances Reporting System to identify providers manifesting unusual prescribing practices;[4]
- Optimizing Prescription Drug Monitoring Programs to support law enforcement activities;[5]and,
- Policy analysis of Florida House Bill 7095 for diversion of psychoactive prescription drugs.

Heroin/Opioids

In response to the heroin/opioid epidemic, multi-agency law enforcement task forces are providing innovative approaches to address this threat. In FY2016, $3.8 million of ONDCP funding supported HIDTA's program funds to support its strategy to respond to the Nation's heroin epidemic. This unprecedented project combines prevention, education, intelligence, and enforcement resources to address the heroin threat across 20 states and the District of Columbia. The effort is being carried out through a unique partnership of eight regional HIDTAs – Appalachia, Atlanta-Carolinas, Michigan, New England, New York/New Jersey, Ohio, Philadelphia/Camden, and Washington/Baltimore. The HIDTA heroin response strategy fosters a collaborative network of public health-public safety partnerships, sharing best practices and innovative pilots and identifying new opportunities to leverage resources. In addition, the OCDETF National Heroin/Opioid Initiative, which was launched in December of 2014, supports 70 regional efforts where federal, state, local and tribal public safety officials work collaboratively to address the national epidemic. The Initiative supports multi-agency, cooperative OCDETF strategic efforts to identify, investigate, and prosecute criminal networks and offenders distributing heroin, fentanyl, and other opioids resulting in death of the people using these substances. Simultaneously, Initiative partners work collaboratively with public health partners such as forensic pathologists and toxicologists, medical examiners, coroners, and state health departments to share real-time data pertaining to drug seizures, overdoses, and deaths in order to best arm the public health and public safety united response to the national threat posed by opioids.

OCDETF has further demonstrated commitment in the fight against the opioid epidemic by employing the Heroin Response Group (HRG) out of the OFC. The OFC is a multi-agency intelligence center that leverages multiple investigative and financial data sources from OCDETF member agencies and non-OCDETF partners to generate actionable intelligence products and leads for the field. The HRG works in conjunction with the Special Operations Division to provide timely information and data support based on the specific needs of ongoing heroin and / or fentanyl investigations in an ongoing effort to establish linkages between heroin and fentanyl distribution networks, trafficking routes, suppliers, and target communities. Pursuant to requests from the DEA, FBI, ICE, ATF, the United States Postal Inspection Service, and the Health Research Group has disseminated 234 products to the field in the fight against the opioid epidemic, with 27 of those requests relating to the collaborative federal, state and local OCDETF funded Heroin Initiative efforts.

Fentanyl and Fentanyl Derivatives

2016 brought dramatic increases in the illicit manufacture and distribution of fentanyl, which has resulted in hundreds of fentanyl-related overdoses and fentanyl- related deaths in several areas of the country. Fentanyl, a Schedule II controlled substance, is one of the most potent opioids available for anesthesia and analgesia purposes in human and veterinary medicine. Fentanyl produces opioid effects that are indistinguishable from morphine or heroin, but fentanyl has a greater potency and a shorter duration of action.

Opportunities for the Future

While many accomplishments have been achieved since the inaugural *Strategy* was released in 2010, there is more work to do. It is important for milestones and objectives to be maintained at or higher than their current level. It is important to continue support for tribal law enforcement. Coordination among Federal, state, and local partners remains an important element in proactively diminishing the

progress of DTOs that will continue to exploit the Southwest, Northern and Caribbean borders. Marijuana cultivation on public lands will continue to be a threat to the environment, and efforts should continue to keep illegal marijuana from reaching markets. Interdicting drug trafficking through mail and parcel services continues to be an area where improvements need to be made. With the likelihood that heroin and other opioid trafficking and overdose deaths will continue to be active threats, and innovative, whole-of-government strategies, like the HIDTA Heroin Response Strategy and the OCDETF Heroin Initiative to facilitate collaboration and spur creative innovations, need to be maintained to combat these threats.

While the majority of methamphetamine available in the United States is produced in Mexico, the presence of small-capacity production laboratories and methamphetamine hydrochloride ("ice") conversion laboratories in the United States poses a serious threat. DEA continues to dedicate enforcement, intelligence, and other resources to prevent the manufacture of methamphetamine and to disrupt the trafficking and transportation of the drug. Their efforts include training state and local law enforcement officers on clandestine laboratories and methamphetamine production.

Recent increases of coca production within Colombia, as well as the related movement of additional shipments of cocaine through the transit zone on the high seas, is a troubling trend. U.S. agencies, including CBP and the DEA, in cooperation with state and local task forces around the country, are working to detect and disrupt increased cocaine wholesale distribution in our communities. This is a trend worth watching closely.

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

At the start of the Administration, an international drug policy based on the principles of partnership and shared responsibilities was developed. The intent was to ensure that policies, programs, and priorities not only served to protect Americans from dangerous drugs, but also to help international partners address their drug-related challenges, including crime, violence, gangs, and corruption. This new spirit of collaboration and acceptance, as a major drug consuming country, of its responsibility to assist partner nations, has enabled the United States to develop stronger, deeper partnerships around the globe.

In communications with international partners, the United States continued to express its concern over the drug production and trafficking threatening the Nation, but also listened to concerns from U.S. allies, especially those within the Western Hemisphere. Many of these governments share concerns over drug production and trafficking but are more focused on drug-related violence, youth gang involvement, and burgeoning drug use among vulnerable populations. The candid exchanges and shared commitment to work together enabled the United States to build new, stronger, more effective partnerships.

Accomplishments

Drug use, drug production, and drug trafficking are a global problem affecting all nations, not just a challenge for producing, consuming, or transit countries to address on their own. This understanding has enabled progress on numerous international initiatives and investigations, as well as on longer-term efforts to build stronger institutions, promote the rule of law, support international demand reduction, and protect human rights. These accomplishments, as well as the significant challenges that require further attention, are described below under three key principles.

Principle: Support the Drug Control Efforts of Major Drug Source and Transit Countries

Illicit drugs pose a serious threat to public health around the world. The United States seeks to work bilaterally and multilaterally to build robust law enforcement, security, and public health institutions that can effectively address drug related threats.

Mexico and Central America

The partnership between the United States and Mexico remains vital to both countries. The bulk of foreign-produced drugs consumed in the United States, including heroin, methamphetamine, cocaine, and marijuana, are produced in or transit through Mexico. The Mexican people have made huge sacrifices to combat the international drug cartels based within its borders. Just as the United States

is focused on drugs moving north into the country, Mexico is concerned about illicit drug proceeds and weapons smuggled south.

Both nations conduct activities to address the illegal drug trade, including interdiction and efforts to address drug production. Over the past year, the Obama and Peña Nieto Administrations have intensified their collaboration with regard to the opioid epidemic. Representatives from both governments have discussed new approaches to address opium production, heroin manufacturing, and poly-drug trafficking. The Mexican government is conducting a poppy yield study with the UNODC, assisted by U.S. experts, to better understand the actual potential production and inform the government on eradication and interdiction issues. Additionally, Mexican law enforcement officials have been working with U.S law enforcement on clandestine lab identification, evidence collection, and safe handling of hazardous chemicals. These exchanges and collaborations have forged a strong foundation for future cooperation.

Mexico, of course, is not the only country upon which drug trafficking has had a significant impact. The lucrative drug trade has expanded the power of gangs, fueled the increase in murder rates, corrupted institutions, damaged the environment, and undermined licit economic development in Central America. In response to their pressing citizen security, economic development, and institutional challenges, the Governments of El Salvador, Guatemala, and Honduras developed the Plan of the Alliance for Prosperity of the Northern Triangle in 2014 and allocated a combined $2.6 billion to support the plan in 2016. In 2015, the U.S. government announced the U.S. Strategy for Engagement in Central America (Strategy), a comprehensive, multi-year interagency initiative to advance security, governance, and economic objectives in all seven countries in Central America. . Congress appropriated $750 million in fiscal year 2016 funding to support the Strategy.

Andean Ridge

Further south, the Andean Region – the source of virtually all the cocaine produced around the world – has long been the focus of the U.S. Government's attention. Through multiple administrations the governments of the United States and Colombia have collaborated to reduce coca cultivation and cocaine production, provide alternative livelihoods for coca farmers, seize cocaine, and bring drug traffickers to justice. Building on these efforts, the Colombian Administration of Juan Manuel Santos has sought to negotiate a peace accord with the Revolutionary Armed Forces of Colombia (FARC). The United States is fully supportive of the peace negotiations and anticipates that a final accord will not only create a stronger, more peaceful, more prosperous Colombia, but also will eventually facilitate intensified initiatives to address coca production and cocaine trafficking. Such efforts will be vital in responding to recent increases in coca cultivation (see below).

Our close partnership with Peru is also vital to efforts to reduce cocaine production. Peru continues to make strides in stabilizing coca cultivation, with over 35,000 hectares eradicated in 2015, and in providing innovative alternative development programs. The strong will and commitment of the government of Peru, even in light of violence by the remnants of the Sendero Luminoso rebels, have produced noteworthy successes over the past five years, with more achievements expected over the next few years.

Principle: Exploit Key Vulnerabilities of Transnational Criminal Organizations

The foreign production and movement of drugs into U.S. communities is the result of a long and complex process that is carefully controlled by drug trafficking organizations. To reduce the supply of drugs, it is necessary to identify drug trafficking networks, determine their most vulnerable points, and disrupt and dismantle these organizations by attacking their vulnerabilities.

Drug Interdiction

United States drug control efforts are focused not only on the land but, of course, also on the water. High seas drug interdiction is extremely efficient, removing drugs from the trafficking flow through multi-ton seizures before they are broken into much smaller shipments. Interdiction not only reduces the flow of dangerous drugs into our country, it provides vital investigative leads and intelligence about how drug trafficking organizations operate. Joint Interagency Task Force South (JIATF-South) coordinates Western Hemisphere interdiction initiatives with 30 partner nations across 42 million square miles of ocean. As a result of these combined efforts, 467 metric tons of cocaine were removed in 2015, according to the Consolidated Counterdrug Data Base (CCDB) year-end report. Stronger intelligence cuing and coordination of DHS (USCG, CBP) resources during 2015 contributed significantly to this accomplishment. The successes in interdiction, accomplished by the men and women serving across the region, often in difficult and dangerous conditions, have helped reduce the amount of drugs entering communities across the Nation and contributed to our effort to keep the pressure on drug cartels and bring their leaders to justice.

Disrupting Synthetic Drug Production and Trafficking

Over the past five years, the United States has seen an increase of New Psychoactive Substances (NPS), threatening the health of our citizens. These synthetic drugs – many of which mimic the physiological impact of controlled drugs such as marijuana or cocaine – can be dangerous and sometimes fatal. In response to a surge in poison control alerts and reports about NPS from communities around the Nation, U.S. agencies, led by DEA, worked to schedule many of these substances on an emergency basis and shared information about this threat with Federal, state, local, and community partners. Congress also has played a vital role in permanently scheduling many of these dangerous drugs. Given the number of existing and potential NPS, Federal agencies are working to determine how best to prioritize and understand the threats these substances pose to public health and how this information can help inform sound policies to reduce their use and availability.

China remains the source of many raw chemical compounds used to manufacture NPS. The United States and China have intensified cooperation between law enforcement agencies through enhanced intelligence exchanges, increased cooperation on investigations, and a series of technical exchanges on precursor chemicals, NPS, and related topics. On October 1, 2015, China placed 116 chemicals – primarily NPS – under national control. This action is expected to have a significant impact on the export of NPS products to the United States.

Methamphetamine continues to be a serious concern to the United States. Mexico-based manufacturers of the drug have been able to evade Mexican precursor controls on pseudoephedrine and ephedrine by altering their production methods. China's Narcotics Control Bureau criminalized illegal production and transportation of drug-making materials in 2015, supplementing a previous law

covering illicit purchase, sale, distribution, and smuggling. China's efforts will make it more difficult for western hemisphere methamphetamine manufacturers to gain access to needed precursor chemicals and are likely to lead to a reduction in foreign-produced methamphetamine entering the United States from Mexico over the next 12 to 24 months. China's actions also could positively change the broader enforcement environment, with greater cooperation between states on investigations.

Joint Interagency Task Force West (JIATF West) continues to work with both U.S. interagency and international partners in the counterdrug community to exploit information in the global commodity logistics chain to assist in the identification, location, and ultimate seizure of suspect precursor chemical shipments before they are diverted to labs that can produce illicit synthetic drugs. The identification of the relative few suspect shipments in the vast global chemical market is a significant challenge. However, through extensive interagency efforts, nearly 4,700 metric tons (MT) of methamphetamine precursor chemicals have been seized by partner nation security forces in Mexico and Central America over the last 6 years.

Transnational Organized Crime

The summer of 2016 marked the 5-year anniversary of the Administration's *Strategy to Combat Transnational Organized Crime*. At the White House in 2011, senior officials from the NSC, ONDCP, and the Departments of Justice, State, and Treasury launched the first comprehensive interagency transnational organized crime strategy in 15 years. Over the past 5 years the implementation of the *Strategy to Combat Transnational Organized Crime* has led to unprecedented efforts to apply all the elements of national power to the leading global crime threats. This multi-faceted attack, using the combined resources of U.S. agencies and partnership with key allies, has increased our capacity to protect our citizens from an array of global crime threats. The 2011 document will guide U.S. policy in the years ahead as we continue to confront the various organized crime threats that are associated with the global economy.

Principle: Collaborate with International Partners

A key mechanism that enables the United States to address the drug problem more effectively is the ability to partner with other governments, multilateral governmental organizations, and non-governmental organizations on both short- and long-term objectives. This collaborative effort greatly serves the interests of our Nation.

The United Nations General Assembly Special Session on the World Drug Problems

The United States is concerned about all transnational organized crime challenges threatening the country, including drugs, which remain the most lucrative illicit activity in the world.[1] Until April 2016, it had been 18 years since the global community came together at United Nations (U.N.) headquarters in New York to take stock of the global drug problem. At the U.N. General Assembly Special Session (UNGASS) on the World Drug Problem, the United States along with many other nations called for balanced and comprehensive approaches to drug control under the framework of the existing international drug control conventions and asked partners around the world to update demand and supply reduction policies based on advances in research and science and the lessons of experience over the decades.

As U.S. agencies and representatives in embassies spanning the globe engage in dialogue with host countries on drug issues, their assistance is frequently requested on demand reduction programs, including alternatives to incarceration, such as drug courts, and community coalitions focused on preventing drug use among youth. In response to this strong interest, the United States has increased U.S. assistance provided for international demand reduction both bilaterally and multilaterally through key partners such as the United Nations Office of Drugs and Crime (UNODC), the World Health Organization, the Colombo Plan, the African Union, and the Organization of American States Inter-American Drug Abuse Control Commission (OAS/CICAD). Support from the United States in piloting model programs, professionalizing staff, developing with international partners needed treatment and prevention standards and curricula, and updating laws not only provided the type of assistance our partners wanted, it created an improved environment for drug-related cooperation on a host of issues.

Opportunities for the Future

Heroin Production and Trafficking

Mexico is the primary supplier of heroin to the United States likely due to our shared border, well-established transportation routes and techniques for bringing the drugs into the United States, and Mexico's ability to efficiently distribute illicit drugs to a vast U.S. drug market. Estimated poppy cultivation in Mexico increased from 12,000 hectares in 2011 with a potential pure heroin yield of 30 metric tons, to 28,000 hectares with a potential yield of 70 metric tons in 2015. The reemergence of illicit fentanyl, a powerful Schedule II synthetic opioid more potent than morphine or heroin, exacerbates the heroin crisis.[2] Illicit fentanyl is sometimes mixed with powder heroin to increase its effects or with diluents and sold as "synthetic heroin," with or without the buyers' knowledge.[3] Increasingly, illicit fentanyl is pressed into pill form and sold as counterfeit prescription pain medications. The majority of the illicit fentanyl in the U.S. market is smuggled into the country after being clandestinely produced in Mexico or China.[4]

Historically, Mexican drug trafficking organizations supplied lower-quality black tar and brown powder heroin to the U.S. market. However, Mexican traffickers have shifted to producing white powder heroin, increasing both the quality and quantity of heroin entering the United States across the Southwest border.[5]

Since the formation of the bilateral Security Cooperation Group in 2014 and ONDCP's National Heroin Coordination Group in October 2015, the relationship with the Government of Mexico has strengthened in many ways.* Leaders in many of Mexico's governmental organizations work cooperatively with ONDCP and its partners such as the Department of State's Bureau of International Narcotics and Law Enforcement Affairs (INL), the DoD, the DOJ, and others, on drug issues with promising results.

As a result of several high level bilateral engagements, the governments of Mexico and the United States have developed a common view of the costs of heroin and fentanyl to public health and

* This summit created an opportunity to share details about security threats in a candid manner and to take a combined approach to strategic priorities on organized crime, counter-narcotics efforts, jointly managing our 2,000-mile shared border, and coordinating to confront new threats from Cybercriminals. To read more: https://www.whitehouse.gov/blog/2015/02/27/third-meeting-us-mexico-security-coordination-group.

public safety for both nations. During the Security Cooperation Group meeting in Mexico City in October 2015, the U.S. government provided insight on its efforts to reduce the demand for illicit opioids, and asked for Mexico's increased cooperation in reducing heroin and fentanyl production and distribution. Following a visit to Mexico City in March 2016, Mexico's Attorney General established an organization within the Attorney General's Office to synchronize the Government of Mexico's heroin and fentanyl efforts. High level engagements led by the Office of National Drug Control Policy in February, March, and July resulted in a stronger relationship with Mexico and a series of formal mechanisms to guide and synchronize both nations' efforts to address the heroin and fentanyl crisis.

In June 2016 the Government of Mexico released its poppy cultivation study, completed in cooperation with the United Nations Office of Drugs and Crime (UNODC). The detailed study reported an average estimate of poppy cultivation nationwide of around 24,800 hectares from July 2014 to June 2015.[6] As part of the U.N.-Mexico partnership, the MEXK54 project adopted the additional goals of estimating Mexican poppy gum yield and the morphine content of the Mexican illicit opium gum which will satisfy a long-standing desire to more accurately assess heroin production throughout the country.

After adding drug policy to the U.S.-Mexico Security Cooperation Group as a shared problem, President Obama and Mexican President Peña Nieto discussed the heroin issue in May 2016 and then again in June 2016 at the North American Leaders Summit (NALS). The Security Cooperation Group is the primary forum for senior U.S. policy makers to work with their Mexican counterparts and devise strategies against the security threats we both face. In addition to our bilateral relationship, at the North American Leaders Summit, President Obama, President Peña Nieto, and Prime Minister Trudeau of Canada agreed for their countries to participate in a trilateral North American Drug Dialogue, which first met in October 2016. The October meeting sought to expand cooperation on the heroin and fentanyl problem set across the entire continent.†

The counterdrug partnership between the United States and Mexico is a crucial element in addressing the heroin and fentanyl crisis in both countries. Formal opportunities for engagement like the North American Drug Dialogue and the Security Cooperation Group provide excellent avenues to address the public health, public safety, and law enforcement opportunities and challenges inherent in countering the illegal drug trade writ large, and the current crisis with illicit opioids. Our efforts to build trust and transparency with our Government of Mexico counterparts should allow us to continue to strengthen collaboration at the policy development and implementation levels. Our Federal counterdrug agencies will continue to build Mexico's capacity to improve clandestine lab identification and neutralization, evidence collection, handling of hazardous chemicals, and poppy eradication all in an effort to disrupt the Mexican drug trafficking organizations whose activities have a direct and negative impact on public health and safety in both countries.

Afghanistan produces over 80 percent of the world's heroin. This drug trade supports insurgent operations in Afghanistan, destabilizes the region, expands OUDs in neighboring countries, and fuels corruption. Afghan opiates do not be currently enter the United States in large known

† The North American Dialogue on Drug Policy was born during the 2014 North American Leaders Summit (NALS) and reenergized during the 2016 NALS. The NADD summit would smooth cooperation on issues of common concern by bringing together senior national drug policy officials for North America to convene at least once a year and more often, if needed. The Dialogue would provide a forum to exchange best practices, share information, and shape future engagements in international fora.

quantities. However, because Afghanistan represents the majority of global heroin trade, and there is the risk that trade will change in response to U.S. successes against Mexican heroin, efforts to disrupt and reduce the production and trafficking of Afghan heroin should continue in coordination with our international partners.

The Regional Narcotics Interagency Fusion Cell located in Bahrain is an example of interagency and international efforts to interdict Afghan opiates. This cell includes analysts and law enforcement officers the United States, United Kingdom and Australia that fuse information on drug trafficking operations primarily stemming from Afghanistan towards the east coast of Africa. That fused information is then shared with action elements that can interdict this illicit trafficking. The Coalition Maritime Force supports most of the interdictions in the Indian Ocean.

Cocaine Resurgence

As referenced above, there has been great progress over the past decade in reducing both cocaine production in the Andean Ridge and cocaine consumption within the United States. Unfortunately, even taking into account efforts in Colombia and Peru to reduce coca cultivation and cocaine production, the United States estimates that total cocaine production capacity has increased over the past year in all three of the Andean coca-producing countries.[7] At the same time, U.S. consumption remains below historic peaks but past year cocaine use may be increasing among young adults aged 18-25.[8] Consistent with recent increases in consumption, drug poisoning deaths related to cocaine have increased to 5,415 from in 2014 from a low of 4,183 in 2010, a 29 percent increase.[9]

It also is important for our anti-cocaine and anti-heroin efforts that future administrations provide resources to support core data sets needed to understand drug production and supply trends. Among this array of data sets are the crop reports provided by the intelligence community. In addition, OCDETF-supported and DEA-led Operation Breakthrough provides essential manufacturing efficiency analysis that enables the U.S. Government to provide credible potential drug production estimates based on the crop reports. These and other resources are truly vital. Without them, future administrations will become increasingly blind to the drug threats facing the Nation.

Need for International Treatment Capacity

The United States, as highlighted above, has increased its training and support for international demand reduction initiatives. However, the need around the globe has greatly outpaced the ability of donor countries to provide support. The United States should continue to work with other donors to increase foreign assistance to support the development of evidence-based treatment and prevention capacity here and abroad. It should also continue to encourage countries to invest their own resources in this area.

There is a large unmet need for trained drug related health care personnel, adequate facilities, and funded public behavioral and medication-assisted treatment slots. In addition, the widely sought goal, endorsed at the recent UNGASS in New York by U.N. Member States, of increasing alternatives to incarceration for drug dependent offenders, can be achieved only if sufficient evidence-based treatment is available.

National Cocaine Coordination Group

The Office of National Drug Control Policy established the National Cocaine Coordination Group (NCCG) in August 2016 in response to a series of indicators foreshadowing the resurgence of cocaine availability in the United States. The NCCG will develop options for the current and next Administrations and share the multi-disciplinary team of interagency subject matter experts supporting the National Heroin Coordination Group (NHCG).

The United States estimates that total cocaine production capacity increased in 2015 in all three of the Andean Region coca-producing countries. Detections and seizures of increased flow on the high seas add to this troubling trend. U.S. consumption remains below historic peaks, but lagging domestic indicators are forecasting a rise in cocaine consumption. An increase in the availability of cocaine is likely to increase consumption and create public health, law enforcement, and Western Hemisphere stability issues.

Current potential pure cocaine production in Colombia, Peru, and Bolivia is estimated at 995 metric tons. Present interdiction assets are not sufficient to detect or seize numerous drug movements on which we have sufficient intelligence. Interdiction is important, as it not only reduces the volume of available illegal drugs, but also provides vital investigative leads and intelligence about smuggling organizations.

The United States has opportunities and options to address this challenge in the Andean Region, Central America and Mexico, the Southwest Border, and in the areas of Interdiction and Investigation, Prevention and Education (especially for vulnerable communities), and Demand Reduction.

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

Crucial to this Administrations' approach to drug policy has been the use of timely and accurate information in all areas of drug control, including prevention, treatment, recovery, law enforcement, interdiction, and source country efforts. Information systems have helped to illuminate the road ahead for evidence-based drug policy. These same systems have been used to measure the effectiveness of drug treatment strategies, focus supply-reduction activities, and prioritize resource decisions. ONDCP has worked collaboratively with our Federal partners to strengthen data systems and prioritize data and analytic efforts to support decision-making and monitor progress toward the Administration's goals. Ongoing workgroups, such as the Interagency Work Group on Data, provide regular opportunities to share information and develop collaborations that enhance individual agency efforts and improve coordination on emerging drug issues.

Without question, one of the most significant and consistent findings from these data over the past decade has been the emerging public health crisis resulting from chronic, non-medical use of prescription drugs, particularly prescription pain medications. More recently, there has been an alarming increase in the use of heroin. According to NSDUH, from 2002 through 2009, more Americans initiated the misuse of psychotherapeutics than initiated marijuana.[1] By 2009, over 5.2 million people were misusing prescription pain medications, a significantly higher number than in 2002 (4.4 millions).[2] [3] From 2000 through 2011, the number of treatment admissions for these substances doubled every four years.[4] Information tracking the supply of prescription pain medications showed parallel rises in sales[5] and street seizures.[6] This supply of prescription pain medications, often obtained from friends or relatives, was the source of nearly 70 percent of the opioids used non-medically in the past year.[7] Data from the National Seizure System showed a rise in heroin availability and use over the same time period. Southwest border heroin seizures rose 180 percent from 2008 to 2011.[8] Drug overdose death statistics, collected by the NCHS from a census of death certificates in the United States, was the strongest indicator of the consequences of opioid and heroin use. In 1999, there were about 17,000 drug overdose deaths, which then increased by approximately 2,000 every year through 2014. About half of these deaths involved opioids (prescription pain medications or heroin). These data and the coordinated work of our Federal partners informed the Administration's Prescription Drug Abuse Prevention Plan[9] to reduce the supply through education, tracking and monitoring potential diversion sources, proper medication disposal, and law enforcement efforts.

A number of significant policies, such as increased access to the life-saving drug naloxone, which reverses opioid overdoses, are the result of using data systems to enhance our understanding of what is happening at the community level and then using that data to develop a coordinated public health and public safety response. Recent years have seen the development of a number of policy initiatives informed by data and analytic work, as described below.

Policy Changes Informed by Data

Opioid Abuse and Heroin Use Initiative

Data on drug poisoning deaths from the National Vital Statistics System (CDC/NCHS) and treatment admissions from the Treatment Episode Data Set (HHS/SAMHSA) provided critical information to support the need for a major expansion of medication-assisted treatment and additional trained clinicians who could be deployed to underserved areas of the country. Data highlighting the impact of opioid use on treatment admissions at the state level were important in the development of cooperative agreement proposals found in the President's FY 17 budget. These proposals are designed to scale up activities to develop pain management and opioid prescribing quality measures. At the same time, ONDCP analysis of data on opioid-involved drug poisoning deaths found significant increases in the rate of deaths involving prescription opioids and heroin across the Nation as well as in rural settings. This data, coupled with the understanding that rural communities often have fewer resources for responding to public health crises such as the opioid epidemic, prompted the President to ask Department of Agriculture Secretary Thomas Vilsack to lead a new interagency effort to address opioid use in rural communities.

Prescription Drug Response

Data from a number of federally supported data collections, including the National Survey on Drug Use and Health (NSDUH), Monitoring the Future, the Defense Health Related Behaviors Among Active Duty Military Personnel, and the National Vital Statistics System, helped to identify targets outlined in the Administration's 2011 Prescription Drug Abuse Prevention Plan. The plan focused on four major areas: education, monitoring, proper disposal, and enforcement. Subsequent Strategies have reinforced the need to sustain efforts in these areas while expanding access to evidence-based prevention, treatment, and recovery services.

Drugged Driving

For decades, significant attention has been given to the problem of drunk driving, but awareness about the prevalence of drugged driving rose dramatically in 2009, when the NHTSA Roadside Survey (NRS) results were reported. The 2007 NRS, the first national prevalence estimate for drug-involved driving, found that among nighttime weekend drivers, 16.3 percent tested drug-positive based on the combined results of either or both oral fluid and blood tests. These findings led to the inclusion of drugged driving as an important prevention effort within the *National Drug Control Strategy*. December is National Impaired Driving Month, a time to focus on drugged driving and other behaviors that impede the safe operation of motor vehicles. NHTSA, NIDA, and ONDCP continue to collaborate on monitoring and tracking progress in the Nation's efforts to address the problem of drugged driving.

Identifying Providers Who Intentionally Overprescribe Opioids

An enduring legacy of this Administration is its emphasis on the use of data to guide policy and monitor its impact. Perhaps one of the most significant outcomes can be seen in how data have been used to address the role of pain clinics and their expansion in Florida during the last decade. Automation of Reports and Consolidated Orders System (ARCOS) data showed that Florida physicians dispensed more oxycodone than those in all other states combined during the first six months of 2010 and reported that 90 of the top 100 oxycodone purchasing physicians in the Nation were located in Florida. The combination of law enforcement activity and regulatory actions against doctors' licenses dramatically decreased the availability of pain medicine diversion. New Florida laws stripped doctors of their ability to dispense controlled substances, including opioid-based pain relievers, at rogue pain clinics. Florida mortality data showed a 69 percent decrease in deaths caused by oxycodone: from 1,516 in 2010 to 470 in 2014

Accomplishments

Over the past seven years, the Administration has encouraged open, transparent communications among Federal partners to create opportunities for a comprehensive understanding of substance use and strategies to intervene early with at-risk populations and provide evidence-based care when substance use progresses to a stage when specialized care is needed. A hallmark of this policy is that survey, administrative, and research data be disseminated widely to inform policy and decision-making. As science has allowed us to better understand that SUD is a brain disease, policies that are informed from valid and actionable data are more likely to lead to interventions that prevent and delay drug use and offer hope for long-term recovery for those who become addicted to drugs. The sections below outline some of the significant accomplishments that have strengthened the Nation's data infrastructure related to substance use and challenges that remain.

Principle: Existing Federal Data Systems Need to be Sustained and Enhanced

A number of Federal data sets aid in monitoring drug use and related health consequences as well as supply issues across the Nation. These data are critical for the development of informed policy.), which tracked drug-related emergency room admissions, and the Arrestee Drug Abuse Monitoring (ADAM) program, which tracked drug use among arrestees – are no longer operational. The DAWN sample of hospital emergency departments became increasingly hard to sustain with declining support from hospitals, while insufficient funds were available to continue ADAM. Sustained efforts have been applied to obtain such information from other sources. This Administration's position is that systems such as those mentioned above should not only be sustained but enhanced to allow for more timely dissemination of findings. The Administration has encouraged Federal agencies involved in drug-related data collection to expand efforts to develop and enhance systems that are responsive to the needs of tribal nations and local communities. Doing so may require the development of new data systems and the identification of new measures that are sensitive to emerging drug problems. Although there have been some discouraging trends in support of these vital data systems, there also have been important advances, as described below.

Systems Monitoring Drug Use, Health Consequences, and Treatment Services

In partnership with the National Center for Health Statistics at CDC (NCHS/CDC), FDA, and SAMHSA began a process to replace DAWN with a new system to track drug-related emergency room visits. The new system, SAMHSA's Emergency Department Surveillance System (SEDSS), has been developed and implemented through NCHS's new National Hospital Care Survey. Similar to DAWN, it utilizes data collected from emergency departments to provide national estimates on drug-related emergency department visits. In addition, SAMHSA will be able to look at referrals to inpatient treatment and to other units within the hospital system. NCHS/CDC has been successful in obtaining meaningful use credit for hospitals that participate in the survey, and it piloted with SAMHSA a new tool to review electronic health records. Data collection began in calendar year 2016, and reports are expected in early 2017.

Another SAMHSA-supported data system, the NSDUH, serves as the primary population data collection effort for substance use and related attitudes and behaviors. Findings from this survey have been instrumental in understanding an array of prevention, treatment, and recovery policy issues, including trends in opioid use. In 2015, SAMHSA implemented a partial redesign to enhance questions focusing on drug use, including past-year prescription drug use. SAMHSA also has engaged with the National Academy of Sciences to develop a series of expert panels to examine strategies for expanding data collection on such topics as trauma and recovery.

Over the past seven years, SAMHSA has continued to enhance the Treatment Locator System, which draws from the National Survey of Substance Abuse Treatment Services (NSSATS) and the Mental Health Systems Survey (MHSS). Beginning in 2013, SAMHSA developed a mechanism to sort programs managed by the VA, and in 2014, SAMHSA partnered with the HRSA to integrate data on health centers into the locator system. SAMHSA plans to enhance the treatment locator by including National Health Corps Service health centers and programs run by the IHS. This National resource supports several key principles under the ACA to identify programs, services provided, and the types of insurance that can be used to access care.

People with SUDs disproportionately consume a large share of the market for illicit substances. The ADAM program was developed to collect arrestee-reported data on drug use and related behaviors in selected counties across the country because individuals who are arrested and/or convicted of crimes demonstrate

substantially higher rates of drug use – especially chronic use – than the general population. Understanding the interplay between chronic drug use and crime is critical for policymakers, administrators, and communities. When the ADAM program was terminated in 2013, ONDCP initiated a cooperative agreement with the University of Maryland's Center for Substance Abuse Research (CESAR) to pilot-test a methodology to detect new drugs, particularly variants of synthetic cannabinoids, by re-testing already collected urine specimens from criminal justice populations. The Community Drug Early Warning System (CDEWS) study was completed in 2013, and a CDEWS replication study was completed in April 2015. A third cooperative agreement to implement the CDEWS methodology in criminal justice populations in other locations is ongoing, with expected completion in late 2016.

Principle: New Data Systems and Analytical Methods Should Be Developed and Implemented

Since the inaugural *National Drug Control Strategy* in 2010, a number of advances in analytic techniques have taken advantage of information contained in federally supported data systems. This has led to significant improvements in how we understand trends in the prevalence of drug use and in turn helps to highlight which drugs are being consumed by Americans. Combining such information with additional data on emerging trends have informed analyses used to improve public safety and public health responses.

Estimating the production, movement, and removal of illicit drugs is useful to decision-makers by providing context for supply-reduction activities and indicating improving or worsening market environments. The U.S. Government and the United Nations Office on Drugs and Crime (UNODC) cooperate to improve each other's annual estimates of illicit crop cultivation and illicit drug production in key source countries. Movement of illicit drugs toward U.S. markets is tabulated by the Consolidated Counterdrug Data Base (CCDB). The CCDB was originally created to track cocaine movement, but two modules were added in recent years to document heroin and amphetamine-type stimulants, including precursors. Data on interdictions at and within the U.S. border are maintained by the National Seizure System, which is continually expanding its sources of seizure information to provide a better understanding of the magnitude of supply-reduction activities.

In August 2014, the NIDA launched the National Drug Early Warning System (NDEWS) through a cooperative agreement. This effort builds upon the former NIDA Community Epidemiology Work Group (CEWG) that created a network of local substance use experts to report on drug trends and emerging issues across a number of sentinel metropolitan sites and states. The NDEWS project will continue to monitor trends using some of the same sentinel sites from the CEWG program, but also will incorporate a national perspective using innovative data collection strategies to monitor emerging problems.

Principle: Measures of Drug Use and Related Problems Must be Useful at the Community Level

Developing new data collection efforts that exploit existing data, especially community-level data that are responsive to local needs, can be a cost-effective strategy. A recent example is the DEA program that connects state and local forensic laboratories. The National Forensic Laboratory Information System (NFLIS) collects existing data on drug use and uses it to estimate regional and national trends in use, trafficking, emerging substances (such as synthetic cannabinoids), and how use varies by geography. Another system, which anticipates utilizing existing community resources, is the Community Early Warning and Monitoring System (C-EMS) being developed at SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ). Beginning in 2012, SAMHSA entered into an agreement with the Department of Agriculture to begin development of the Community Early Warning and Monitoring System (C-EMS). The goal of this program is to provide tools to increase access relevant data at the local level in order to monitor

the behavioral health of the community. In addition, CBHSQ is working to develop and implement a web-based application that will allow local communities to populate a targeted set of indicators and use that data to generate community profiles with dashboard and mapping features. During 2015, CBHSQ/SAMHSA incorporated a Community Epidemiology Team with deployment capacity to respond to local outbreaks related to drug use. In 2016, CBHSQ/SAMHSA will begin phase two of this project in partnership with Council of State and Territorial Epidemiologists to identify and promote a core set of behavioral health indicators that will contribute to a national behavioral health surveillance system that responds to community-level needs.

Opportunities for the Future

The *Strategy* promotes prevention, treatment, and law enforcement policies and programs that are evidence-based and proven to be effective. Accurate and timely data are required to fully understand the various aspects of the issue. There are challenges to maintaining current information systems in these times of increasing diversity of the threat, but there also are opportunities to improve the situation by merging and standardizing competing or parallel systems. Data systems need to be as adaptable as the traffickers to provide policymakers with the most complete, accurate, and meaningful information possible.

Standardization

Many national information systems related to drugs are based on the integration of information collected at the state or local level. Differences in standards challenge the aggregation of such information for comparative purposes. For example, national mortality information on drug overdose deaths is based on the collection of all death certificates, and categorizing them, sometimes by scanning hand-written information documenting the forensic investigation. Transcription errors may be compounded by varying standards for the conduct of forensic investigations that in turn, may lead to the omission of drug names involved in the overdose.[10] Forensic investigations are conducted by a variety of state and county public safety organizations, including coroners and medical examiners, and often are guided by different standards, further contributing to differences and confusion. The DOJ and the National Institute of Standards and Technology are currently leading an effort to standardize the process for forensic investigations.[11] Standardization of investigations and reporting will permit improvements to the timeliness and completeness of mortality reporting statistics. Collaboration between Federal and State agencies will benefit both groups by minimizing the differences. Examples of information that could be improved with greater standardization include drug overdose deaths, fatal motor vehicle crashes involving drugs, and drug seizures.

Challenges that Impact the Survival of Systems

Large surveys can be costly and time-consuming but are important in the development of estimates of drug use and its consequences – especially when a large sample is required to investigate the relatively small number of Americans who use cocaine, methamphetamine, heroin, and New Psychoactive Substances such as synthetic cannabinoids. As noted above, two systems that were ended in recent years are the DAWN and the ADAM program. In both of these cases, alternative information systems are being developed.

Merging Data Systems

In order to achieve efficiencies some agencies have merged parallel activities. SAMHSA's Drug and Alcohol Services Information System (DASIS) was combined with its counterpart in mental health to become the Behavioral Health Services Information System (BHSIS). This allowed for greater coordination of data collection across the substance use and mental health service systems. The Federal-wide Drug Seizure System (FDSS) was integrated into the National Seizure system. This new approach combines data on national seizures with state and local seizures, including detailed information on the personnel and conveyance aspects of the seizures. Agencies seeking to preserve systems that are important for informing policy and tracking progress may benefit from a review of current systems to determine where merging components could lead to efficiencies and savings while strengthening the network of data systems supporting the drug control effort.

Increasing Capacity to Collect and Disseminate Community Level Data

We know from recent experience in developing a comprehensive policy to address substance use and its consequences that there is a great need for community-level data to help decision-makers at the national level target resources more effectively. Two examples of such efforts include NIDA's National Drug Early Warning System (NDEWS) and SAMHA's Community-Early Warning and Monitoring System (C-EMS). Each of these programs were developed to address a real gap in information systems for enhancing the health of the community. These programs bring to light problems that impact drug use and related consequences and opportunities for improvement. Future efforts might focus on identifying and supporting collaborations that utilize existing community-level indicators in conjunction with Federal and state systems to guide actions and support policy changes to increase the effectiveness of public health and public safety programming that addresses substance use and related conditions.

Data System Flexibility

Large population-based surveys like NSDUH require significant planning years in advance in order to collect, process, analyze, and disseminate information, and they can be slow to respond to emerging drug use trends. Recent drug trafficking activity indicates that changes in the design and production of illicit substances are increasingly influenced by clandestine chemical labs, which provide traffickers with flexibility of location, product, and precursors. Covert labs challenge existing data systems to accurately and completely tabulate new or modified drugs, as routine tests, analysis, classifications, and data systems are often not designed to be flexible.

Future administrations may look for ways to maintain core data collection efforts and encourage agencies to pursue innovations that are agile for collecting and analyzing data and that extend traditional data collection enterprises. For example, scanning social media can signal localized trends that can then be pegged to quick data collections via mobile applications to augment local emergency room data. New technologies that allow for real time estimation of use within communities and can complement traditional survey studies used to measure use and the impact of policy. Expanding the number of tools that enhance the flexibility and diversity of data systems creates more opportunities for accuracy in understanding substance use in the United States and can have a profound impact on buy-in from stakeholders in contributing to data submission and policy responses.

Access to Data

Sharing public health data and analytic information is critical for developing comprehensive policies and programs to address substance use. Sharing law enforcement data and analyses is important for developing comprehensive policies and programs to reduce the threats posed by the production and distribution of dangerous drugs. Public health and public safety agencies often face legal and policy obstacles for sharing data within their own divisions, much less across public health and public safety agencies. Moving forward, the Nation will benefit from an effort to review the potential for sharing and combining data systems to better inform coordinated policies to address current and future challenges at the Federal, state, local, and tribal level. The Nation also will benefit from a review of current policies and practices that limit public access to data systems in order to improve transparency and ultimately increase the public's understanding and input into future strategies. This process will require attention to both legal and privacy issues that arise from sharing data across agencies as well as attention to infrastructure needs to support the efficient sharing and use of data from these systems.

Policy Focus: Drugged Driving

The National Roadside Survey has been conducted voluntarily five times since 1973 on drivers on the Nation's roads from across the country. In 2007, the National Roadside Survey estimated the use by drivers of illicit drugs and potentially impairing medications for the first time. Previous surveys had only estimated the prevalence of alcohol use among drivers.[1] The latest version of the Roadside Survey found the number of drivers with alcohol in their system had declined by nearly one-third since 2007 and by more than three-quarters since the first Roadside Survey in 1973. While drunk driving is down, there has been a large increase in the number of drivers using marijuana or other illegal drugs. Marijuana is the most frequently detected drug (other than alcohol) in crash-involved drivers.[2] In the 2014 survey, nearly one in four drivers tested positive for at least one drug that could affect safety. The number of weekend nighttime drivers with drugs in their system was 20 percent in 2015, and the number of drivers with marijuana in their system grew by nearly 50 percent compared with the 2007 survey results.[3]

According to MTF, 11.3 percent of high school seniors reported driving after smoking marijuana within two weeks of their interview. Since 2009, more high school seniors reported driving after smoking marijuana than driving after drinking alcohol.[4] A recent meta-analysis of studies looking at marijuana-involved roadside traffic crashes (RTC) raises questions about earlier research findings that found no difference or moderate increased risk in the odds of crash involvement due to marijuana intoxication. First, most studies do not investigate the relationship between RTC's and acute intoxication because the timing of the retrieval of samples was such that only presence of cannabinoids could be assessed and not the level that existed at the time of driving. Second, several of the studies did use the same or equivalent definitions of exposure for cases and controls which may create a bias in the estimates. These limitations may lead to a bias that there is a lower risk of being involved in an RTC while acutely intoxicated than currently supported.[5] Additional research with updated methodologies would help inform strategies to address marijuana use, marijuana intoxication, and driving.

The 2010 *National Drug Control Strategy* set a goal of reducing drugged driving in America by 10 percent by 2015. It has been a focus of the Administration, in collaboration with state and local governments, nongovernmental organizations, and Federal partners, to meet the President's goal and keep more Americans safe on our country's roadways. There are four key focus areas with regard to reducing drugged driving: increased public awareness; enhanced legal reforms to get drugged drivers off the road; advancing technology for drug tests and data collection; and increasing law enforcement's ability to identify drugged drivers.

Accomplishments

Collaboration across the interagency is imperative to reduce the number of drugged drivers on our roads and to ensure more public awareness of the dangers of drugged driving. In January 2016, the National Transportation Safety Board (NTSB) announced that ending substance-impaired driving would remain one of its top 10 "Most Wanted" transportation advocacy goals for the year. Impaired driving has appeared on the NTSB's "Most Wanted" list since 2013. The Board will focus on all modes of transportation that can be impaired, including flight.

The year 2015 was the sixth year President Obama declared December "National Impaired Driving Prevention Month." During December, ONDCP, NTSB, and NHTSA principals partnered to write a comprehensive blog about the importance of not driving after using drugs or alcohol. The blog was posted and shared by all three agencies. In 2015, the President encouraged drivers to promote road safety and avoid all forms of impaired driving: "No person should suffer the tragedy of losing someone as a result of drunk, drugged, or distracted driving, but for far too long the danger of impaired driving has robbed people of the comfort of knowing that when a loved one leaves home they will return safely. Impaired driving puts drivers, passengers, and pedestrians at risk, and each year it claims the lives of thousands of Americans. During National Impaired Driving Prevention Month, we recommit to preventing these incidents by acting responsibly and by promoting responsible behavior by those around us. Together, we can enhance public safety and work to ensure a happy, healthy life for all our people."[6]

Over the past six years, the Administration has hosted events, coordinated interagency engagement, issued joint statements with other Administration leaders, and utilized social media to discuss drugged driving. In 2014, ONDCP joined more than 30 national partners for a Twitter chat focused on awareness and prevention of drugged driving.

In October 2011, the Administration convened a drugged driving summit with stakeholders from prevention, youth-serving, and safety organizations, automobile and insurance industry representatives, and Federal agencies. At the summit, Mothers Against Drunk Driving (MADD) and the Administration announced a partnership to raise awareness of the consequences of drugged driving, and to support the victims of poly-substance use (both alcohol and drugs) and drugged driving. In 2015, MADD revised its mission statement to read "MADD's mission is to end drunk driving, help fight drugged driving, support the victims of these violent crimes and prevent underage drinking."[7] Current MADD National President Colleen Sheehey-Church has suffered personally from poly-use driving. Her 18-year-old son died in a car driven by a teen with alcohol and drugs in her system.

ONDCP has continued to focus on providing law enforcement with tools that improve their ability to identify drugged drivers on the road. The online Advanced Roadside Impaired Driving Enforcement (ARIDE) program is a free tool that the NHTSA, in partnership with ONDCP, developed in August 2013. To date, more than 1,814 law enforcement officers and prosecutors have enrolled in the online ARIDE training to learn more about impaired driving through the virtual training course. ONDCP promoted the ARIDE program to law enforcement partners – including the International Association of Chiefs of Police, National Association of Police Organizations, DOJ's Community Oriented Policing Services Office, National Alliance of State Drug Enforcement Agencies, Fraternal Order of Police, National Criminal Justice Association, and HIDTA DHE program – who delivered targeted information about the program to law enforcement communities of interest and other stakeholders.

ONDCP has been focused on youth drugged driving education. In 2014, Director Michael Botticelli met with NTSB Chairman Christopher Hart, NHTSA leadership, researchers, and youth-serving organizations in Columbus, Ohio, for a one-day RADD-ONDCP Ohio Teen DUID Summit to review data and prevention messaging. The Drugged Driving Toolkit,[8] created by ONDCP, has been shared with thousands of parents and community leaders to encourage dialogue about the dangers of impaired driving.

Opportunities for the Future

ONDCP supports the development of guidelines on toxicology laboratory standards for detecting drugs in oral fluids to make on-site drug screening by law enforcement possible and to enhance how drug testing is carried out in the workplace. SAMHSA has proposed final oral fluid testing guidelines.

More research needs to be done regarding the impact of drug use on driving and the cognitive skills needed to operate a motor vehicle. The National Institute of Drug Abuse, with support from ONDCP and NHTSA, conducted a 2014 study to show how marijuana and marijuana with alcohol impacts driving. Using a driving simulator, researchers concluded that drivers who used alcohol and marijuana together were more likely to weave in and out of the driving lane than drivers who used either substance independently.[9] This is the first study of the effects of inhaled vaporized marijuana on driving; more analysis is needed to fully understand how different blood concentrations of THC, the main active ingredient of marijuana, impact driving ability. More recent research points to the challenges in assessing the level of marijuana intoxication due to variability in rates of individual decreases in concentration and the time between use and collection of the sample.[10]

Policy Focus: Preventing and Addressing Prescription Opioid Misuse and Heroin Use

With the release of the inaugural *National Drug Control Strategy* (*Strategy*) in 2010, the non-medical use of prescription drugs and the consequences of their use, particularly prescription pain medications, were recognized by this Administration as a significant and growing problem in the United States. Data from the 2009 NSDUH showed non-medical use of prescription drugs was the second most used illicit substance in America with 2.8 percent of Americans reporting past month use. People who used prescription pain medications non-medically made up the largest proportion of those who misused prescription drugs (76%).[1]

However, misuse of prescription pain medications has been declining. Data from the 2014 NSDUH shows that between 2009 and 2014, there was an 11 percent decrease (2.8% to 2.5%) in non-medical use of prescription drugs overall, and an even larger decrease (24%) in the non-medical use of prescription pain medications (2.1 %to 1.6%).[2] Additionally, there was a 35 percent decline in the number of individuals initiating non-medical use of prescription pain medications. [3]

According to the CDC, approximately 129 Americans on average died from a drug overdose every day in 2014, including 78 per day from opioids.* Of the 47,055 drug overdose deaths in 2014, heroin was involved in 10,574 drug overdose deaths, while natural and semi-synthetic opioids, the most commonly prescribed opioid analgesics, and methadone were involved in 14,838 drug overdose deaths.[4] Additionally, 5,544 drug overdose deaths involved synthetic opioids other than methadone, which includes both illicitly-manufactured and pharmaceutical fentanyl. This number has more than doubled from two years earlier (2,628 in 2012).

There was a significant increase in 2014 in the number of current heroin users aged 12 and older compared to 2013 (from 289,000 to 435,000 individuals).[5] And, although there is evidence some people who use prescription pain medications non-medically have initiated heroin use, it remains only a small percentage of this population. Figure 1 illustrates a recent SAMHSA study finding that only 3.6 percent (approximately 360,000 of more than 10 million) of individuals who non-medically used prescription pain medications initiated heroin use within the 5-year period following their first non-medical use of prescription pain medications.[6]

Between 2000 and 2014, the rate of drug overdose deaths rose 137 percent; and the rate of drug overdose deaths involving opioids (including prescription pain medications and heroin) rose by 200 percent and accounted for 61 percent (28,647) of all drug overdose deaths.[7] These deaths are a part of a 15 year trajectory of increasing opioid overdose deaths that began with nonmedical use of prescription pain medications, and recently punctuated by a surge in deaths involving heroin, and illicit, lab-created fentanyl and its analogs.[8]

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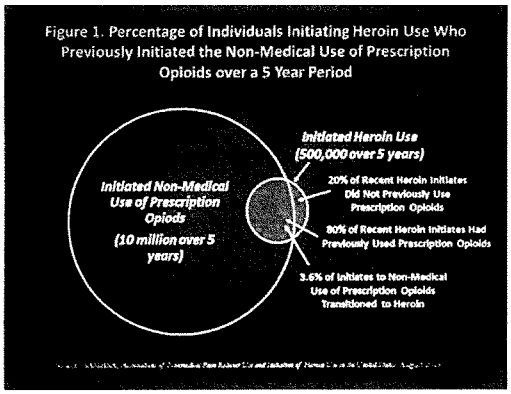
*Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death, 1999-2014 on CDC WONDER Online Database, released 2015. Extracted by ONDCP from http://wonder.cdc.gov/mcd-icd10.html on December 9, 2015.



The significant rise in the availability, acceptability, and use of opioids and the devastating consequences on communities across the United States including overburdened emergency departments, opioid overdoses, increasing numbers of infants born with neonatal abstinence syndrome, and overdose deaths. The complexity of this crisis creates special challenges for Federal, state, tribal, state, local and non-governmental partners who must confront the growing negative impacts of opioid use on communities while safeguarding the role of some of these medications in relieving pain and reducing human suffering.[9] Because this crisis, in large part, concerns federally regulated products, it demands a comprehensive response from Federal leadership. In this context, ONDCP and Federal partners formulated an initial coordinated Prescription Drug Abuse Prevention Plan (Plan) to address the non-medical use of prescription drugs. Titled, *Epidemic: Responding to America's Prescription Drug Abuse Crisis,*[10] the Plan balances the need to ensure patient access to prescription opioids to treat chronic and acute pain, while minimizing nonmedical use and misuse of these potent, addictive medications.

The Plan contains the following four pillars to address the opioid medication misuse crisis:

1. **Education.** Educating the public and healthcare providers to increase awareness about the dangers of prescription drug misuse, and about the ways to appropriately dispense, store, and dispose of controlled substance medications.
2. **Tracking and Monitoring.** Enhancing and increasing the use of prescription drug monitoring programs (PDMPs) to provide opportunities for early intervention and detect therapeutic duplication and drug-drug interactions.
3. **Proper Medication Disposal.** Developing consumer-friendly and environmentally-responsible prescription drug disposal programs can help limit the diversion of drugs, as most people who use these drugs non-medically obtain prescription pain medications from family and friends.

4. **Enforcement.** Providing law enforcement agencies with the support and tools they need to expand their efforts to shut down "pill mills" and decrease diversion.

Since 2011, the Plan emphasized the need for patients and families to receive evidence based treatment for an SUD and for first responders to be equipped with naloxone, an opioid overdose reversal drug. The remainder of this chapter discusses accomplishments across these areas and remaining challenges to be addressed.

Accomplishments

The Nation has made substantial progress in implementing the four pillars of the Prescription Drug Prevention Plan. Additionally, the Nation has made advances in other policy areas targeting the opioid crisis, including addressing perinatal withdrawal, investing in strategies to reduce the burden of pain without necessarily resorting to prescription pain relievers, slowing the increase in opioid overdose deaths, and expanding access to medication-assisted treatment (MAT), and developing an action plan to address the resurgence of heroin use across the Nation. Accomplishments in each of these areas are discussed below.

Prescription Drug Prevention Plan

In 2011, the ONDCP released *Epidemic: Responding to America's Prescription Drug Abuse Crisis* which expanded on the Administration's *National Drug Control Strategy* and included action in four major areas: Education, enhancing and increasing use of prescription drug abuse monitoring programs, developing consumer friendly and environmentally-responsible drug disposal programs, and providing law enforcement agencies with the support and tools necessary to shut down "pill mills" and stop "doctor shoppers." Progress on this plan is highlighted below.

Education

Federal, state, local and non-governmental partners have worked together on a number of initiatives to educate the Nation about the risks of non-medical use of prescription pain medications. These efforts include providing training and resources for community-based providers through the DFC and HIDTA programs. A number of initiatives have been implemented to enhance prescriber skills in terms of pain management, helping patients learn to use opioids safely, identifying an emerging or existing SUD, and providing or connecting patients with an SUD to treatment.

In October 2015, the White House announced a commitment by medical organizations to train 540,000 controlled substance providers on these practices. To date, almost 280,080 providers have been trained with updated standards on pain management and opioid prescribing. Medical schools and the Addiction Medicine Foundation have committed to expand substance use education in medical school curricula and create fellowship positions to offer advance training in primary care and pediatric programs.

In March 2016, the CDC released the *CDC Guideline for Prescribing Opioids for Chronic Pain*[11] *(Guideline).* The *Guideline* equips primary healthcare providers with information and recommendations to improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including OUD, overdose, and death.

A 2015 Presidential Memorandum required Federal agencies to provide training on the appropriate and effective prescribing of opioid medications to all employees who are health care professionals and prescribe controlled substances as part of their Federal responsibilities and duties.[12] These mechanisms are currently in place and more than 52 percent of Federal providers across the DoD, VA, BOP, NIH, and the IHS have completed this training. .

In, September of 2016, ED Secretary King issued an open letter to the education sector on Supporting Students to Prevent Substance Use and Substance Use Disorders that highlighted how educational organizations could help to prevent and reduce drug use among the Nation's students in K-12 and colleges and universities. This letter also provided a number of Federal resources that are available to educators and parents.[13]

Prescription Drug Monitoring Programs

There have been significant advances in implementing PDMPs, 49 states and Washington, D.C. now have operational PDMPs. PDMPs help providers understand their patients' medication histories, as well as problematic behaviors that signal a need for more in-depth conversations about pain and substance use. The Bureau of Justice Assistance (BJA) supported PDMP expansion grants in 11 states in 2015. ONC, SAMHSA, and CDC all have funded research and standards development for PDMP improvements. The IHS, DoD, and VA have piloted the integration of PDMP systems within their electronic health records systems. In July 2016, both VA and IHS announced new policies that require prescribers to check the PDMP prior to making a decision to prescribe controlled medications.

Historically, the ability of states to share data has been limited, but agencies are currently involved in efforts to enhance the interoperability of state PDMPs. At the time of this writing, two electronic data sharing hubs are operational, enabling 43 states to work through one or both to share PDMP data with at least one other state. Funding from BJA and DoD has been used to enhance this interstate data sharing.

PDMPs are only one approach to monitoring. The DoD, VA, and CMS all have initiated drug utilization review programs for some of their patient populations to better coordinate care for individuals who are prescribed opioid medications. Many hospitals administer patient surveys to determine whether their pain was managed adequately. CMS has proposed new questions for these surveys that avoid the perception that performance is linked to prescribing opioid medications for pain control.[14]

Storage and Disposal of Excess Prescription Medications

In September 2014, the DEA issued a new rule governing the secure disposal of controlled substances. Regulations promulgated through this rule helped implement the Responsible Drug Disposal Act of 2010, which expands options to collect unused controlled substances, and allows for expanded "take-back" events, mail-back programs, and the placement of collection receptacles at police departments, pharmacies, and some hospitals with on-site pharmacies. The rule also permits disposal via drug deactivation products, as long as the medications are rendered "non-retrievable." These systems may be helpful where incineration is not available or collection boxes are not within easy driving distance.

Federal agencies have taken actions to safely dispose of expired, unneeded and unwanted prescription pain medications. In April 2016, DEA held its 11th National Prescription Drug Take Back Day. DEA collected a record 447 tons of unwanted prescription drugs from 5,359 community sites.[15] As of

October 2016, more than 6.4 million pounds of prescription drugs have been collected by DEA through this initiative.[16] Additionally, the VA has installed medication disposal receptacles at over 70 locations, and mail-back envelopes are available at all VA facilities. As of August 1, 2016, approximately 38,700 pounds, almost 19 tons, of prescription pain medications have been collected by VA and destroyed in an environmentally responsible manner.[17] However, though safe disposal programs have helped reduce the amount of prescription pain medications that can be diverted for misuse, a recent review suggests that the evidence of these types of initiatives on health outcomes is weak.[18]A number of private companies and other organizations have also elevated the disposal issue. In February 2016, for example, Walgreens Pharmacy announced its intent to provide 500 disposal receptacles in 39 states by the end of 2016; and CVS Pharmacy made donations of drop boxes to local law enforcement. Additionally, the National Community Pharmacists Association reports more than 1,400 independent pharmacies engaged in disposal activities across the United States.[19]

Local governments have found it challenging to identify financial support for disposal programs. In response, Alameda County, California, and King County, Washington, have passed product stewardship laws that require prescription drug manufacturers to develop and pay for county prescription drug disposal programs.

Enhancing Existing Laws and Supporting Enforcement

DEA has deployed an innovative approach that combines public health and public safety strategies to address the opioid epidemic. The DEA *360 Strategy* coordinates law enforcement operations that target drug trafficking organizations and violent gangs distributing drugs in our Nation's communities, but DEA also engages drug manufacturers, wholesalers, practitioners, and pharmacists to limit the diversion of prescription pain medications by increasing awareness of the opioid epidemic and its consequences. There is also outreach and partnership with local organizations to provide communities with the skills and resources necessary to continue to address the consequences of the opioid epidemic.

DEA agents and investigators also are integrating with other Federal, state, tribal and local law enforcement officers in 66 Tactical Diversion Squads across 41 states, Puerto Rico, and the District of Columbia. As DEA has worked to expand partnerships across public health and public safety agencies, it has continued enforcement efforts to crack down on "pill mills" and doctor shopping; and is working to thwart individuals who use the internet to illegally sell and purchase controlled substances.

The HIDTA Heroin Response Strategy is a multi-state effort to coordinate anti-heroin activities by taking a balanced public health and public safety approach. This effort enhances intelligence sharing, increases development of effective enforcement strategies and operations, and maximizes resources and minimizes the supply of heroin and diverted prescription pain medications in designated areas. Through this strategy, a collaborative network of public health-public safety partnerships is being fostered to identify new innovative practices to address the heroin epidemic more effectively. The HIDTA Heroin Response Strategy currently encompasses 8 regional HIDTA programs in 20 states and the District of Columbia.

In 2015 DOJ and ONDCP also co-lead a Heroin Task Force comprised of experts from Federal agencies engaged in domestic public health and public safety responses to the opioid crisis. DOJ released their report to congress on December 31, 2015.

Addressing Perinatal Withdrawal

In 2012, a study found that the number of newborns with withdrawal from opioid exposure (neonatal abstinence syndrome, or NAS) appeared to be growing as the opioid epidemic expanded. Recent research suggest that there is a five-fold increase in NAS since 2000.[20] Many communities faced knowledge gaps and demanded improved care for opioid-exposed mothers and infants. ONDCP held a leadership meeting with various stakeholders, including the March of Dimes, American College of Obstetricians and Gynecologists, and American Academy of Pediatrics. Later that year, Congress passed, and President Obama signed the bipartisan *Protecting our Infants Act (Act)* which promotes additional research on treatment for women and infants exposed to drugs during pregnancy, and requires CDC to track trends in prevalence of the condition over time.

Transforming Pain Management

In 2016, the NIH released the *National Pain Strategy*, the aim of which is to decrease the prevalence of pain across the continuum from acute to high-impact chronic pain and associated morbidity and mortality. The report addresses six key areas including:

- population research
- prevention and care
- disparities
- service delivery and payment
- professional education and training
- public education and communication

Taking a lifespan perspective, the *National Pain Strategy* is part of a long-term effort seeking to transform the way pain is perceived, assessed, and treated across the Nation, which would be a significant step toward what the report highlights as the ideal state of pain care. [21,22]

Preventing Opioid Morbidity and Mortality

This Administration supports the use of naloxone to reverse the effects of opioid overdose. In 2001, New Mexico became the first state to expand access to naloxone, allowing health care professionals to prescribe naloxone to lay persons, and for lay persons to administer naloxone, without being subject to civil liability or criminal prosecution. Since then, overdose prevention laws have expanded dramatically, with most being passed since 2012. As of December 2015, a majority of states have enacted statutes that expand access to naloxone or provide "Good Samaritan" protections for possession of a controlled substance if emergency assistance is sought for a victim of an opioid overdose.[23]

Federal, state, tribal, and local agencies and stakeholders across the country have increased the availability and use of naloxone. Today, hundreds of law enforcement agencies equip and train officers to administer this life-saving medication. At the Federal level there have been a number of initiatives to expand access to naloxone:

- DoD is working to ensure that opioid overdose-reversal kits and training are available to all first responders on military facilities;

- The IHS and BIA are collaborating to reduce opioid overdoses among American Indians and Alaskan Natives. Beginning in 2016, 90 IHS-funded pharmacies will dispense naloxone and train 500 officers from the BIA Office of Justice Services to administer this drug to individuals experiencing an opioid overdose;
- VA has provided more than 45,000 naloxone kits from when it began piloting its VA Opioid Overdose Education and Naloxone Distribution Initiative in 2013 in Cleveland, Ohio and rolled out nationally in May of 2014. Over 39,000 Veterans had received a kit by the end of September, 2016;
- In 2016, SAMHSA provided additional funding to increase access to naloxone across the Nation which will allow states to purchase naloxone and train and equip first responders;
- The FDA has used its fast-track and priority review systems to approve an easy-to-administer nasal spray version of naloxone that was developed through partnerships with NIDA to apply new technology to interventions for opioid overdose;
- USDA announced $1.4 million in funding for its rural Health and Safety Education grants program to develop projects that work to educate the public about overdose and opioid use.[24] Additionally, since 2009, USDA Rural Development has provided more than $213 million in grants for 634 Distance Learning and Telemedicine projects in rural areas nationwide, many providing mental health treatment; and
- NIDA is funding implementation science to understand how to best implement naloxone distribution programs.

In FY 2016, SAMHSA released two new grant programs to address the ongoing epidemic of prescription drug and opioid misuse: Grants to Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO) and the Strategic Prevention Framework for Prescription Drugs (SPF Rx). PDO is the first grant program in the Center for Substance Abuse Prevention (CSAP) that will allow grantees to purchase naloxone in a fashion that is tailored to meet the specific needs of their communities. The purpose of this program is to reduce the number of opioid-related overdose deaths and adverse events among individuals 18 years of age and older through the use of SAMHSA's Opioid Overdose Prevention Toolkit. The program will educate key community sectors and implement secondary prevention strategies such as the distribution of naloxone. SAMHSA's Toolkit and other resources will be utilized to help grantees develop a comprehensive prevention program that educates the public about the dangers of sharing medications, raises awareness among pharmaceutical and medical communities on the risks of overprescribing, and implement overdose death prevention strategies. SAMHSA funded 12 PDO grant applications. The SPF Rx grant program is designed to assist grantees in developing capacity and expertise in the use of data from state run prescription drug monitoring programs (PDMP). SAMHSA funded 25 SPF-Rx grant applications.

Preventing overdose deaths has been a central component of the Administration's efforts to mitigate the consequences of opioid use. However, the Nation also faces continuing challenges, such as outbreaks of blood-borne infections like HIV and hepatitis that stem from intravenous drug use and sharing injection equipment, engaging in risky sexual behavior, and non-compliance with medication regimens. In December 2015, the President signed the Consolidated Appropriations Act, 2016 which modifies restrictions on the use of Federal funds for programs that distribute sterile needles and syringes. HHS issued guidelines in 2016 allowing syringe services programs (SSP) to use Federal funds, other than for the purchase of syringes or needles and where there is a demonstrated need, such as significant increases in hepatitis infections or HIV outbreaks. See the accompanying text box on injection drug use and blood-borne infections for additional information on this topic.

Medication-Assisted Treatments

In 2015, HHS announced an initiative aimed at reducing prescription pain medication and heroin overdose, death, and dependence. The Initiative targets three priority areas: (1) providing training and educational resources to assist health professionals in making informed decisions regarding the prescribing of opioids;[25] (2) expanding the use of naloxone to reduce the number of preventable deaths resulting from prescription and illicit opioid overdoses, including heroin and fentanyl; and (3) expanding the use of MAT combined with counseling and behavioral therapies to treat OUDs

As part of this initiative, HHS finalize a rule to raise the buprenorphine patient cap to increase patient access to MAT. Buprenorphine is an opioid medication used to treat OUDs in the privacy of a physician's office. Released in July 2016, the final rule qualified physicians with advanced credentialing and those working in settings that provide high-quality care, the ability to treat up to 275 patients and expands access in emergency situations, such as disasters, epidemics, or incapacitation of the physician in underserved communities. HHS estimates that within the first year of the rule change, 10,000 to 90,000 additional people will gain access to MAT; and an additional 2,000 to 15,000 patients in each subsequent year.[26] SAMHSA is also developing guidance on MAT for pregnant and post-partum women that will be released in 2016.

The HRSA has provided funding to expand SUD services, hire mental health professionals, and invest in integrated models of primary care. Additionally, in 2013, the DoD removed the ban on using MAT to treat OUD. The DoD and VA have also been working with SAMHSA to implement training programs and increase the number of providers that can prescribe buprenorphine.

The President's FY 2017 budget proposed $1.1 billion to address the opioid epidemic and help all Americans who want treatment for their OUD get the help they need Within this amount proposed for DOJ and HHS to continue and build on efforts to expand state-level overdose prevention strategies, increase the availability of MAT services and fund implementation research to integrate MAT practices, make naloxone more available, including nasal naloxone, develop population-level guidance to manage pain, and support targeted enforcement activities. In December 2016, the President signed the 21st Century Cures Act which included $500 million in FY2017 for States to fund expanded prevention and treatment for OUD.

On June 17, 2016, ONDCP, in collaboration with BJA and the National Institute of Corrections (NIC) convened a meeting titled, *Medication-Assisted Treatment for Justice Involved Populations.* This meeting brought together leaders from the corrections field, various national associations (National Sheriffs Association, American Correctional Association, American Jail Association, American Probation and Parole Association, National Association of Counties, and National Association of Drug Court Professionals), research and policy practitioners (the Urban Institute, the Community Oriented Correctional Health Services, the Vera Institute of Justice, and the PEW Charitable Trusts), and Federal agencies (SAMHSA, CMS, HRSA, and IHS) to discuss opportunities and challenges in expanding the use of MAT for justice–involved populations.

Injection Drug Use and Blood-Borne Infections

People who inject drugs are at greater risk for acquiring and transmitting blood-borne viral infections, such as HIV, hepatitis B (HBV), and hepatitis C (HCV).[i] ONDCP and our federal partners have worked to align the *National Drug Control Strategy*, the National HIV/AIDS Strategy and Action Plan, and the National Hepatitis Action Plan to ensure the best care and treatment for people with opioid use disorders who engage in injection drug use, or its past effects.

As a result of the opioid epidemic, the connection between injection drug use and blood-borne infections has become more pronounced. The number of reported acute cases of HCV infection has increased since 2010,[ii] and a 2015 HCV and HIV outbreak in southeastern Indiana was linked to injection of the prescription opioid oxymorphone.[iii] To date, 191 persons have been diagnosed with HIV as a result of the Indiana outbreak;[iii] and 93 percent were co-infected with hepatitis C.[iii] And this was in a community of only 4,200 people.[ii]

Evidence-based strategies and integrated-service provisions are needed to comprehensively address the intersection of opioid use disorder, and HIV, HBV, and HCV infection. Individuals that are at high risk of acquiring and transmitting blood-borne viral infections may engage syringe service programs (SSP) that are linked to health care centers, drug treatment programs, and other facilities that promote education and vaccination for hepatitis.[iv,v] In addition to receiving sterile needles and injection equipment (e.g., alcohol swabs, vials of sterile water or "works"), and access to treatment, some syringe service programs offer basic health care services and provide naloxone. Research indicates that SSPs can positively impact HIV and HCV incidence and prevalence rates and reduce injection-related risk behaviors.[vi,vii]

Syringe exchange or possession of syringes is illegal in many states, and in states where these programs are legal, funding these programs can be challenging. On December 18, 2015, President Obama signed the Consolidated Appropriations Act of 2016 which modified the restriction on use of Federal funds for programs distributing sterile needles or syringes.[viii] A provision in the Act now allows Federal funds to be used by state or local health departments, where legal, to support syringe access in areas with demonstrated need (i.e. currently experiencing, or at risk of increases in hepatitis or HIV outbreaks due to injection drug use).[ix] Federal agencies (HHS,[xi] CDC,[xii] SAMHSA,[xiii] and HRSA[xiv]) have released guidance on how to establish eligibility for Federal funding. Health Departments interested in starting new syringe service programs should first contact CDC for a determination of eligibility, and then follow agency guidance on applying for funding or repurposing existing funds as permitted.[xv]

Individuals with an opioid use disorder who inject drugs may also take a daily medicine that prevents the contraction of HIV (Pre-exposure Prophylaxis or PrEP).[xvi] CDC recommends PrEP for anyone who has injected drugs in the past 6 months and has shared needles or who has been in drug treatment. Additionally, Hepatitis C can now be cured using a number of new medicines, VA policy offers Veterans with Hepatitis high quality care and appropriate treatment and their policy states that ongoing substance use or participation in opioid use disorder treatment should not exclude people from treatment. Additionally VA's policy strongly discourages using length of abstinence as a way to disqualify patients from treatment.[xvi]

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Compelling information showed that providing MAT and recovery support services to justice-involved populations reduced recidivism and realized cost-savings for institutions. This highlighted the need for greater adoption of MAT in the correctional setting. Additionally, NIC Director James Cosby announced the creation of a new behavioral health program that will establish 10 Centers of Excellence to expand access to MAT for justice-involved individuals with OUD.

National Heroin Coordination Group

Several factors contribute to the current nationwide heroin crisis: the increased availability of heroin in the US market,[27] the availability of purer forms of heroin that allow for non-intravenous use,[28] its relatively low price,[29] and individuals transitioning from the non-medical use of prescription drugs to heroin.[30] Heroin use has spread into suburban and rural communities and is growing among most socioeconomic classes, age groups, and races.[31]

The United States typically addresses the heroin threat as a global issue. However, Mexico is currently the primary supplier of heroin to the United States, with Mexican drug traffickers producing heroin in Mexico and smuggling the finished product into the United States.[32] Opium poppy cultivation in Mexico has increased substantially in recent years, rising from 17,000 hectares in 2014, with an estimated potential pure heroin production of 42 metric tons, to 28,000 hectares in 2015 with potential production of 70 metric tons of pure heroin.[33]

The heroin crisis is being compounded by the reemergence of fentanyl, a powerful Schedule II synthetic opioid analgesic more potent than morphine or heroin.[34] Fentanyl is sometimes mixed with powder heroin to increase its effects or mixed with diluents and sold as "synthetic heroin," with or without the buyers' knowledge.[35] Fentanyl used for illicit purposes comes from several sources including pharmaceutical fentanyl diverted from legal medical use, which accounts for a small percentage of the fentanyl in the illicit market, and clandestine fentanyl that is manufactured in Mexico or China and smuggled into the United States through a variety of means.[36] Fentanyl is extremely dangerous and deadly. Between 2013 and 2014, at least 700 deaths in the United States were attributed to fentanyl and its analogues, [37] although the actual number is likely higher.

The dramatic increase in the availability and use of heroin and fentanyl is a national security, law enforcement, and public health issue, and it has become the highest priority illicit drug threat to the Nation. [38]

Departments and agencies, in consultation with the National Security Council (NSC) staff, agreed with the establishment of the National Heroin Coordination Group (NHCG) within ONDCP to act as the hub of a network of colleagues and partnerships across the interagency who can leverage their home agency authorities and resources to disrupt the heroin and fentanyl supply chain coming into the United States. This NHCG was established in 2015. One of its primary responsibilities has been the development of a Heroin Availability Reduction Plan (HARP). This task has been coordinated closely with the IPC and NSC and lays out actions, goals, and measures to provide a roadmap to guide and synchronize interagency activities to reduce the supply of heroin in the US market. The NHCG is responsible to the Director of National Drug Control Policy for overseeing the implementation of the HARP and ensuring that its activities are coordinated across the drug control agencies and all internal ONDCP components.

The HARP is a five-year plan, partitioned into six-month time periods, focused on the following strategic end state: *a significant reduction in the number of heroin-involved deaths in the United States due to a*

disruption in the heroin and fentanyl supply chains, a detectable decrease in the availability of those drugs in the US market, and the complementary effects of international engagement, law enforcement, and public health efforts.

The HARP is not a separate, stand-alone plan divorced from the many existing strategies, plans, and activities focused on addressing the heroin epidemic. Rather, it is a strategic plan designed to bring together, contextualize, and synchronize the strategies and partnerships currently taking place at the Federal, state, local, and tribal levels to reduce availability of heroin and fentanyl. The range of demand reduction efforts, while not explicitly addressed in this plan, is a critical element of achieving the HARP's strategic end state and are included in the HARP's measures of effectiveness. This single plan provides the Director of National Drug Control Policy and the NSC staff awareness of the full array of U.S. activities related to the heroin and fentanyl problem set including international engagement, interdiction, law enforcement, and intelligence, and their effects on heroin and fentanyl availability and demand within the United States. This enables them to establish necessary policies, priorities, and objectives, and ensures that the drug control agencies and interagency partners are adequately aligned and resourced to implement their efforts to combat the consequences of the growing supply and use of heroin and fentanyl in the United States.

The HARP focuses on effects and not simply performance. In a singular fashion, the HARP identifies the efforts currently underway to address the heroin and fentanyl supply chain, the current demand within the United States driving that supply, and the complementary effects of supply reduction efforts on the availability of heroin and fentanyl within the Nation's communities.

This plan deliberately conflates heroin and fentanyl into a single problem set. Addressing both heroin and fentanyl in a singular fashion is intended to minimize the chance of accelerating the growth of exclusive fentanyl use by addressing it as part of the larger heroin problem.

The HARP is organized along two complementary primary lines of effort, each with supporting lines of effort. This allows for the clear identification of redundancies, gaps, and those particular activities that show the greatest potential for complementary effects among both primary lines of effort.

The Supply Chain Disruption primary line of effort includes supporting lines of effort on cultivation and production; precursor chemicals; fentanyl and other adulterants; intra-national movement; international movement; and domestic movement, distribution, and sale.

The Detection and Intelligence primary line of effort has supporting lines of effort to address international drug trafficking organizations (DTOs); domestic DTOs; cultivation and production; intra-national movement; international movement; and domestic movement, distribution, and sale.

The Nation's heroin and fentanyl availability reduction effort is altering the dynamics of the heroin and fentanyl supply chains and their markets in the United States, and some of these changes could bring negative results. Identifying the risks associated with the HARP's success was a crucial part of planning, and developing the mechanisms to detect emerging trends, along with mitigating measures, is a key component of HARP implementation. There is a risk that the increased application of effort toward the heroin and fentanyl issue may threaten the hard-earned gains we have made in cocaine availability and use within the United States. Moreover, an exclusive focus on Mexican heroin and fentanyl coming across the southwest border of the United States risks opening the door for those drugs produced in other areas of the world and trafficked by different organizations to flow into the United States through other means. Finally, any comprehensive effort to reduce the supply of heroin into the United States from Mexico should include collaboration with the Mexican government to

increase manual poppy eradication and the destruction of production laboratories by Mexican security forces. An increase in manual eradication and lab neutralization efforts may lead DTOs to conduct increased violence against Mexican security forces attempting eradication and neutralization, making these already cumbersome and force-intensive missions even more dangerous.

The implementation of the HARP involves several discrete efforts which include the development of information requirements and Key Intelligence Questions (KIQs), as well as the synchronization of intelligence collection, analysis and information gathering efforts, developing and monitoring measures of effectiveness, executing the mechanisms agreed to by the IPC for interagency collaboration and information sharing necessary to implement the plan, and updating the Director of National Drug Control Policy and NSC staff on the plan's progress.

Opportunities for the Future

Despite the many accomplishments over the past seven years, there is still much to be done. Reducing the availability and use of heroin and illicitly produced synthetic opioids, like fentanyl remains a critical priority. The NHCG will continue its work to address this challenge. In addition, efforts to expand the availability and use of naloxone will continue as will work to educate the public and prescribing communities about the dangers of misusing opioid medications, overprescribing, the sharing of medications, proper pain management, and identifying and treating SUD must be bolstered.

Grants made available through SAMHSA will support education efforts and provide for the purchase and distribution of naloxone to communities across the country. Training and education of the entire medical profession must continue, but also coordination with professional groups in psychology, social work, nursing, and counseling to create a consistent standard in terms of education for health care professionals.

Preventing overdose deaths is not enough. It is also important for individuals with SUDs to be moved into treatment. However, the treatment infrastructure has not kept pace with the opioid problem. Research shows that the number of people aged 12 and older reporting heroin use doubled from 2002 to 2014, and the percentage of people with a SUD in 2014 was significantly higher than in 2002.[39] And yet, according to a Federal survey of more than 14,000 U.S. SUD treatment programs, from 2003 to 2013 the percentage of treatment facilities offering Opioid Treatment Programs grew by only 1 percent.[40] Moreover, the vast majority (91%) of the U.S. SUD treatment programs surveyed in 2013 were not SAMHSA–accredited to offer MAT.

The FDA has approved new medicines for treating OUDs, including medicines that can be offered by primary care providers in regular office-based settings. However, the number of providers who have received training for certification to offer MAT with office-based buprenorphine is only at 30,000. Consistent with a 2016 Presidential memorandum, agencies offering health care or health plans are examining policies that present barriers to accessing MAT. Additionally, efforts to address MAT reimbursement issues, as well as payment for alternative pain management treatments to have just begun, and will continue into 2017.

Conclusion

The impact of the Administration's balanced approach in the *Strategy* continues to be felt across the Nation as Federal, state, local and tribal officials and community stakeholders work together to address the challenges of drug use and its consequences. The central guiding principle of the Strategy is that SUDs are a brain disease that can be successfully prevented and treated, and from which people can and do recover and remain vital contributors to their community. In recognition of this understanding, the President's FY 2017 request for $1.1 billion would address the opioid epidemic, with a focus on expanding treatment for OUD. Further, implementation of the ACA and the Parity Act creates the most important expansion of SUD treatment services in decades and provides unprecedented opportunities for the more than 22 million Americans with SUDs to access quality, evidence-informed care.

The Administration also has created additional opportunities for individuals to receive care with trained physicians by expanding the number of patients that a qualified physician can treat with buprenorphine. The *Strategy* has emphasized preventing overdose deaths by expanding resources and training for first responders to deliver naloxone, a lifesaving medication that can reverse the negative effects of excessive opioid use. The Administration also has supported efforts to reduce stigma and advance recovery services for individuals and families.

The Administration remains committed to working with our international partners in Mexico and Central and South America to monitor and reduce the cultivation of opium poppy and coca and the resulting production and distribution of heroin and cocaine. Last year, ONDCP established the NHCG to improve Federal, state, local and tribal efforts to reduce the availability of heroin and illicitly manufactured fentanyl in the United States and the consequences of their use, especially deaths. In 2016, the NHCG developed the *Heroin Availability Reduction Plan* which already has resulted in improved communications among participating agencies and increased situational awareness of heroin- and fentanyl-involved deaths from a network of cooperating medical examiners across the country. With the looming threat of an increase in cocaine availability in the United States, ONDCP has established the National Cocaine Coordination Group to fulfill a similar role with respect to a potential resurgence of cocaine use.

The Administration also is working closely with China to reduce the production and distribution of precursor chemicals used to manufacture a wide range of synthetic drugs, including methamphetamine and fentanyl. In terms of public safety, there has been tremendous progress in domestic efforts to disrupt and dismantle domestic drug trafficking organizations, as well as progress toward integrating public health approaches to implement innovative community models for rebuilding communities following successful law enforcement efforts

Opportunities to build on the last seven years of progress remain. During the final months of this Administration, there will be continued efforts to expand access to treatment across a number of settings, such as primary care practices, community health clinics, and in specialty care programs. The Administration will continue to advance opportunities to provide screening, brief interventions, and referral to quality treatment where individuals are seen for care. Efforts also will continue to expand access to MAT paired with counseling to engage individuals with SUDs, particularly OUDs, in treatment and recovery. The Administration will continue to improve coordination among drug control agencies to address the opioid epidemic and the potential threat of increased cocaine availability. Further, this Administration will continue to use science to drive policies that stress prevention and treatment over incarceration and actively confront the misunderstanding and stigma that create barriers to recovery for millions of Americans.

List of ACRONYMS

ACA	Patient Protection and Affordable Care Act
ADAM	Arrestee Drug Abuse Monitoring
AIDS	Acquired Immunodeficiency Syndrome
ARIDE	Advanced Roadside Impaired Driving Enforcement
ATTC	Addiction Technology Transfer Center
BEST	Border Enforcement Security Task Force
BJA	Bureau of Justice Assistance (U.S. Department of Justice)
BOP	Federal Bureau of Prisons (U.S. Department of Justice)
CBP	U.S. Customs and Border Protection (U.S. Department of Homeland Security)
CBSA	Canadian Border Security Agency
BSI	Caribbean Basin Security Initiative
CDB	Consolidated Counterdrug Data Base
CDC	Centers for Disease Control and Prevention (U.S. Department of Health and Human Services)
CDEWS	Community Drug Early Warning System
CHIP	Children's Health Insurance Program
CHC	Community Health Center
CMS	Centers for Medicare & Medicaid Services (U.S. Department of Health and Human Services)
CND	Commission on Narcotic Drugs
CPG	Clinical Practice Guidelines
CSAP	Center for Substance Abuse Prevention/SAMHSA (U.S. Department of Health and Human Services)
CSAT	Center for Substance Abuse Treatment/SAMHSA (U.S. Department of Health and

	Human Services)
CEWG	Community Epidemiology Working Group
DAWN	Drug Abuse Warning Network
DEA	Drug Enforcement Administration (U.S. Department of Justice)
DFC	Drug Free Communities Support Program
DHS	U.S. Department of Homeland Security
DoD	U.S. Department of Defense
DOJ	U.S. Department of Justice
DOL	U.S. Department of Labor
DOS	U.S. Department of State
DOT	U.S. Department of Transportation
DS4P	Data Segmentation For Privacy
DTO	Drug Trafficking Organizations
ED	U.S. Department of Education
EHR	Electronic Health Record
EPIC	El Paso Intelligence Center
FAFSA	Free Application for Federal Student Aid
FBI	Federal Bureau of Investigation (U.S. Department of Justice)
FDA	Food and Drug Administration (U.S. Department of Health and Human Services)
FDSS	Federal-wide Drug Seizure System
FQHC	Federally Qualified Health Center
HBV	Hepatitis-B
HCV	Hepatitis-C
HHS	U.S. Department of Health and Human Services

HIDTA	High Intensity Drug Trafficking Area
HIT	Health Information Technology
HIV	Human Immunodeficiency Virus
HOPE	Hawaii's Opportunity Probation with Enforcement or Honest Opportunity Probation with Enforcement
HRSA	Health Resources and Services Administration (U.S. Department of Health and Human Services)
HSI	Homeland Security Investigations
HUD	U.S. Department of Housing and Urban Development
ICE	U.S. Immigration and Customs Enforcement (U.S. Department of Homeland Security)
IHS	Indian Health Service (U.S. Department of Health and Human Services)
INCB	International Narcotics Control Board
IRS	Internal Revenue Service
JTF	Joint Task Force
MAT	Medication-Assisted Treatment
MH	Mental Health Disorders
MHPAEA	Mental Health Parity and Addiction Equity Act
MTF	Monitoring the Future
NAS	Neonatal Abstinence Syndrome
NATIVE	Native American Targeted Investigation of Violent Enterprises
NCI	National Cancer Institute
NCHS	National Center for Health Statistics Centers for Disease Control and Prevention (U.S. Department of Health and Human Services)
NDEWS	National Drug Early Warning System
NFLIS	National Forensic Laboratory Information System

NHTSA	National Highway Traffic Safety Administration (U.S. Department of Transportation)
NIAAA	National Institute on Alcohol Abuse and Alcoholism (U.S. Department of Health and Human Services)
NIC	National Institute of Corrections (U.S. Department of Justice)
NIDA	National Institute on Drug Abuse (U.S. Department of Health and Human Services)
NIH	National Institutes of Health (U.S. Department of Health and Human Services)
NIJ	National Institute of Justice (U.S. Department of Justice)
NPS	New Psychoactive Substances
N-SSATS	National Survey of Substance Abuse Treatment Services
NSDUH	National Survey on Drug Use and Health
NVSS	National Vital Statistics System
OAS/CICAD	Organization of American States/Inter-American Drug Abuse Control Commission
OCDETF	Organized Crime Drug Enforcement Task Forces (U.S. Department of Justice)
OFC	OCDETF Fusion Center
ONC	Office of the National Coordinator for Health Information Technology
ONDCP	Office of National Drug Control Policy
PCSS	Physician Clinical Support Center
PDFK	Partnership for Drug Free Kids
PDMP	Prescription Drug Monitoring Program
RCMP	Royal Canadian Mounted Police
RCSO	Recovery Community Service Program
RCO	Recovery Community Organization
REMS	Risk Evaluation and Mitigation Strategy
SADD	Students Against Destructive Decisions

SAMHSA	Substance Abuse and Mental Health Services Administration (U.S. Department of Health and Human Services)
SBA	Small Business Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SEDSS	SAMHSA Emergency Department Surveillance System
SMI	Serious Mental Illness
SSP	Syringe Service Programs
SUD	Substance Use Disorders
TEDS	Treatment Episode Data Set
UNGAS	United Nations Global
UNODC	United Nations Office on Drugs and Crime
USCG	U.S. Coast Guard (U.S. Department of Homeland Security)
USUHS	Uniform Services University of Health Science
USMLE	United States Medical Licensing Exam
USMS	U.S. Marshals Service
VA	U.S. Department of Veterans Affairs

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