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2015 NATIONAL DRUG CONTROL STRATEGY

MESSAGE

FROM

THE PRESIDENT OF THE UNITED STATES

TRANSMITTING

THE ADMINISTRATION'S 2015 NATIONAL DRUG CONTROL STRATEGY, PURSUANT TO 21 U.S.C. 1705; PUB. L. 109–469, SEC. 706(a); (120 STAT. 3513)

NOVEMBER 17, 2015.—Message and accompanying papers referred to the Committees on Energy and Commerce, the Judiciary, Foreign Affairs, Transportation and Infrastructure, Veterans' Affairs, Natural Resources, Armed Services, Homeland Security, Intelligence (Permanent Select), Education and the Workforce, Oversight and Government Reform, Financial Services, Ways and Means, and Agriculture and ordered to be printed

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To the Congress of the United States:

I am pleased to transmit the 2015 National Drug Control Strategy, my Administration's 21st century approach to drug policy that works to reduce illicit drug use and its consequences in the United States. This evidence-based plan, which balances public health and public safety efforts to prevent, treat, and provide recovery from the disease of addiction, seeks to build a healthier, safer, and more prosperous country.

Since the release of my Administration's inaugural National Drug Control Strategy in 2010, we have seen significant progress in addressing challenges we face along the entire spectrum of drug policy—including prevention, early intervention, treatment, recovery support, criminal justice reform, law enforcement, and international cooperation. However, we still face serious drug-related challenges. Illicit drug use is a public health issue that jeopardizes not only our well-being, but also the progress we have made in strengthening our economy—contributing to addiction, disease, lower student academic performance, crime, unemployment, and lost productivity.

Therefore, we continue to pursue a drug policy that is effective, compassionate, and just. We are working to erase the stigma of addiction, ensuring treatment and a path to recovery for those with substance use disorders. We continue to research the health risks of drug use to encourage healthy behaviors, particularly among young people. We are reforming our criminal justice system, providing alternatives to incarceration for non-violent, substance-involved offenders, improving re-entry programs, and addressing unfair sentencing disparities. We continue to devote significant law enforcement resources to reduce the supply of drugs via sea, air, and land interdiction, and law enforcement operations and investigations. We also continue to partner with our international allies, helping them address transnational organized crime, while addressing substance use disorders and other public health issues.

I thank the Congress for its continued support of our efforts. I look forward to joining with them and all our local, State, tribal, national and international partners to advance this important undertaking.

BARACK OBAMA.

THE WHITE HOUSE, *November 17, 2015*.

NATIONAL DRUG CONTROL STRATEGY

2015

Table of Contents

Introduction 1

Chapter 1: Strengthen Efforts to Prevent Drug Use in Our Communities. 11

Chapter 2: Seek Early Intervention Opportunities in Health Care. 23

Chapter 3: Increasing Access to Treatment and Supporting Long-Term Recovery 29

Chapter 4: Criminal Justice Reform: Making the System More Effective and Fair. 41

Chapter 5: Disrupt Domestic Drug Trafficking and Production 53

Chapter 6: Strengthen Law Enforcement and International Partnerships to Reduce the Availability of Foreign-Produced Drugs in the United States 65

Chapter 7: Improve Information Systems for Analysis, Assessment, and Local Management . . . 79

Policy Focus: Preventing and Addressing Prescription Drug Misuse and Heroin Use 87

Policy Focus: Drugged Driving 105

List of Abbreviations. 109

Notes. 115

4

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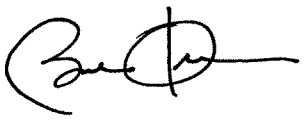


President Barack Obama
The White House

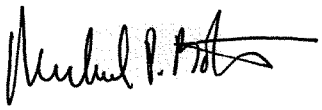
Preface from Director Botticelli

The 2015 *National Drug Control Strategy* continues our dynamic, reform-oriented approach to drug policy, and reflects our desire to continuously seek out individuals who will help improve and refine our efforts. As I traveled the country as a part of our consultation process, I went to Boston for a roundtable discussion with some of the most influential names in the substance use disorder field. While stopping for coffee, I happened to meet Melissa, who told me her story.

Melissa started misusing pain medication after being prescribed OxyContin for a back injury. For a while, she was able to take it as directed. But she eventually started misusing her medication, developed a serious substance use disorder, and began using heroin. Eventually, Melissa lost her apartment and became homeless. She knew she needed help, so she turned to a local clinic that provides substance use disorder services, including medication-assisted treatment (MAT), for the homeless. Fortunately, Melissa lives in a state where she qualified for Medicaid coverage and which supports all the Food and Drug Administration (FDA)-approved medications for opioid use disorders. She was also tested at the clinic for infectious diseases associated with injection drug use. We are thankful that Melissa does not have viral hepatitis or HIV. She still lives in a shelter for homeless women, but she is on the path to recovery. Not long ago, she landed a job at that same coffee shop. She is well on her way to getting back to life without drugs.

I met Michael at a recovery celebration at the White House. Michael was born in Compton, California. He was a bright teenager, and his mom did her best, but the circumstances he was born into prevailed and he got involved with a gang in high school. He dropped out. He developed a substance use disorder involving crack cocaine, and found himself homeless, alone, and in despair. In 1996, he was arrested and convicted for possession of less than a gram of crack. Under California's Three Strikes Law, he was sentenced to 25 years in prison. In prison, he began to study in the prison law library and spent his time appealing his sentence. In 2002, six years after his conviction, his appeal went to the U.S. District Court, where a judge, after reviewing his case for two and a half years, overturned the sentence and freed Michael. Since his release, Michael has spent his time mentoring others in recovery and working to prevent teens in Compton from joining gangs or using drugs. He earned his GED, and now he is enrolled in college and working full-time.

Hearing from Melissa and Michael, and countless other Americans reaffirms my belief in the importance of our work and the role public policy can play in helping to improve lives. While we continue to pursue the goals set by the President's inaugural *National Drug Control Strategy*, we remain mindful of the people the *Strategy* seeks to serve. I look forward to working with the Congress and the American people throughout the next year to implement the *Strategy* and reduce illicit drug use and its consequences.



Michael P. Botticelli
Director of National Drug Control Policy

6

Introduction

Throughout much of the last century, our understanding of drug use was influenced by powerful myths and misconceptions about the nature of addiction. People who used illicit drugs and had substance use disorders were thought to be morally flawed or lacking in willpower. These views shaped our responses to drug policy, resulting in punitive rather than therapeutic approaches to reduce drug use. Today, the Nation's response to addressing substance use disorders and our views about those who suffer from the disease of addiction have begun to change. Groundbreaking discoveries about the brain have revolutionized our understanding, therefore enabling us to develop evidence-based and humane interventions to reduce drug use and its consequences.

Substance use disrupts our families, schools, and communities and limits the hopes and dreams of young people across the country. Illicit drug use is associated with addiction, disease, and lower academic performance among our young people, and contributes to crime, injury, lost productivity and serious dangers on our Nation's roadways. Successfully addressing these complex issues requires a range of approaches. The Obama Administration is committed to restoring balance to U.S. drug-control efforts by coordinating an unprecedented government-wide public health and public safety approach.

The Administration's goal is to make sure services for substance use disorders remain a priority. We are focusing on improving access to services and treatment across the continuum of care, from prevention and intervention to treatment and recovery. We know how to effectively prevent youth substance use, we have treatment interventions that work, including MAT for alcohol and opioid use disorders, and we know how to sustain recovery. The Patient Protection and Affordable Care Act (ACA) enables millions more people to have access to health care and treatment for their conditions. The ACA presents tremendous opportunities to reform drug policy. But to fulfill this promise, we must make sure that substance use disorder treatment is truly integrated into mainstream health care, and that the millions currently without access to necessary treatment for the disease of addiction get the care they need and are aided in their recovery.

Substance use disorders are medical conditions, and reducing stigma surrounding these medical conditions is a particularly important component of drug policy reform—one in which every American can play a part. As we have worked to help millions of people into recovery and support the millions more who are already in long-term recovery, we have learned that how we describe or refer to people with substance use disorders can have an important effect on outcomes. Research demonstrates that the use of stigmatizing words like "addict" can:

- Discourage individuals from seeking help.[1]
- Reinforce the idea that someone with a substance use disorder is exhibiting a willful choice rather than suffering from a recognized medical condition.[2]
- Evoke less sympathy than if the individual is described as having a disease.[3]

Avoiding these terms, thereby reducing the stigma, can play an important role in encouraging these individuals to seek help at an earlier stage in the disease.

In terms of prevention, there is much more we can do to keep young people from ever initiating drug or alcohol use. There are many evidence-based prevention efforts but they are underutilized—they must exist in our schools, our communities and in our homes. Prevention is critical because the most cost effective way to deal with drug and alcohol use and substance use disorders is to prevent them from occurring in the first place. The Nation has seen remarkable success in preventing young people from smoking cigarettes. The prevalence of past 30 day cigarette use among 8th, 10th and 12th graders, as measured by the 2014 Monitoring the Future (MTF) study, are at their lowest levels ever recorded by the survey.[4] MTF also demonstrates significant reductions over the past five years in the rates of alcohol use in all grades and a significant drop in binge drinking among high school seniors, which is now under twenty percent. Still, nearly 1 in 5 high school seniors report binge drinking within the past two weeks. We can continue to reduce the rates of substance use through implementing evidence-based prevention programs that promote positive messages and advise young people of associated risks and consequences.

The Administration is also committed to criminal justice reform—reforming our sentencing policies so that scarce resources are applied in the most effective ways, supporting evidence-based alternatives to incarceration that mitigate risks to the general public and reduce recidivism, and ensuring access to evidence-based treatment models—including MAT for the treatment of opioid use disorders—and recovery support.

At the Federal level, legislative and policy changes have resulted in more just sentencing, ensuring that the most violent criminals serve sentences of appropriate length and allowing low-level, non-violent drug offenders to repay their debt to society in less costly methods that also allow them to access treatment and supportive services. At the state level, justice reinvestment principles have led state leadership to rely on data about their own costs and outcomes to pass legislation and expand alternatives to incarceration. In the future, by fully implementing these policies, non-violent drug offenders will be diverted away from jails and prisons and toward community-based solutions that allow them to be held accountable while also rejoining their families and communities.

One way the justice system can prepare people to succeed is by offering evidence-based treatment while individuals are incarcerated or under community supervision and helping them with treatment and recovery support for their return to the community. Facilitating connections with health insurance coverage, through either private insurance or Medicaid, is a critical step to maintaining continuity of care. A number of jurisdictions are working with criminal justice-involved people to enroll them in health care coverage, which is vital to connecting them with health care after they are no longer in custody.

The Administration wants to help people find stability and success once they leave the justice system, which means helping them attain safe, stable housing; educational opportunities; and employment. A criminal record can be a barrier to attaining these important supports; policymakers should consider record expungement policies and processes that are easily understood and followed, to prevent a criminal conviction from haunting someone for decades after a crime is committed and punishment completed.

The Administration's balanced approach to international efforts are ultimately targeted at reducing drug production and trafficking, promoting alternative livelihoods, and strengthening the rule of law,

democratic institutions, citizen security, and respect for human rights. Countries facing the threats of drug production and trafficking often experience increasing rates of drug use. International programs promote effective demand reduction interventions, to include building institutions to provide alternatives to incarceration, healthy alternatives for at-risk youth, improved drug treatment capacity, and programs that help build strong and resilient communities. International drug control partnerships protect public health and safety, while contributing to overall national security. The success of these international efforts is highly influenced by the commitment and cooperation of governments, international institutions, and civil society organizations that provide drug-related assistance around the globe. The Administration will continue to prioritize international programs with a focus on those regions most important to reducing drug availability, drug use, and their consequences in the United States.

Progress Toward Achieving the Goals of the *Strategy*

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

- Curtail illicit drug consumption in America; and
- Improve the public health and public safety of the American people by reducing the consequences of drug abuse.

The *Strategy*, including its two Goals, was developed through an extensive consultation process with Federal, state, local, and tribal partners, and addressed the Nation's call for a balanced policy of prevention, treatment, recovery, enforcement, and international cooperation. The *Strategy* also reflected the close and strong collaboration between the Office of National Drug Control Policy (ONDCP) and its Federal drug control agency partners to undertake evidence-based programs, policies, and practices to achieve desired performance outcomes by 2015.

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

The 2010 *Strategy* called for reductions in the rate of youth drug use over 5 years and similar reductions in chronic drug use and drug-related consequences, such as drug deaths and illnesses and drugged driving. A suite of seven measures has been developed to assess progress (see Table 1-1) toward achieving the two Goals. Described in detail in this chapter is each of the seven *Strategy* Goal measures along with their baselines, FY 2015 targets, data sources, and assessments of progress-to-date.

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

National Drug Control Strategy Goal/Measure	Base-line	Progress-to-date	2015 Target	Assessment
Strategy Goal 1: Curtail illicit drug consumption in America				
Strategy Measures				
1a: Decrease the 30-day prevalence of drug use among 12–17 year olds by 15%[5]	10.1% (2009)	8.8% (2013)	8.6%	Progress sufficient to enable meeting 2015 target
1b: Decrease the lifetime prevalence of 8th graders who have used drugs, alcohol, or tobacco by 15%[6]				
- Illicit Drugs	19.9% (2009)	20.3% (2013)	16.9%	No progress to date, accelerated progress required to meet 2015 target
- Alcohol	36.6% (2009)	27.8% (2013)	31.1%	No progress to date, accelerated progress required to meet 2015 target
- Tobacco	20.1% (2009)	14.8% (2013)	17.1%	Progress sufficient to enable meeting 2015 target
1c: Decrease the 30-day prevalence of drug use among young adults aged 18–25 by 10%[7]	21.4% (2009)	21.5% (2013)	19.3%	No progress to date, accelerated progress required to meet 2015 target
1d: Reduce the number of chronic drug users by 15%[8]				
- Cocaine	2,700,000 (2009)	2,500,000 (2010)	2,295,000	Progress sufficient to enable meeting 2015 target
- Heroin	1,500,000 (2009)	1,500,000 (2010)	1,275,000	No progress to date, accelerated progress required to meet 2015 target
- Methamphetamine	1,800,000 (2009)	1,600,000 (2010)	1,530,000	Progress sufficient to enable meeting 2015 target
- Marijuana	16,200,000 (2009)	17,600,000 (2010)	13,770,000	Significant progress required to meet 2015 target
Strategy Goal 2: Improve the public health and public safety of the American people by reducing the consequences of drug use				
Strategy Measures				
2a: Reduce drug-induced deaths by 15%[9]	39,147 (2009)	46,471 (2013)	33,275	Significant progress required to meet 2015 target
2b: Reduce drug-related morbidity by 15%				
- Emergency room visits for drug misuse and abuse[10]	2,070,452 (2009)	2,462,948 (2011)	1,759,884	Significant progress required to meet 2015 target
- HIV infections attributable to drug use[11]	5,300 (2009)	5,500 (2010)	4,505	Significant progress required to meet 2015 target
2c: Reduce the prevalence of drugged driving by 10%				
- Data Source: National Roadside Survey[12]	16.3% (2009)	20.0% (2013/2014)	14.7%	Significant progress required to meet 2015 target
- Data Source: National Survey on Drug Use and Health[13]	4.4% (2009)	3.8% (2011)	4.0%	Progress sufficient to enable meeting 2015 target

Assessment of Progress

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

Drug use typically begins in the adolescent years; consequently, the Strategy's efforts focus on preventing such initiation. The Nation has made substantial progress toward achieving this measure. According to the 2013 National Survey on Drug Use and Health,[14] past 30-day use of any illicit drug among 12-to-17-year olds has declined 13 percent from 2009 (10.1 percent) to 2013 (8.8 percent), needing only a further decline of 0.2 percent to achieve the 2015 target of 8.6 percent. This decline includes a 10 percent drop in marijuana use from 2011 to 2013 and is even more apparent when drug use other than marijuana is considered. Such use has declined 35 percent from 2009 (4.6 percent) to 2013 (3.0 percent), well below the 2015 target of 3.9 percent (assuming a similar 15 percent target reduction).

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

This goal targets the lower ages of the youth age group, 8th graders, when youth are most vulnerable to initiation of many substances. According to data from the 2014 Monitoring the Future (MTF) study,[15] the Nation has already exceeded the targets for reducing alcohol and cigarette[16] use among 8th graders: 27 percent for alcohol and 33 percent for cigarettes. Until this past year, the Nation was on target to achieving the goal for illicit drugs; in 2013, the estimate rose again to the level of the 2009 baseline (20.3%).

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

Young adults typically have the highest rates of illicit drug use of any age group. The Nation has made no progress on achieving the goal of reducing drug use among 18-25 year olds according to the 2013 NSDUH.[17] 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 has actually already doubled the targeted reduction—a 20 percent decline from 2009 to 2013. This decline has been driven by a 25 percent decline in past month nonmedical use of prescription drugs overall, which in turn was driven by a 31 percent decline in past month nonmedical use of pain relievers.

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

Research suggests that about 20 percent of the user population for a specific drug accounts for about 75 percent of the amount consumed of that drug—these are chronic, heavy users.[18] The Nation is exceeding the projected tracks for achieving the targets for reducing the number of chronic users of cocaine and methamphetamine, and based on available data (through 2010),[19] is on the tracks for reducing the number of chronic users of heroin (other more current data sources suggest there may be a rise in heroin use during recent years). However, the estimated number of chronic users of marijuana is going

in the wrong direction—it has been rising since 2007 when it was about 14 million, through the baseline estimate of 16 million in 2009 to nearly 18 million in 2010.

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

While the Nation has not made progress in achieving the target for the goal of reducing drug-induced deaths, there has been progress in arresting the alarming growth in deaths involving prescription drugs, the largest class of drugs contributing to overall drug deaths. According to Vital Statistics data[20] from CDC, over the past decade drug-induced deaths have been driven by deaths involving prescription drugs (in 2013, they totaled 22,767—slightly less than half of all drug-induced deaths), especially prescription opioids (16,235). The good news is that for the first time since 1999, these deaths may have stabilized or even declined slightly. Deaths involving prescription drugs peaked in 2011 at 22,810, then dropped in 2012 to 22,114 before rising slightly to 22,767 in 2013. At the same time deaths involving prescription opioids peaked at 16,917 in 2010 and declined 4 percent to 16,235 in 2013. Unfortunately, deaths involving heroin have risen sharply since 2010, from 3,039 to 8,260, or about half the number of deaths involving prescription opioids.

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

The data source for this measure was the Drug Abuse Warning Network (DAWN), which estimated the number and percentage of drug-related visits to hospital emergency departments. In 2011, DAWN was discontinued. The Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Center for Health Statistics are currently collaborating to launch a new data system to collect this information. It is anticipated that it will begin reporting in late 2015. Through 2011, data from DAWN indicated that the Nation was going in the wrong direction to achieve this target of reducing drug-related morbidity, rising from 2.1 million visits in 2009 to slightly more than 2.4 million in 2011.[21]

The second source is the number of people with Human Immunodeficiency Syndrome (HIV) who were infected through injection drug use.[22] This measure tracks progress at reducing the incidence of HIV infections attributable to injection drug use (including men who have sex with men and inject drugs). The estimates are calculated by the Centers for Disease Control and Prevention based on data from selected states that conduct HIV incidence surveillance. No progress has been made at achieving this target. In 2010, the number of new persons infected with HIV through injection drug use (5,500) was unchanged from the 2009 baseline estimate (5,300). Data on new HIV infections have not yet been reported after 2010.

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

The National Highway Traffic Safety Administration (NHTSA) periodically conducts the National Roadside Survey to estimate the prevalence of impaired driving; in 2007, they included measures to estimate the prevalence of driving after consuming drugs, including medications that can impair driving skills. At ONDCP's request, NHTSA conducted the survey again in 2013/2014 to assess the progress on achieving this goal. Unfortunately, the Nation is moving in the wrong direction on this primary measure of drug-involved driving. Results from the 2013/2014 survey indicated that the prevalence of driving after consuming drugs on weekend nights was 20 percent, up from 16.3 percent in 2009.[23] ONDCP also is

tracking the prevalence of drugged driving with self-report data from the National Survey on Drug Use and Health (NSDUH). According to data from the 2013 NSDUH,[24] the Nation has achieved the target of reducing drugged driving by 10 percent; the 2015 target is 4.0 percent, the level that was attained in 2013.

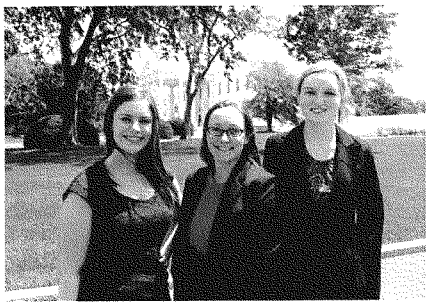
Advocates for Action

Across America, individuals are doing extraordinary things to improve the health and safety of their communities. Whether it is developing groundbreaking programs to break the cycle of drug use and crime, conducting innovative research that expands our understanding of how drugs affect the human body, expanding treatment opportunities, or preventing drug use before it starts, the 2015 ONDCP Advocates for Action are making a difference by reducing drug use and its consequences. Throughout this *Strategy* you will meet these exceptional individuals.

Conclusion

The President's *Strategy* is national, not merely Federal, in scope. The efforts discussed in the following pages demonstrate the Administration's ongoing commitment to the goals, principles, and actions articulated in the President's 2010 *Strategy*. Further progress in its implementation will require a comprehensive effort that includes Federal, state, local, tribal, and territorial government agencies, international institutions and partner nations, nongovernmental organizations, academia, private industry, and American citizens from all walks of life. The Administration looks forward to a continued partnership with the Congress to address a growing problem of illicit drug use that affects our lives.

Advocate for Action: Dover Youth to Youth (Y2Y), New Hampshire



Dover Youth to Youth (Y2Y) is a 70-student y outh empowerment program coordinated by the Dover (New Hampshire) Police Department. These students in grades 6-12 meet weekly to develop creative ways to address substance use issues. They have been the most active sector of the Dover Coalition for Youth and have helped the Coalition achieve its goals as part of the Drug-Free Communities Support Program.

In the past year alone, Youth to Youth students have given presentations to more than 2,000 youth and parents in the community about substance use issues, created 10 public service announcements (PSAs) that were broadcast on local radio stations, created two video PSAs that aired on New Hampshire's ABC affiliate, proposed and testified for a city ordinance banning smoking in a city music venue, spoke before the New Hampshire Senate against the legalization of marijuana, and convinced a gas station near a school zone to remove 15 tobacco advertising signs. These youth advocates also conducted two street demonstrations on alcohol awareness issues, including the multi-faceted "Fridge Campaign" to heighten parental awareness that young kids often access alcohol in the home.

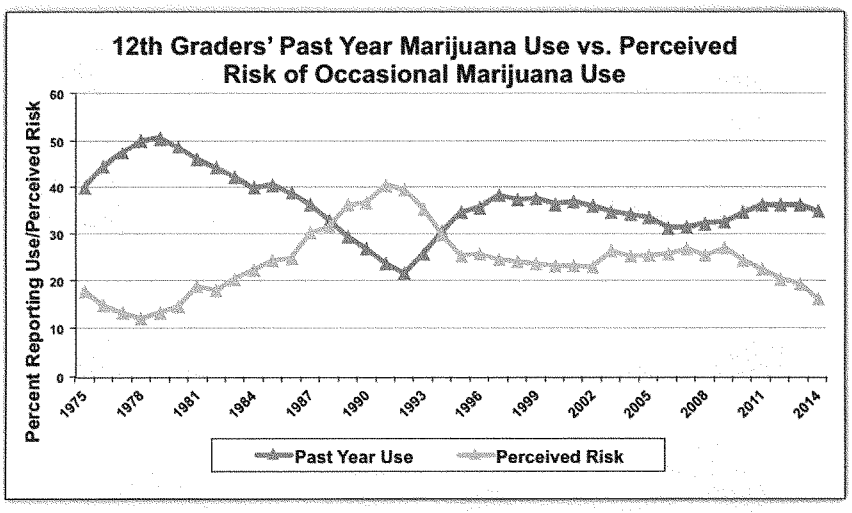
In addition to its positive impact in the local community, Y2Y is known for its work helping other coalitions and youth groups. Regionally, the group has established a network of 7 youth groups in surrounding communities that are following the Dover model and replicating many of these activities. Dover Youth to Youth has developed a youth empowerment Toolkit to allow other youth groups to take advantage of the resources they created. The Toolkit materials are now being used by more than 100 communities across the country. Dover Youth to Youth's model of youth empowerment and the supporting Toolkit have been added to New Hampshire's list of evidence-based programs.

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

Preventing drug use before it starts is a fundamental element of the *National Drug Control Strategy*. As noted in the introduction, there has been overall progress in reducing illicit drug use among young people, including youth (ages 12-17) and young adults (ages 18-25). Data from the 2013 NSDUH show a decline in the rate of current illicit drug use since 2002 among youth (from 11.6 percent to 8.8 percent), including declines in the rates of current nonmedical use of prescription-type drugs and the nonmedical use of pain relievers.[25] This trend is also reflected in the results of the 2014 MTF study, which shows that overall drug use in the past year among 8th, 10th, and 12th graders was generally lower in 2014 compared to 2001.[26] MTF also indicates positive trends in reduced use for marijuana, alcohol, and tobacco.

However, while progress has been made in a number of areas among youth, the overall rates of use of drugs and alcohol and tobacco among adolescents remain concerning,[27] especially as we learn more about the negative effects of illicit substances and alcohol on the developing brain. The rate of past month illicit drug use among the nation's young people rapidly escalates as they move through adolescence, from 2.3 percent of 12-year-olds to over 24 percent of 20-year-olds.[28]

Furthermore, MTF shows that historically when the perceptions of harm related to drug use decrease, rates of drug use are likely to subsequently increase. As shown in the chart below, over the five-year period between 2009 and 2014 among 12th graders, there has been a 40 percent drop in the perceived risk of occasional use of marijuana, accompanied by a 7 percent increase in past year use of marijuana.[29]



The nation's vitality and ability to succeed globally depends on the ability of the next generation to succeed academically, achieve their ambitions, and live healthy, productive lives. Drug use among youth and its impact on their academic achievement are linked. For example, marijuana use is associated with cognitive impairment, including lower IQs among people who use marijuana early and persistently over the long-term;[30] students with an average grade of "D" or lower are more likely to be substance users compared to students whose grade average is better than "D;"[31] and higher levels of substance use were reported by students who were involved in truancy.[32] Substance use appears to contribute to college students skipping more classes,[33] spending less time studying,[34] earning lower grades,[35] dropping out of college,[36] or being unemployed after college or some combination of these factors.[37, 38, 39, 40, 41] Alcohol consumption among youth is also known to impact academic achievement; it can cause problems with short-term memory and other brain functions[42, 43] and undermine the efficiency and effectiveness of study time.[44] It has been observed that alcohol-related differences in sleep patterns contribute to greater daytime sleepiness and, consequently, lower grades.[45] Finally, college students who drink excessively tend to spend less time studying[46, 47] and skip more of their classes.[48]

Fortunately, by working together, we can improve academic performance and reduce substance use among students by implementing evidence-based practices that address both issues simultaneously and comprehensively. The Strategic Prevention Framework[49] is an evidence-based process that states can use to inform policies and programs and introduce change at the community-level. The Framework employs the following 5-step process to guide states, jurisdictions, tribes, and communities in the selection, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities: (1) assess needs, current resources, and community readiness; (2) build capacity; (3) develop a plan to address state, local, and tribal needs; (4) implement the plan; and (5) evaluate implementation. By using this framework and bringing together willing partners, community coalitions can foster the development of comprehensive prevention approaches. Research investments lead to more robust understanding of causal factors. When schools are included in the coalition activities, we can also help achieve our nation's academic goals and make sure every child in America has access to a world-class education and a chance to succeed.

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

Effective substance use prevention must bring together state and local sectors to assess illicit substance use issues and challenges and develop comprehensive, multi-sector approaches to reduce use and its consequences. The formation of strong partnerships coupled with understanding the needs of the community will support the development of successful strategies to address community-level challenges. These partnerships are also uniquely poised to identify emerging threats.

Action Item: Collaborate with States to Support Communities (1.1.B)

The need for comprehensive prevention programming is critical to ensure a healthy and safe Nation. While progress has been made in reducing tobacco use and binge drinking, youth today are faced with challenges including messages about marijuana use and the dangers of non-medical use of prescription and other illicit drugs. The Administration continues to support efforts to meet these challenges and prevent illicit drug use before it starts. The U.S. Department of Education has focused on keeping students safe and improving their learning environments. In FY 2014, School Climate Transformation

grants to school districts provided support to 71 school districts in 23 states, Washington, D.C., and the U.S. Virgin Islands. The grants help schools develop, enhance, or expand systems of support for implementing evidence-based, multi-tiered behavioral frameworks for improving behavioral outcomes and learning conditions for students.

In FY 2014, SAMHSA provided funding to 50 states, eight territories, and one tribe in support of substance use prevention initiatives. Specifically, states use the Substance Abuse Prevention and Treatment Block Grant Prevention Set-Aside to fund substance misuse prevention programs; the Prevention Set-Aside is the sole Federal source of substance use prevention funding available to all states and territories. Additionally, SAMHSA's Strategic Prevention Framework State Incentive Grant program supports states in using a data-driven decision-making process that includes assessing needs to guide the implementation of evidence-based strategies.

The Muskegon Community Health Project

Established in 1994, the Muskegon Community Health Project, the community benefit office of Mercy Health hospital in Muskegon, Michigan, has convened multiple community collaborative groups to increase access to health care for dental care, diabetes, and substance use disorders, and reduce health disparities. One of their groups, the Coalition for a Drug Free Muskegon County, an ONDCP-funded Drug Free Community (DFC) coalition with over 70 members from organizations such as public health, law enforcement, substance abuse agencies, health care, and student organizations had a long history of working on alcohol and tobacco issues. In a 2009 survey, the Coalition found that 17.4 percent of youth had ever used prescription medications for non-medical purposes.[50] Aware that other community programs, organizations, and businesses were interested in addressing the availability of prescription drugs, the DFC Coalition established the Muskegon Area Medication Disposal Project. The DFC leaders facilitated meetings and acted as a fiduciary, while leveraging resources from the hospital. Multiple hospital leaders provided assistance by organizing the events, branding, marketing, and communications assistance, accessing pharmacists and pharmacy technicians, providing supplies, grant writing, and offering to pay for upfront costs for take back events.

Since the first take-back event in 2010, the Muskegon Area Medication Disposal Project has collected more than seven tons, (more than 15,000 pounds) of medications through collection events and permanent drop sites throughout the county.[51] The team also counted and classified the medications to determine their source, thereby helping physicians, hospital leaders, pharmacists and health plan managers change their policies and practices to reduce the excess availability, use, and abuse of prescription drugs.

In 2014, the Coalition was awarded Community Anti-Drug Coalitions of America (CADCA)'s Got Outcomes Coalition of the Year Award, due in part to its multiple projects and its ability to measure its community level impact. As the Coalition for a Drug Free Muskegon County concludes its 10th year of DFC funding, the hospital's financial support through its community benefit funding is now well established and will help in its long-term sustainability in supporting collaborative staff members and paying for some of the other project costs.

More information on the Health Project and the Coalition for a Drug Free Muskegon County can be found at www.mchp.org.

Action Item: Promote Prevention in the Workplace (1.1.C)

The workplace is an important place for employees to receive information on illicit substance use prevention. It is an opportunity to encourage and educate employees on relevant materials and resources available to them and their families. Workplace programs also play a key role in promoting safe and productive work environments.

The Division of Workplace Programs at SAMHSA is responsible for two principal activities mandated by Executive Order 12564 and Public Law 100-71. These are oversight of the Federal Drug-Free Workplace Program to eliminate illicit drug use within Executive Branch agencies and the regulated industry; and oversight of the National Laboratory Certification Program, which certifies laboratories to conduct forensic drug testing for Federal agencies, Federally-regulated industries, and the private sector. The program is further supported by the Workplace Helpline, a toll-free telephone service (800-WORKPLACE) for business and industry that answer questions about drug testing in the workplace.

In addition, the Department of Transportation (DOT) regulates a strong industry-based drug and alcohol testing program that conducted approximately 3.1 million drug screenings in the first 6 months of 2014.[52] This Federal testing program protects public health and safety by ensuring that safety-sensitive transportation employees in the aviation, trucking, railroad, mass transit, pipeline, and other transportation industries are screened for substance use issues. While ensuring public health and safety, the DOT process allows an individual to return to safety-sensitive work after he or she tests negative on a return-to-duty test, thereby providing an incentive for successful completion of treatment. The DOT program is a model for other programs in the U.S. and internationally as an effective tool for accurate testing, deterrence, and recovery.

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

Implementing effective prevention approaches for youth requires paying special attention to the sectors that influence young people's lives. By working together states, communities, schools, parents, and health professionals can use evidence-based prevention programs and policies to make a positive impact on youth drug use.

Action Item: Strengthen the Drug-Free Communities Support Program (1.2.A)

Coalitions across the United States are rallying to address the drug trends unique to their communities. Since the program's inception, DFC grantees have targeted areas that cover 37 percent of the U.S. population.[53] DFC-funded coalitions are required to work with various sectors of their community to identify local drug problems and implement comprehensive strategies to create community-level change. The contributions of community coalitions constitute a critical part of the Nation's drug prevention infrastructure. DFC-funded community coalitions are a catalyst for creating local change where drug problems manifest. Findings from the 2013 DFC National Cross site Evaluation indicate that prevalence of youth substance use has declined significantly in DFC-funded programs. Prevalence of past 30-day use declined significantly between the first and the most recent data reports across all substances (alcohol, tobacco, marijuana) and school levels (middle and high school). Collectively the data suggest DFC grantees' activities are associated with positive outcomes among youth in DFC communities. Between February

2013 and August 2013, DFC grantees distributed more than 1.5 million prevention materials; reached over 600,000 people with special events; held direct face-to-face information sessions with more than 230,000 attendees; trained over 350,000 youth, parents, and community members; recognized more than 9,000 businesses for compliance (or noncompliance) with local ordinances; and were instrumental in educating on more than 500 laws or policies.

Action Item: Leverage and Evolve the Above the Influence (ATI) Brand to Support Teen Prevention Efforts (1.2.B)

The Above the Influence (ATI) campaign, introduced in 2005, is dedicated to demonstrating the power of young people living "above the influence" of drugs and alcohol. To ensure the continuation of the ATI brand after Congressional funding was discontinued, ONDCP transitioned ATI to The Partnership for Drug-Free Kids (The Partnership). The Partnership has maintained and expanded its direct outreach to teens in social media, including through Facebook, Tumblr, Twitter, and Instagram. The Partnership has maintained ATI-related toolkits and resources that provide support to community organizations working to engage their youth in drug and alcohol prevention efforts. ONDCP promotes the availability of these resources to its DFC grantees that have free access to these tools at www.atipartnerships.com. ONDCP provides The Partnership with input and expertise to ensure the tools remain current and consistent with ONDCP's strategic priorities.

Action Item: Support Mentoring Initiatives, Especially Among At-Risk Youth (1.2.C)

Mentoring initiatives focused on young people and vulnerable groups are an important component of a comprehensive approach to prevention that includes families, communities, schools, and states. Mentoring provides support to youth with structured activities and often includes a focus on achieving life and career goals. ONDCP partners with both Federal agencies and community-based organizations to promote support for mentoring initiatives, for example: the Department of Defense (DoD) Education Activity, Students against Destructive Decisions (SADD), the Mentor Foundation USA, U.S. Department of Agriculture's (USDA) 4-H Program, and U.S. Department of Education's 21st Century Community Learning Centers Program.

The Administration's My Brother's Keeper initiative has taken steps and inspired others to ensure that all young people can reach their full potential—including through mentoring that will help our youth find opportunities for career growth and skill building. The initiative has brought together Federal, state, tribal, and community partners to build on successes and promising ideas and implement strategies which have been shown to have the greatest impact at key moments in the lives of the Nation's young people. In addition, the White House Council on Women and Girls works across departments and agencies to provide a coordinated response to issues that have a distinct impact on the lives of women and girls, as part of the Administration's broader focus on expanding opportunity for each American.

Action Item: Mobilize Parents to Educate Youth to Reject Drug Use (1.2.D)

Parents play a critical role in reducing substance use among youth, and many underestimate the power they have to influence their children to make sound decisions. It is important to continue to provide resources and materials for parents to educate them on the dangers of illicit drug use. ONDCP continues to collaborate with organizations and Federal partners to build the capacity of parents to support their

youth. Helping parents understand the nexus between improving academic achievement and reducing substance use is vital to ensure every child can pursue a healthy and productive life.

In recognition of National Substance Abuse Prevention Month, ONDCP hosted a twitter chat with youth and parents focusing on experiences and strategies that can be used to keep youth drug free. In addition, SAMHSA released two new products as part of the "Talk. They Hear You." campaign. One product is a new public service announcement encourages American Indian and Alaskan Native parents and caregivers to talk to their young people as early as 9 years old. A second product introduced a role-playing mobile application designed to teach parents and caregivers how to effectively use a conversation to influence their child's behavior and attitudes toward alcohol. In addition, the National Institute on Drug Abuse's (NIDA) Family Check-Up is a program that provides practical, evidence-based information to promote good communication between parents and children. Developing good communication skills helps parents stay aware of what is happening in their children's lives, catch problems early, support positive behavior, and prevent illicit drug use.

The Drug Enforcement Administration's (DEA) Demand Reduction Program supports national efforts to reduce the demand for drugs by educating parents and youth about the dangers associated with using illegal drugs and misusing prescription and over-the-counter drugs. Through DEA's two websites, www.getsmartaboutdrugs.com for parents, caregivers, and educators and www.justthinktwice.com for teens, DEA provides drug prevention and education awareness through drug fact sheets, publications, true stories, and videos that are all downloadable.

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

A key element of creating a safe, healthy, and drug free environment is the dissemination of accurate information on drug use. It is especially important to share information regarding the impact of substance use on young people including school-aged children. As noted earlier, the apparent effects of drug use on these children is concerning (i.e., long-term effect on IQ, diminished academic achievement, and altered brain function). With sound information dissemination communities, parents, schools, and health care providers can better prevent use before it starts and intervene early, when necessary.

Action Item: Support Substance Abuse Prevention on College Campuses (1.3.A)

Drug use and its consequences affect every sector of society and hampers the ability of young people to reach their full potential. Approaches that keep young people from using drugs and alcohol, identify risky behaviors, treat those with substance use disorders, and support individuals in recovery are vital to maintaining safe and healthy campus communities in the United States. The Administration has also launched the "It's On Us" initiative—an awareness campaign to help put an end to sexual assault on college campuses, which is often related to substance use.

In 2014, SAMHSA awarded 23 grants under its Minority Serving Institutions (MSIs) Partnerships with Community-Based Organizations (CBOs) grant program.[54] The purpose of this illicit substance use prevention education and testing program is to equip and empower MSIs located in communities at the highest risk of substance abuse, HIV, and Hepatitis-C (HCV) infections with evidence-based preven-

tion methodologies. The goals of the program are to: 1) increase access to comprehensive, integrated substance abuse, HIV, and HCV prevention services on the grantees' campuses and/or institutions and surrounding community; and 2) achieve normative and environmental changes to prevent and/or reduce substance use problems as risk factors for the transmission of HIV/AIDS among African-American, Hispanic/Latino, Asian American/Pacific Islander), and American Indian/Alaska Natives young adult (ages 18-24) populations on campus.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) supports studies to better understand both individual and environmental approaches to prevention and treatment for college students that are necessary to reduce harmful drinking and its consequences.[55] Working with researchers in the college drinking field, NIAAA is developing a research-based, interactive, user-friendly decision tool and guide to help colleges and universities select appropriate strategies to meet their alcohol intervention goals. In 2015, the College Alcohol Interventions Matrix (College-AIM) will be launched to help college leadership select effective interventions. NIAAA's *Clinician's Guide: Helping Patients Who Drink Too Much* [56] is another important resource for use with this age group; the *Guide* is an alcohol screening tool that health care practitioners can use with individuals aged 18 and older, including young adults and college students.

Action Item: Expand Research on Understudied Substances (1.3.B)

It is important to monitor substance use trends in the community continually in order to adapt to emerging needs. NIDA's prevention program supports large surveys and surveillance networks to monitor drug-related issues and trends locally and nationally such as the emergence of synthetic drugs and e-cigarettes. NIDA also supports an enhanced understanding of prevention approaches by identifying and characterizing human candidate genes that influence risk for substance use disorders. NIAAA supports research on preventing and reducing underage drinking, recognizing the harmful effects of alcohol use among young people, and the connection between early initiation of alcohol use and future substance use problems.

NIDA recently launched an innovative National Drug Early Warning System (NDEWS) to monitor emerging trends related to illicit drug use and to identify increased use of synthetic drugs such as methamphetamine and New Psychoactive Substances (NPS). NDEWS will generate critical information about new drug trends in specific locations around the country so rapid, informed, and effective public health and prevention-focused responses can be developed and implemented precisely where and when they are needed. In addition, NIDA's intramural research program (IRP) recently established a Designer Drug Research Unit (DDRU) to help address the problem of synthetic drugs including NPS. NPS are marketed as safe, cheap, and legal alternatives to illicit drugs like marijuana, cocaine, and ecstasy. The DDRU collects, analyzes, and disseminates current information about the pharmacology and toxicology of newly emerging synthetic drugs. This information can be used to inform public health and prevention oriented responses.

Action Item: Prepare a Report on the Health Risks of Youth Substance Use (1.3.C)

The Department of Health and Human Services (HHS) continues to implement the *National Prevention Council Action Plan*[57] that outlines the Federal government's commitment to implementing the Nation's first ever National Prevention Strategy. This Action Plan focuses on a number of public health issues important to the Nation. Preventing illicit substance use is one of the Action Plan's key priorities and

identifies several recommendations including: creating environments that empower young people not to drink or use other drugs; identifying alcohol and other drug use disorders early and providing early intervention and referral to treatment; and educating health care professionals on proper opioid prescribing and reducing inappropriate access to and use of prescription drugs.

Principle: Criminal Justice Agencies and Prevention Organizations Must Collaborate

Bringing together all sectors in a community to work together towards a common goal is an important component in developing effective approaches to reduce drug use. When public health, public safety, and school sectors share information and work together they are able to have a more complete view of the challenges and are better equipped to develop more comprehensive solutions.

Action Item: Provide Information on Effective Prevention Strategies to Law Enforcement (1.4.A)

Participation by law enforcement professionals in prevention activities in schools, community settings, and organizations is an essential component of regional efforts to reduce illicit drug use and make communities safer places in which to live. Twenty of the 28 High Intensity Drug Trafficking Areas (HIDTAs) are engaged in activities that connect law enforcement with community-based prevention efforts through mentoring, role modeling, and life skills education. For example, the Central Florida HIDTA has partnered with the Orange County Drug Free Coalition in an initiative to engage, advocate, inform, and bring awareness of alcohol and illicit substance use issues among Central Florida youth to build a healthy, safe, and drug-free community. A report funded by the National Institute of Justice (NIJ) of the Department of Justice (DOJ) identifies regional efforts supported by HIDTAs to reduce illegal prescription drug demand through training, education, and drug take-back programs.[58] ONDCP is additionally working to expand prevention activities to all 28 HIDTAs.

The New York National Guard Counterdrug Civil Operators partnered with the NY State Office of Alcohol and Substance Abuse and their Prevention Resource Centers (PRC). These PRCs are located around the state and serve as a focal point for coalitions and community-based organizations to obtain resources, technical assistance, training, and assessment data. Civil Operators coordinate and synergize local education authorities and community initiatives. Serving in this role allows alignment of efforts between law enforcement and community prevention entities, and leverage of National Guard resources supporting Federal, state, tribal, and local law enforcement agencies to aid community coalitions in gathering timely and relevant substance use data to create comprehensive strategies that address local drug problems.

Action Item: Enable Law Enforcement Officers to Participate in Community Prevention Programs in Schools, Community Coalitions, Civic Organizations, and Faith-Based Organizations (1.4.B)

Collaboration with multiple sectors of the community is vitally important to community change. To address the number of messages youth face today promoting substance use, we must work together to encourage a safe and healthy nation free from addiction and violence. To support this goal, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) of the Department of Justice (DOJ) is partnering with the Department of Education and SAMHSA to coordinate grant programs that fund

communities and local education agencies to improve school climate and respond early to the mental health/substance use disorder needs for at-risk youth.

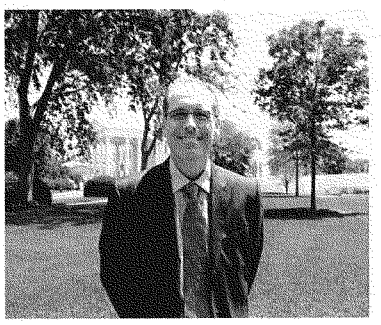
To improve academic achievement among youth, collaboration and coordination among schools, mental health/substance use disorder specialists, law enforcement and juvenile justice officials must help students succeed in school and prevent negative outcomes for youth and communities. The National Association of School Resource Officers continues to focus on substance use prevention in school settings. Relevant and current culturally appropriate training on prevention programs and evidence-based programs will educate officers on best practices to implement programs in school settings.

Action Item: Strengthen Prevention Efforts Along the Southwest Border (1.4.C)

ONDCP has engaged with the U.S. Border Health Commission to promote improved and culturally appropriate prevention, screening, brief intervention, and referral to treatment (SBIRT). ONDCP coordinated with the U.S. Border Health Commission to support substance abuse training for promotores[59] along the border. With the collaborative work of SAMHSA, the U.S. Border Health Commission has set the groundwork for a train-the-trainer model to expand the capacity for promotores along the U.S.-Mexico border. These trainings focus on how to conduct screenings and make referrals to appropriate care for persons with substance use disorders within their communities. The training efforts took place along each of the 10 border cities with an estimated total of 250 to 300 promotores trained upon completion. These train-the-trainer efforts were based on the Mental Health Gap Action Program (mhGAP) Intervention Guide for mental, neurological, and substance use disorder in non-specialized health settings developed by the World Health Organization and adapted by SAMHSA.

23

Advocate for Action: Dr. Andrew Finch, Tennessee



Andy Finch, Ph.D., is a pillar in the recovery school movement. He is a highly dedicated Association of Recovery Schools (ARS) board member, innovative recovery school researcher, and recovery school advocate. When ARS began 13 years ago, Dr. Finch and a few other dynamic leaders laid the groundwork for the national expansion of recovery high schools and collegiate recovery programs.

Dr. Finch helped start a recovery high school in Nashville in 1997, and in 2002 he co-founded the ARS. Since then, he has worked tirelessly to raise awareness about high school and college student recovery support and best practices. He is also one of a select group of professionals who developed and helped implement an accreditation process for recovery high schools (the first and only of its kind). Thanks in part to his research and subsequent best practices development, recovery schools have expanded and are now helping to alter perceptions of adolescent treatment and recovery support services in the United States.

Chapter 2: Seek Early Intervention Opportunities in Health Care

Health care providers must be vigilant to identify individuals with patterns of risky substance use and/or substance use disorders during routine health care visits. Screening is essential for health care providers to either identify patients at risk of developing a disorder or detect patients that may need further assessment and potential treatment for a disorder. Screening also may raise patients' awareness of the harmful effects of drug use, improve the general medical care and health of patients, and increase the rate at which patients are admitted to treatment, when needed. Screening needs to be integrated into public and private health care and mental health/substance use disorder delivery systems to identify substance use disorders among patients.

Educating both health care and mental health/substance use disorder providers on the benefits of integrating screening into practice is important because only a small portion of patients that need treatment from a specialty care provider are referred for services by health care providers.[60] Information obtained from patient screenings enables health care providers to consider and discuss the relationship between the negative effects of patients' drug use on their health, and discuss referral to specialty treatment for further assessment with patients who may be in need of continued care. As health care providers have these discussions with patients, it is useful for providers to understand that behavioral change is an incremental process. People change when a new action or behavior is in line with their personal beliefs or values, and motivation to change is often dictated by unique factors.[61] Motivating patients with a substance use disorder to address their condition may require repeated offers of referrals, sustained problem solving of barriers to treatment, and ongoing education concerning clinical treatment options.[62] Resources and efforts should focus on expanding screening, interventions, and efforts to link patients to specialty care along with the full range of services that health care practitioners provide for their patients, including office-based substance use disorder treatment.

Practices for identifying substance use through screening should be governed by evidence-based research. There is a need for further investigation into brief intervention techniques in general medical settings for patients who use drugs. Further research also is needed on practitioners' referral methods for patients needing treatment for substance use disorders when specialty care is necessary. These research results can guide practitioners in effective referral methods. Research communities need to continue to test ways to assimilate screening and care for patients' substance use into routine care in medical settings so prevention, intervention, and treatment are integrated. In addition, health systems should implement continuing education for health care professionals on the health consequences of substance use, the addictive risks of controlled substances, and the importance of screening and referral to treatment to address the complex treatment needs of patients with substance use disorders.

Principle: Identifying Substance Use Disorders Early Saves Lives and Money

Screening can alert providers to patients who may have a substance use disorder and need additional specialty care. Since 2010, the Administration has recognized that screening remains essential, and

encourages health care providers to have conversations with their patients about their drug and alcohol use. ONDCP and its Federal partners from SAMHSA, NIDA, and NIAAA coordinate efforts to disseminate information on the role of SBIRT to enhance access and care for people with substance use disorders, encourage focused research on screening and treatment in medical settings and referral to specialty treatment, and ensure ongoing education for health care professionals on the health consequences of substance use and the importance of screening and referral to treatment to address the treatment needs of patients with substance use disorders.

Action Item: Expand and Evaluate Screening for Substance Use in All Health Care Settings (2.1.A)

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, web portals, etc. Each of the state SBIRT program grantees have 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.

SBIRT in Action: *Kern County, CA, Mental Health Project Care*

As more residents gain access to primary care, mental health, and substance use disorder services as a result of the ACA, community health centers will need to identify and address more mental health/substance use disorder issues in their primary medical practice. As such, Kern County Mental Health directs funds from the Mental Health Services Act to Project Care. Project Care supports the provision of mental health/substance use disorder services in four Federally-Qualified Health Centers providing interventions for mental health and substance use disorders in a primary care setting using the SBIRT model. Referrals to specialty mental health and addiction treatment are facilitated when more intensive services are deemed appropriate.

Project Care goals include increasing capacity of the community health centers to address mental health and substance use disorder for under-served or inappropriately served individuals; increasing knowledge among primary care providers to understand the interplay between primary and specialty care; and identifying mental health and substance use disorders, and preventing them from worsening by addressing them as part of routine medical care. The Project Care program has been in place for four years.

Also in 2014, the SBIRT training curriculum was disseminated through an online portal and CD ROM to new SBIRT grantees to assist them with creating their individual training programs. This information is also available to the public. The SBIRT Addiction Technology Transfer Center (ATTC) continues to provide extensive technical assistance and training to all organizations interested in implementing SBIRT. Additionally, they continue to provide free training sessions open to the public on numerous aspects of SBIRT implementation and integration with primary care. SAMHSA also provided technical assistance to the Hilton Foundation-funded SBIRT grantee YouthBuild, a not-for-profit educational and job skills program for youth ages 16–24 of low-income status.

Action Item: Increase Adoption and Reimbursement of SBIRT Codes (2.1.B.)

In 2014, several SBIRT state grantees worked with their respective Medicaid officials to update their SBIRT codes to ensure that the codes are comparable with medical screening codes for overall reimbursement rates and specifically, reimbursement for annual screening and brief interventions. Also in 2014, the SAMHSA-funded SBIRT ATTC released its interactive SBIRT codes reimbursement map that provides detailed information on SBIRT codes state by state.[63] Throughout 2015, efforts will continue to increase the number of states that update their SBIRT codes.

The Centers for Medicare & Medicaid Services (CMS) also provide guidance to states for reimbursement through Medicare and Medicaid state plans for conducting SBIRT. CMS disseminated a fact sheet that provides health care professionals with an overview of Medicare and Medicaid coverage of SBIRT services, including who may perform these services, documentation requirements, billing and coding guidance, payment information, and resources for additional information.[64]

Action Item: Enhance Health Care Providers' Skills in Screening and Brief Intervention (2.1.C.)

During 2014, SAMHSA continued its SBIRT program efforts by providing funds to grantees to train health care professionals. SBIRT training grantees have trained over 5,200 health care professionals, which includes resident physicians, nurse practitioner students, nursing students, master of social work students, master's-level counselors, and master's degree and PhD level psychologists.[65] In 2014, SAMHSA awarded an additional 11 institutions with SBIRT Medical Professional Training grants. To date, SAMHSA has funded a total of 25 SBIRT Medical Professional Training grants. In 2015, SAMHSA will continue to work with grantees to ensure medical professionals are receiving the training they need to fully implement the SBIRT program.

Action Item: Identify and Make Available Additional Training in Evidence-based Practices for Substance Use Disorder Assessment and Care to Health Care Professionals Providing Care to Military Health System Beneficiaries (2.1.D)

In 2013, DoD removed the ban on MAT to treat patients with opioid use disorder. As a result, in 2014, DoD conducted four buprenorphine training sessions in their Military Treatment Facilities (MTFs) that resulted in over 100 providers becoming Drug Addiction Treatment Act 2000 (DATA) waive certified.[66]

Additional DoD Joint Services training in application of SBIRT will occur in 2015; also, an electronic tool supporting the use of the SBIRT process will be piloted at three MTFs at Fort Belvoir and Fort Carson, and, subsequently, at Navy and Air Force sites.

Advocate for Action: Nora Gallegos, Mexico

Nora Gallegos is a recognized leader in the fight against addiction. She has worked for more than 25 years with community, public, and international organizations to create awareness, empower people and ensure safe and drug-free environments for young people.

Ms. Gallegos has been General Coordinator of the Red de Coaliciones Comunitarias (Network of Community Coalitions) Mexico under the umbrella of two organizations: Alliance of Border Collaboratives and Programa Compañeros, A.C. She and her team have worked with Community Anti-Drug Coalitions of America to strengthen capacity-building practices for improving community involvement. Her group also has worked with the Mexican government through the National Commission against Addiction.

The coalitions have made a positive impact in substance use prevention and addressing violence and crime, in some cases taking control of spaces in decay or previously overrun by gangs. The U.S. and Mexican governments have provided resources to the Coalitions Network to develop a second phase and expand its reach into 7 states and 11 cities, for a total of 21 new coalitions. The Network has also developed tools to assess coalition readiness and implementation of their action plans. The results show that member coalitions have held more than 400 activities, some including as many as 1,000 participants.

A tireless worker who is committed to achieving positive results in preventing substance use disorders, Mrs. Gallegos is currently developing a methodology to link anti-drug community coalitions and drug treatment court activities.

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

When science began to study addictive behavior in the 1930s, people with substance use disorders were thought to be morally flawed and lacking in willpower. Those views shaped society's responses to substance use disorders, treating them as a moral failing rather than a health problem, which led to an emphasis on punitive rather than preventative and therapeutic responses. Even now, discussions are too often relegated to the shadows, steeped in stigma and misunderstanding. However, today, our Nation's responses to substance use disorders have begun to change. Groundbreaking discoveries about the brain have revolutionized our understanding of these disorders, enabling us to respond more effectively to the problem.

In 2013, 22.7 million adults needed treatment for illicit drug or alcohol use but only 2.5 million, or 11 percent of those individuals received specialty treatment.[67] The ACA provides opportunities for increased access for people across the Nation who are in need of substance use disorder services. Improved and more broadly available insurance coverage coupled with new and modified service delivery models marks a significant change to the way services for substance use disorders have been delivered, which historically has been through a separate delivery system for only the most chronic patients. Thus, full implementation of the ACA gives more Americans in need of substance use treatment an opportunity for treatment and recovery from the disease.

To achieve long-term recovery among people with substance use disorders, both treatment and recovery support services need to be available in the same way medical treatments and services are accessible to people with other types of medical conditions, such as diabetes or heart disease. This includes a continuum of care that meets the unique needs of each individual in a range of settings with a range of services and supports. The spectrum of services include education and prevention, early identification with brief interventions, acute and long term treatment, and post-acute recovery support services.

New delivery models employ enhanced communication and reach across public and private sector systems, the boundaries of specialty and non-specialty health systems, and cross-disciplines to better understand and address patient needs. Practitioner teams should include counselors, nurses, social workers, physicians, recovery support specialists, dentists, and pharmacists. Comprehensive delivery of services requires the teams to receive adequate training on substance use disorders and an understanding of the science of the disease of addiction. These practitioners need to adopt and integrate evidence-based approaches into their practice for addressing substance use disorders and take a collaborative patient care approach that includes specialists from other medical fields. Furthermore, to sustain treatment gains, these models ideally link patients to recovery support services in the community.

Central to effective treatment for people with an opioid use disorder is the use of MAT provided in conjunction with counseling. MAT includes the use of FDA-approved medications such as methadone, naltrexone and buprenorphine in conjunction with behavioral therapies. Medications for treating opioid addiction—including addiction to prescription pain medications and illegal opioids like heroin—work by interacting with some of the same receptors in the brain that are triggered by the opioid drug. MAT is necessary to address the prescription pain medicine crisis and the rise in heroin use across our Nation.

ONDCP's Interagency Treatment Coordination Group (TCG), comprised of Federal agency representatives, is committed to ensuring the adoption of quality, evidence-based services, and systems of care across the Federal government. A main priority of the TCG is to ensure that MAT, which includes medications and evidence-based psychosocial treatment, such as contingency management interventions/motivational incentives and community reinforcement plus vouchers, are accessible as part of a comprehensive approach to treating nonmedical prescription and illicit drug use. To accomplish this, the TCG coordinates, facilitates, and participates in activities that support the use of MAT to treat opioid use disorders.

Federal Government Agency Efforts to Increase Access to Medication-Assisted Treatment

Research and evidence-based treatment program efforts funded by Federal agencies have demonstrable relevance and value for the substance use disorder field. While Federal agencies function differently, with very distinct roles and responsibilities, they each play a major role in the advancing of a comprehensive public health approach to deliver evidence-based substance use disorder intervention and treatment services. Most notable are Federal efforts to address opioid misuse, including the nonmedical use of narcotic pain relievers and heroin. Each of these opioids has a similar effect on the brain, and addictions to these drugs can be successfully treated with FDA approved medications such as methadone, naltrexone, and buprenorphine plus behavioral therapies.

NIDA and SAMHSA's Blending Initiative offers a suite of tools and training materials that address opioid addiction. This suite, *Buprenorphine Treatment: Training for Multidisciplinary Addiction Professionals* includes a section entitled "The Prescription Opioid Addiction Treatment Study: Treatment Strategies for Prescription Opioid Dependence." The suite houses tools and training resources for substance use disorder treatment providers, describes how buprenorphine works, and presents the results of a National Drug Abuse Treatment Clinical Trials Network study, that compared brief and extended buprenorphine treatments in prescription opioid dependent participants. The results of the study have implications for the treatment of adults with opioid use disorders. The Blending product suite helps treatment providers incorporate study findings and recommendations into their practice.

SAMHSA and NIDA jointly convened the Consensus Panel on New Pharmacotherapies for Opioid Use Disorder and Related Comorbidities that developed the *Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide*. This document provides an overview of the evidence on the effectiveness of available medications for the treatment of an opioid use disorder and a guide for clinical practice.

In his FY 2016 Budget, the President proposed critical investments to help address the growing problem of opioid addiction throughout the country, including expanding access to MAT. Moving forward, ONDCP will coordinate these investments with Federal agencies and look for opportunities to enhance them in the future, particularly for communities hardest hit by the opioid crisis.

Recovery support, whether from community-based programs or peer-to-peer support systems, can help people maintain their recovery. It is also essential to pay particular attention to special populations such as students in recovery from substance use disorders. For students, it is critical that recovery support services are offered in secondary and higher education settings and after-school programs. Recovery support initiatives in these settings promote positive social engagement among students and help them sustain their recovery.

Terms such as substance abuse, substance abuser, addict, and alcoholic tend to place stigma or blame on the individual with a substance use disorder. Even trained professionals are affected by the terms used to describe people who have used drugs. In a study where clinicians were asked to respond to client vignettes that were identical except one referred to an individual as a "substance abuser" and the other as a "person with a substance use disorder," the responses where the subject was described as a "substance abuser" were more likely to be seen as personally responsible for their use and deserving of punishment.[68] The language used to describe substance use disorders should not signify it as a personal or family failing, but as a disease requiring a public health approach in order to increase the number of people accessing treatment and sustained recovery.

Principle: Substance Use Disorder Treatment Must be an Integrated, Accessible Part of Mainstream Health Care

Today, our Nation's response to substance use disorders has begun to change. Groundbreaking discoveries about the brain have revolutionized our understanding of the science of drug addiction, enabling us to respond more effectively to the problem with a balanced public health and public safety approach. The Administration's objective has been to make sure substance use disorder services remain a priority for our Nation. In 2013, HHS finalized and released the regulations that apply to the Mental Health Parity and Addiction Equity Act, passed in 2008, for mental health and substance use disorder benefits, including in the ACA's Essential Health Benefits. As a result, Americans accessing health insurance coverage through non-grandfathered plans in the individual and small group markets will now have access to mental health and substance use disorder services coverage that is comparable to their general medical and surgical coverage. Thus, ONDCP focuses on improving access to services and treating substance use disorders through the identification and dissemination to stakeholders of valid, evidence-based tools to advance treatment for substance use disorders.

Action Item: Expand Substance Use Disorder Specialty Services in Community Health Centers (3.1.A.)

Models that involve multidisciplinary teams of health care providers are recommended to treat patients with substance use disorders. Positioned well to address patients' mental health/substance use disorder and primary care needs, primary care providers are integrating mental health/substance use disorder care services into practice. In 2014, Health Resources and Services Administration (HRSA) funded 220 organizations through its Health Center Program grantee sites to improve, expand, and integrate mental health/substance use disorder with primary care services and vice versa. Health centers are community-based and patient-directed organizations that serve populations with limited access to health care.

Under this funding opportunity, grantees are required to implement substance use disorder services including SBIRT.

Action item: Increase Substance Use Disorder Treatment Services Within the Indian Health Service (3.1.B.)

In 2014, the SAMHSA/HRSA Center for Integrated Health Solutions held a series of webinars[69] for Indian Health Service (IHS)-funded provider organizations along with the broader health care safety net provider community. Also in 2014, the IHS' Tele-Behavioral Health Center of Excellence conducted a series of webinars[70] on substance use disorder services for IHS, Tribal, and Urban (I/T/U) Indian health care providers. In 2014, the IHS Scholarship Program awarded funding for 18 behavioral health scholars in the areas of clinical psychology, pre-clinical psychology, social work, pre-social work, and substance abuse counseling.

Action Item: Expand Substance Use Disorder Services Delivery Innovations in the Department of Veterans Affairs (3.1.C.)

The Department of Veterans Affairs (VA) Veterans Health Administration (VHA) is America's largest integrated health care system, serving nearly 9 million veterans a year at more than 1,700 sites of care.[71] VHA provides a comprehensive range of services for treatment of substance use disorders across inpatient, residential, and outpatient settings. The VA and DoD have a collaborative process for the development of evidence-based Clinical Practice Guidelines including one for Management of Substance Use Disorders. The Management of Substance Use Disorders guideline was most recently updated in 2009 and has been widely disseminated within the departments.[72] In 2014, the VA and DoD started the process to revise all guidelines to be consistent with principles identified by the Institute of Medicine for "guidelines we can trust." Included in this process are revisions to the accompanying implementation tools to be shared with other stakeholders. The revisions to the guidelines and tools will be completed in 2015 and disseminated.

VHA is steadily expanding the availability of MAT for Veterans with opioid use disorders. In 2014, MAT for opioid use disorders, including office-based treatment with buprenorphine, was provided to patients at all but 7 VA Medical Centers (over 95 percent of the total). Over 300 total sites of service provided at least some buprenorphine, including Community-Based Outpatient Clinics separate from the medical centers. VA operates federally regulated opioid treatment programs (OPTs) that can provide methadone maintenance, as well as buprenorphine and naltrexone, on-site at 31 larger urban locations and at a growing number of VHA facilities that maintain contractual arrangements or arrange non-VA care for providing these services through community-based licensed OTPs.[73]

In addition, the VA expanded its pharmacy benefit plan to include extended-release naltrexone, another FDA approved medication to treat opioid use disorders. In 2015, the VA will continue its efforts to expand MAT for veterans with opioid use disorders.

Action Item: Enhance Public and Private Insurance Coverage of Substance Use Disorder Treatment (3.1.D.)

Throughout 2014, and following the release of the 2008 Mental Health Parity and Addiction Equity Act regulations, SAMHSA led and participated in a variety of educational efforts and provided technical information to states, plans, consumers, and other stakeholders about the content and implications of the final rules. These efforts included SAMHSA organizing webinars in collaboration with the National Association of Insurance Commissioners and conducting technical assistance calls with leading subject matter experts for officials in selected states. SAMHSA, along with the Department of Labor's (DOL) Employee Benefits Security Administration and the Internal Revenue Service, also participated in a national call with consumers and stakeholders led by the Office of the Vice President. DOL also conducted a variety of educational efforts, including webinars, conference calls, and seminars to educate stakeholders and the public on the provisions of the 2008 Mental Health Parity and Addiction Equity Act regulations as they relate to private employer-sponsored group health plans. Planning for the development of consumer-focused educational materials has also begun, and they are expected to be released in 2015. Also, in 2014, DoD expedited changes to the TRICARE policy manuals to allow MAT in TRICARE-authorized Substance Use Disorder Treatment Facilities.

Action Item: Inform Public Health Systems on Implementation of Syringe Exchange Programs (3.1.E.)

The Administration continues its commitment to reducing drug use and its consequences by underscoring the importance of screening and integrated treatment for HIV and viral hepatitis along with substance use and mental health disorders within behavioral health and primary care settings. Patients with these disorders need to be provided an opportunity to achieve long-term recovery through the use of approved medications. It is crucial that providers in both primary and specialty care settings become trained in MAT, particularly for patients with opioid use disorders. As part of the National HIV/AIDS Strategy, SAMHSA has begun a program in collaboration with partner agencies—ONDCP, HRSA, and the CDC—to assist with provider training on MAT for opioid use disorders including trainings that will authorize physicians to engage in office-based treatment of opioid use disorders. SAMHSA's Physician's Clinical Support System (PCSS-MAT) program facilitated these trainings and SAMHSA's Division of Pharmacologic Therapies worked collaboratively with partners to determine innovative approaches to expand office-based treatment for opioid use disorder.

Although the 2012 Consolidated Appropriations Act bans federal funding for syringe service programs (SSPs), the Administration remains steadfast in addressing infectious diseases, such as HIV and viral hepatitis, and substance use disorders with a public health approach. Injection drug use is a risk factor for contracting blood-borne infections. The Administration continues to support a consistent policy that would allow Federal funds to be used in locations where local authorities deem SPPs to be effective and appropriate. Studies show that comprehensive prevention and drug treatment programs, including SSPs, have dramatically cut the number of new HIV infections among people who inject drugs. SSPs can also serve to facilitate access to general medical care, social services, and counseling.

Principle: Patients with Substance Use Disorders and Their Families Must Receive High-Quality Care

Since the passage of the ACA and the Mental Health Parity and Addiction Equity Act, there has been a coordinated and synchronized effort by Federal Agencies to increase the Nation's understanding of the "state of the art" services available for substance use disorders. In support of these efforts, CMS and Federal partners developed an Informational Bulletin highlighting the benefits of MAT for substance use disorders[74] while the VA continues to expand the availability of MAT for Veterans with opioid use disorders. The ONDCP-EHR Interagency subcommittee continues to advance the Administration's 2010 National Drug Control Strategy; supports the mission of the Office of Science and Technology Policy (OSTP);[75] and helps advance the HIT initiatives at the SAMHSA, the Office of the National Coordinator for Health Information Technology (ONC), and the NIH Office of Behavioral and Social Sciences Research. In addition, the use of these innovative technologies supports the tenets of the ACA: to improve health, improve quality care, and increase patient engagement.

Action Item: Support the Development of New Medications for Substance Use Disorders (3.2.A.)

NIDA continues to support the development of a vaccine to treat methamphetamine use disorders. The FDA has allowed an investigational new drug (IND) application for a patented antibody that targets and destroys methamphetamine to proceed. In 2014, NIDA funded a new grant to complete the safety studies of the antibody in methamphetamine users. Provided these are successful, researchers will begin studies of the drug as a treatment for methamphetamine use disorders. In addition, NIDA's Division of Pharmacotherapies and Medical Consequences is conducting cocaine medication development studies. NIDA is evaluating the safety and efficacy of the medication nepicastat to treat of cocaine dependence.

NIDA is also continuing to support the development of lofexidine to treat opioid withdrawal. NIDA is currently completing new FDA-required studies on the interaction of buprenorphine and methadone with lofexidine which are required in order to examine the safety and efficacy of lofexidine for withdrawal in human opioid users. Results from these studies are expected in 2015.

Action Item: Integrate and Coordinate Substance Use Disorder Services Under the Affordable Care Act (3.2.B.)

A health home is a care management model that offers coordinated care to individuals with multiple chronic health conditions, including mental health and substance use disorders. The health home is a team-based clinical approach that includes the patient, his or her providers, and family members, when appropriate, and builds linkages to community supports and resources. To help states implement this model, SAMHSA and CMS developed a state consultation plan for states submitting proposals for State Plan Amendments to create health home programs. In 2014, 16 states approved State Plan Amendments for health homes, 13 of which included enrollment of persons with serious mental illness and/or substance use disorders.

Twelve Step Approach Integrates Medication-Assisted Treatment

The Hazelden Betty Ford Foundation, developed an innovative opioid treatment protocol under the direction of Dr. Marv Seppala, their Medical Director, integrating medication assistance with Twelve Step Facilitation and other evidence-based therapies. Hazelden developed this approach to be more responsive to patients with opioid use disorders. According to Dr. Seppala, "We cannot stick to treatment as usual. Americans with opioid use disorders are difficult to treat and always run the risk of death if they relapse. The stakes are too high to leave anything on the table. Treatment for opioid use disorders needs to utilize all of the best available evidence-based practices so that we address the unique and complex mix of physical, mental, emotional, and spiritual aspects of the illness."

Action Item: Promulgate the National Quality Forum Standards for Addiction Treatment (3.2.C.)

In 2014, NIDA worked with SAMHSA to complete the work started in 2013 on a Composite Measure for Substance Use Screening[76] for potential inclusion in the Medicare and Medicaid EHR Incentive Programs "Meaningful Use," which provides incentive payments and Medicare payment reductions to encourage the adoption and meaningful use of certified EHR technology. This composite measure includes screening and follow up counseling for drug use, prescription drug misuse, alcohol abuse, and tobacco use. This work is expected to be completed in 2015. As the gold standard for healthcare quality, NQF-endorsed measures are evidence-based and valid, and work in tandem with the delivery of care and payment reform.

The ONDCP-EHRs Interagency sub-committee developed consensus recommendations on 10 mental health/substance use disorder-related clinical quality measures (CQMs) to be included in Meaningful Use. Following up on these recommendations, SAMHSA, through an interagency agreement with HHS' Assistant Secretary for Planning and Evaluation (ASPE), has been working to update the electronic specifications in the event that the measures are included in future rulemaking for the EHR Incentive Program. This work is expected to be completed by June 2015. To address the nation's challenges with opioid and alcohol addiction, SAMHSA continues to work across agencies and with stakeholders to develop measures that address both prevention and treatment. Because of SAMHSA's work with the other Federal agencies, seven measures were included in the Measures Under Consideration (MUC) list. SAMHSA is also working on additional measures for screening patients at hospital discharge for alcohol abuse; brief intervention during the hospital stay to screen for alcohol and other drug use disorders and possible referral to MAT; and a measure on inappropriate prescribing of opioids for migraine headache in in-patient, out-patient and emergency department settings.

The ONDCP Interagency Treatment Coordination Group is working toward establishing MAT as a standard of care for opioid use disorders. This goal is in line with the NQF standard that specifies MAT as the standard of care for opioid use disorders. Also, ASPE is working to develop a code in the EHR to track whether patients with an opioid use disorder are offered MAT as a treatment option.

Action Item: Equip Health Care Providers and First Responders To Recognize and Manage Overdoses (3.2.D.)

The Administration is committed to ensuring that people are educated about recognizing and responding to an overdose situation. In 2014, ONDCP, CDC, and SAMHSA continued to work with first responder and provider organizations to expand use of naloxone—a medication used to reverse the effects of opioid overdose. SAMHSA has held webinars on its opioid overdose toolkit, and CDC continues to provide the toolkit and other information on naloxone to states to reduce opioid overdose through engagements with Association of State and Territorial Health Officers (ASTHO) and National Governors Association (NGA).

In 2014, DOJ's Bureau of Justice Assistance (BJA) released its Law Enforcement Naloxone Toolkit. This toolkit is a clearinghouse of resources to support law enforcement agencies in establishing a naloxone program, including guidance on acquiring and administering naloxone and information on the risks and liability law enforcement officers may face. The Law Enforcement Naloxone Toolkit was developed at the urging of the Attorney General in response to the growing opioid overdose epidemic. First responders who carry naloxone will be able to administer this drug quickly and effectively immediately restoring breathing to a victim in the throes of a heroin or opioid overdose.

Action Item: Integrate Substance Use Treatment and HIV Prevention and Care, Including in the Criminal Justice System (3.2.E.)

NIDA is supporting the development and implementation of a research protocol within the nine academic research centers in the Criminal Justice Drug Abuse Treatment Studies (CJ-DATS) research cooperative to increase HIV testing and linkage to treatment following incarceration. CJ-DATS, funded by the National Institutes of Health (NIH), is a collaborative research project involving research centers from across the country to develop organizational or systems-wide changes relating to substance use treatment interventions for those involved with the criminal justice system. Each research center partnered with one or more criminal justice agencies, and a Coordinating Center is overseeing the implementation of the research protocol. Publications are currently in preparation.

NIDA's Seek, Test, Treat, and Retain (STTR) Initiative funded 12 new grants to test the STTR paradigm with incarcerated people with drug use histories. STTR attempts to find drug users in the criminal justice setting who may have HIV, test them, and initiate treatment for HIV (e.g., highly active antiretroviral therapy, HAARTS). STTR particularly focuses on continuity of HAART during and after community re-entry following incarceration.

The process improvement model used by the CJ-DATS HIV-STIC protocol was successful in increasing the likelihood that a correctional facility would successfully deliver HIV services to incarcerated populations as compared to facilities that only received training on HIV services.[77] The process improvement model also resulted in more positive attitudes toward HIV service delivery among correctional staff.[78] A survey of sites participating in the CJ-DATS HIV-STIC protocol prior to study commencement indicated wide variation in the degree to which these correctional facilities adhered to national guidelines around HIV prevention, detection and care. Gaps in HIV service delivery were primarily attributed to limited resources.[79]

Principle: Celebrate and Support Recovery from Substance Use Disorders

The recovery community spans geographic, cultural, social, economic, and national boundaries. Therefore, since 2010, ONDCP has worked with the Office of Personnel Management (OPM), the Equal Employment Opportunity Commission (EEOC), and the Department of Labor to identify and begin to address barriers to employment for people in recovery from substance use disorders, to foster the development of workplace peer recovery support services, and the adoption of evidence-informed policies regarding substance use in the workforce. ONDCP continues efforts to expand access to recovery housing in partnership with the Department of Housing and Urban Development (HUD) and national organizations. In partnership with the VHA, ONDCP continues to explore mechanisms for expanding access to recovery support services for veterans and their families with a special emphasis on expanding access to online peer recovery support services.

Action Item: Review Laws & Regulations that Impede Recovery from Substance Use Disorders (3.3.B.)

ONDCP identified three focus areas in which to address such barriers to recovery—education, employment, and housing. In collaboration with the U.S. Department of Education, a fact sheet was developed and widely distributed to clarify opportunities for college students to access Federal Financial Aid. Working with Federal partners at the OPM, Department of Labor, and the EEOC, the Administration is encouraging Federal employers to hire persons in recovery, and highlight resources such as recovery community organizations (RCO's), peer-based organizations, and Employee Assistance Professionals to support employees in their recovery. ONDCP has also partnered with HUD to disseminate existing regulations that allow access to vital housing resources. Additionally, several models of housing initiatives for justice involved people will be profiled as examples of publicly funded housing programs for persons in recovery. In late 2015, these models can be accessed on HUD's and ONDCP's websites.

Action Item: Foster the Expansion of Community-Based Recovery Support Programs, Including Recovery Schools, Peer-led Programs, Mutual Aid Groups, and Recovery Community Organizations (3.3.C)

ONDCP has collaborated with numerous stakeholder groups to identify and promote resources in schools, workplaces, and communities to support persons on pathways to recovery. ONDCP and SAMHSA have engaged leaders in state, local, and tribal governments and non-government organizations (NGOs) to promote the widespread adoption of recovery-oriented supports, services, and systems in SAMHSA grantee states and beyond. ONDCP also convened several rounds of Recovery-Oriented Systems of Care (ROSC) Learning Communities to facilitate exchange of technical support to states and communities building comprehensive systems. Additionally, SAMHSA's Center for Social Innovation administered the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS), providing funding to assist peer-run recovery community organizations, policy academies, shared decision making tools and other resources.

University High School, a Recovery High School

Founded in 2013, University High School is the first recovery high school in Central Texas and the only recovery high school established on a college or university campus. University High School enables each of their students to fulfill his or her personal and academic potential within a supportive and sober recovery environment. University High School is dedicated to transforming student's lives by providing individualized, challenging academics in an engaging, safe, and sober environment.

The school's location on campus and mentoring relationships with recovering University of Texas at Austin students help make college an expectation among the high school's students, many of whom never imagined they would attend college. The creation of the school was a collaboration with partners at The University of Texas at Austin, among others; the school is independent of the university.

Advocate for Action: Denise Herbert, Michigan

Denise Herbert has used her position as a Prevention Coordinator to challenge health systems and providers to address increasing marijuana use among young people of color in Kent County. She also sought innovative ways to engage multiple sectors and community organizations, such as Central City Weed & Seed and Our Community's Children, to enhance evidence-based protective factors and empower youth voices in the effort to reduce drug use.

Ms. Herbert organized a training campaign with Michigan's Office of Highway Safety Patrol to educate more than 100 school, law enforcement, and health professionals on the legality of the state's medical marijuana law and ways to protect community youth and adults. When data from the Michigan Profile for Healthy Youth survey revealed that young people in Kent County were using alcohol as early as age 12, Ms. Herbert began sponsoring demographically representative focus groups to engage local parents and youth in defining and addressing the problem. Her work led to the creation of TalkSooner.org and, in partnership with anti-drug coalitions in Kent, Ottawa, Berrien, Allegan, and Muskegon counties, a social media campaign to equip youth and parents with resources to reduce underage substance use in West Michigan.

Ms. Herbert created the Kent County Prevention Coalition, whose mission is building a healthier community by preventing and reducing substance use in Kent County, with a major focus on youth. She is the co-creator of the ATI-Kent County youth movement which includes an annual Youth Summit.

Most recently, Ms. Herbert joined efforts with Network180's internal Mental Health First Aid (MHFA) planning team and became a certified Youth MHFA instructor. Her community involvement reflects her life mission to create avenues for youth empowerment, urban renewal, and population-level change. In 2009, she helped create the Faith Community Partners for Change, a multicultural collaborative of area faith communities committed to reducing underage and adult substance use in Kent County using one of the community's most treasured assets and influences, the church.

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

President Obama's reform efforts focus on creating a more effective and fair criminal justice system through evidence-based strategies, innovative pilot projects, and forward-thinking practitioners and experts. Public health and public safety collaboration is imperative to achieving this goal.

The Administration supports the implementation of evidence-based practices that divert individuals to treatment and recovery support services with appropriate supervision;[80] provide treatment during incarceration; and improve system effectiveness and efficiency.[81] The Administration also encourages the development of promising practices to improve and expand the breadth of innovative criminal justice reform strategies and programs, including holistic defense services and the provision of effective and independent defense counsel.

In addition to supporting state and local efforts, the Federal government continues to institute its own reforms. In March 2014, then Attorney General Holder announced that the Bureau of Prisons (BOP) would impose new requirements on Federal reentry centers and on home confinement to provide substance use and mental health treatment to inmates prior to release.[82] As Federal, state, tribal, and local governments are recognizing, interventions for justice-involved individuals with substance use disorders are more effective when evidence-based treatments and other support services are provided. For persons with opioid use disorders, evidence-based treatment includes the use of FDA-approved medications (methadone, buprenorphine, and naltrexone) in combination with behavioral therapies.

Moving forward, the Administration will work to increase the use of these medications for persons under community supervision or in a correctional facility. Individuals newly released from incarceration, particularly within the first two weeks, are more vulnerable to relapse and at a higher risk of overdose.[83] These medications may not only prevent overdose but may also help an individual remain in treatment longer, increasing their ability to sustain recovery and stave off further involvement in the criminal justice system.[84]

Drug convictions often have far-reaching consequences and can preclude individuals from getting an education, housing, or employment. In June 2014, the White House honored 15 individuals as "Champions of Change" who are helping people with criminal records find steady employment and successfully reenter their communities.[85]

The Administration also convened business executives and government officials to discuss improving access to employment for people with a history of criminal involvement. The discussion focused on efforts to be undertaken by business leaders, policy makers, and government officials to encourage employers to modify their hiring policies and practices in accordance with guidance from the EEOC, which makes clear that an arrest or a criminal conviction does not automatically bar individuals from all employment.[86] In 2015, DOJ will fund pilot sites to test innovative employment and workforce development strategies.

New efforts to apply research to juvenile justice reform are underway. OJJDP is promoting reforms based on a study undertaken by the National Research Council.[87] The study calls on juvenile justice policymakers and practitioners to recognize the developmental differences between youth and adults when

creating juvenile programming. Further, NIDA's Juvenile Justice Translational Research on Interventions for Adolescents in the Legal System (JJ-TRIALS)[88] collaborative funds seven research centers that use substance use disorder and HIV research to develop effective juvenile justice practices.

The Administration continues to support alternatives to incarceration and reentry support services. Moving forward, its reform efforts will also focus on pre-arrest, post-booking, and pre-trial diversion; access to treatment, including FDA-approved medications for persons with substance use disorders; and overdose prevention. If we can ensure that justice-involved individuals receive treatment for their substance use disorders, along with recovery and support services, we can reduce recidivism, enhance public health and public safety, and help these individuals become productive members of their community.

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

Organizations that focus on improving public health and public safety can collaborate with community organizations to intervene in the lives of young persons at risk of participating in criminal activity.

Action Item: Organize Community-wide Efforts to Reduce Open-Air Drug Markets and Gang Activity via Drug Market Intervention Approaches (4.1.A)

For several years, DOJ funded training and technical assistance to test the Drug Market Intervention (DMI) approach. Under the DMI approach, police identify individuals who are participating in open-air drug markets (i.e. drug markets operating on the street), arrest the high-level dealers, and build cases against low-level dealers. With the help of family members and community leaders, the police then stage an intervention with the low-level dealers and use the cases against them as leverage to stop their criminal behavior. Education, employment, treatment, and other services are offered to help these individuals change their lives.

Overall, 24 sites received technical assistance from the BJA-funded technical assistance provider to set up DMI.[89] Preliminary results of an evaluation by the RAND Corporation suggest that the intervention reduces crime with minimal displacement to neighboring areas, but the findings are not robust and the impact is not statistically significant.[90] Final results are anticipated in spring 2016.

Action Item: Engage Faith-Based and Neighborhood Community Organizations to Prevent Drug-Related Crime (4.1.B)

The Administration has expanded its efforts to prevent crime and promote academic and career success among youth. Collaborative initiatives such as the National Forum on Youth Violence Prevention ("Forum") and My Brother's Keeper reach young persons before they become involved in criminal activity and direct them toward education and employment. This year, My Brother's Keeper formed numerous public-private partnerships focused on improving academic success, reducing the likelihood of youth entanglement in the criminal justice system, and reducing the likelihood that young people become victims of violent crime.

The National Youth Violence Prevention Forum brings together Federal, local, and private sector partners in each of the 15 Forum cities to reduce the likelihood of violence and gang involvement. Each city team,

consisting of representatives from housing, education, employment, law enforcement, and other sectors develops and operates programs such as job training, academic support, pro-social activities, and other supportive services to help young people avoid violent activity. Previously selected cities (Salinas and San Jose, California; Chicago, Illinois; Boston, Massachusetts; Detroit, Michigan; New Orleans, Louisiana; Memphis, Tennessee; Philadelphia, Pennsylvania; Camden, New Jersey; and Minneapolis, Minnesota) are now working on sustainability efforts for their violence prevention plans. In 2014, the Forum added five new cities: Baltimore, Maryland; Long Beach, California; Louisville, Kentucky; Seattle, Washington; and Cleveland, Ohio.

Action Item: Support Innovative Criminal Justice Research Programs (4.1.C)

NIJ and BJA partnered to implement the Honest Opportunity Probation with Enforcement Demonstration Field Experiment (HOPE DFE) in 2011. Originating in Hawaii in 2004, the HOPE model combines drug testing and court supervision with a series of "swift, certain, and fair" sanctions for violations of the terms of supervision. The field experiment is testing whether successes achieved in Hawaii can be replicated in other jurisdictions.

BJA has funded demonstration projects and training and technical assistance in Clackamas County, Oregon; Saline County, Arkansas; Essex County, Massachusetts; and Tarrant County, Texas. Additionally, NIJ is supporting process, impact, and cost studies. All four sites have completed participant enrollment in the study and the researchers will observe recidivism and other outcomes for 6 to 18 months. The Demonstration Field Experiment team presented preliminary findings from the process study at the November 2014 American Society of Criminology Conference. A project update was published in the fall 2014 issue of the American Probation and Parole Association's quarterly journal, Perspectives.[91]

Principle: Develop Infrastructure to Promote Alternatives to Incarceration When Appropriate

Jurisdictions are looking to decrease corrections costs and implement effective strategies to reduce recidivism. For individuals with substance use disorders, establishing diversion programs with evidence-based treatment and supervision practices requires leadership and collaboration among policymakers, criminal justice professionals, and service providers. Progress has been made and much innovation is underway at the state and local levels; and the Federal government continues to support the implementation of successful models.

States and local jurisdictions are also undertaking legislative reforms, some through the Justice Reinvestment Initiative. Under Justice Reinvestment, state-level bi-partisan coalitions evaluate available data on their criminal justice expenditures and pass legislation to implement policy and procedural changes. The goal is to reinvest the cost-savings into programs that divert people away from the criminal justice system, such as alternatives to incarceration, treatment for substance use disorders and mental illness, or supportive community services. For example, in Idaho[92] and West Virginia,[93] previously planned prison construction was canceled and funding was redirected to expand access to treatment for substance use disorders and viable alternatives to incarceration.

Action Item: Enhance and Promote Diversion Strategies (4.2.A)

In March 2014, the Pretrial Justice Working Group, supported by BJA and the Pretrial Justice Institute, issued a progress report[94] detailing how state and local jurisdictions have implemented the recommendations from the United States Attorney General's 2011 National Summit on Pretrial Justice. The recommendations included a number of measures to improve fairness in pretrial practices, including increased use of assessments to inform detention decisions; improvement of training and technical assistance; and increased collection and availability of data on pretrial practices.

The Pretrial Justice Institute continues to provide training and educational support to jurisdictions implementing a risk assessment tool to inform pretrial release or detention decisions. In 2014, the Pretrial Justice Institute assisted over 65 jurisdictions. Additionally, in late 2014, BJA awarded its inaugural class of "Smart Pretrial" grantees that will employ these principles. Grantees include the city and county of Denver, Colorado; the state of Delaware; and Yakima County, Washington.

Action Item: Support Drug and Other Problem-Solving Courts (4.2.B)

In 2014, BJA released an updated publication developed by the Tribal Law and Policy Institute to improve the operations of Tribal Healing to Wellness Courts. This publication focuses on improving the implementation of drug court principles in treatment courts serving American Indian and Alaska Native populations.[95]

The VA and BJA are expanding training and technical assistance resources for Veterans Treatment Courts. These courts use a problem-solving court model that incorporates aspects of military culture and VA services to help justice-involved veterans with substance use disorders. In partnership with the Center for Court Innovation, these Federal agencies provide online resources to improve Veterans Treatment Court services.

Determining the most effective and fair alternative to incarceration for an individual with a substance use disorder must be based on evidence-based interview and assessment tools. BJA supports efforts to improve these tools for corrections practitioners. The tools assist in determining an individual's risk of reoffending and the appropriate and least restrictive level of supervision. In addition, these tools provide guidance to practitioners on the most appropriate treatment services and programs.

In 2014, NIJ released a Spanish language edition of Adult Drug Court Principles, Research, and Practice. The guide reviews research-based information to assist in the development of more effective programs in seven areas: screening and assessment; target population; procedural and distributive justice; judicial interaction; monitoring; treatment and other services; and relapse prevention, aftercare and community integration.[96] NIJ also produced a Research in Brief for drug courts and other criminal justice program stakeholders on cost-benefit analysis. The brief reviews how cost studies are conducted, information available to support robust studies, and proper interpretation of results using examples from NIJ's Multisite Adult Court Evaluation.[97]

Action Item: Support Systemic Change in Evidence-Based Sentencing Through Training and Outreach (4.2.C)

Through the Drug Court Training and Technical Assistance Initiative (a grant funded by ONDCP), the National Association of Drug Court Professionals (NADCP) convened criminal justice and treatment policymakers, practitioners, and government officials to launch a systems change project in the States of Vermont and Utah, and the City of Hattiesburg, Mississippi. At each site, a thorough assessment of the justice system was through this initiative produced training materials to increase law enforcement involvement in drug courts and other diversion programs. Additionally, the Center for Health and Justice at Treatment Alternatives for Safe Communities, Inc. collaborated with national law enforcement organizations and law enforcement agencies to develop three videos to educate law enforcement officers on addiction as a brain disease and the importance of public health and public safety collaboration. The videos will be released in the summer of 2015.

In December 2014, ONDCP awarded NADCP a grant to continue funding projects within the Drug Court Training and Technical Assistance Initiative, and to increase efforts on front-end diversion, MAT, and overdose prevention.

Action Item: Foster Equitable Drug Sentencing (4.2.D)

Adding to the momentum established by the Administration's commitment to fairness, justness, and effectiveness in drug sentencing, in 2014, the United States Sentencing Commission voted unanimously to reduce the sentences for most Federal drug offenses.[98] The Commission approved the measure to help reduce prison costs and reserve the harshest punishments for drug traffickers and individuals charged with violent offenses. The guideline amendment went into effect on November 1, 2014. People currently imprisoned under old sentencing guidelines can petition the court for sentencing reductions as a result of the amended guidelines.

Action Item: Promote Best Practices as Alternatives to Incarceration (4.2.E)

NIJ funded a policy analysis[99] of New York State's 2009 drug law reform measures that eliminated mandatory prison sentences for most drug offenses and created diversion and treatment alternatives. The project examined the impact of this state law on felony drug cases in New York City[100] and found a modest increase in the use of diversion by judges and a decrease in jail sentences. Aside from drug court participation, arrestees diverted into treatment had lower rates of rearrest.[101] The New York State Division of Criminal Justice Services reported that the 2009 drug law reform measures resulted in a statewide decrease in prison sentences, an increase in drug court enrollment, and a significant decrease in rearrest rates for drug court participants when compared to people who were incarcerated.[102]

Action Item: Improve Intervention and Treatment Services for Girls and Women in the Juvenile and Criminal Justice Systems (4.2.F)

The National Institute of Corrections (NIC) has made significant progress in improving early intervention practices and treatment services for justice-involved women. It has updated curricula within its training and technical assistance program, as well as created a gender-responsive assessment tool. These accomplishments help policymakers and practitioners integrate evidence-based models of care and

confinement into their corrections systems to effectively meet the needs of women in prison. In 2015, NIC will develop a curriculum on sexual safety in women's prisons and produce a policy paper focusing on girls adjudicated in the adult system.

Action Item: Examine Interventions and Treatment Services for Veterans within the Criminal Justice System/Connect Incarcerated Veterans with Critical Substance Abuse and Reentry Services (4.2.G/H)

The Veterans Reentry Search Service (VRSS) is a computer-based system developed to identify veterans in the criminal justice system and is being used by a growing number of prisons, jails, and courts. With the VRSS, the VA connects veterans, prior to their release, to services and benefits, including treatment for those with a substance use disorder. More than half (27) of all state prison systems now use VRSS to identify veterans in their correctional facilities.[103]

The VA continues to help courts and state correctional facilities secure access to the VRSS, increasing the number of veterans engaged in the Health Care for Reentry Veterans and Veterans Justice Outreach programs. In 2015, the VA will expand VRSS access to identify veterans cycling through local jails and connect them to services.

Additionally, BJA and NIC developed an assessment tool to determine the most appropriate supervision and services for veterans. The tool will be field-tested and made available for Veterans Treatment Court practitioners.

Action Item: Address the Issue of Drug Use and Drug-Related Crime for American Indian/Alaska Natives (4.2.I)

The Administration has focused on preventing drug use and drug-related crime in Indian Country. Enacted in 2010, the Tribal Law and Order Act directed Federal agencies to support efforts to enhance policing practices and procedures; improve prosecutorial responses to violent crime; and implement evidence-based strategies and treatment to address alcohol and substance use in Indian Country.[104]

Throughout 2014, SAMHSA, in partnership with IHS, provided in-person and online training to 35 tribes on action planning.[105] These action plans help tribal communities develop prevention, treatment, and recovery support programming that is responsive to the specific needs of the individual communities. As a result of this training, the Northwest Portland Area Indian Health Board developed a regional tribal action plan for 43 federally-recognized tribes in Idaho, Oregon, and Washington. This plan identified service needs for members with substance use disorders and the resources necessary to provide these services. Additional training and technical assistance will continue in 2015.

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

Effective alternatives to incarceration promote accountability but are also combined with evidence-based treatment and recovery support services for justice-involved individuals with substance use disorders. The Federal Government, in partnership with state, local, tribal, and non-governmental entities, is expanding these alternatives in hopes of reducing substance use and recidivism.

Action Item: Support Drug Testing with Certain and Swift Sanctions in Probation and Parole Systems (4.3.A)

Funded by ONDCP and in cooperation with NIDA, in 2010 NIJ awarded a grant to the University of Delaware to evaluate a supervision pilot. Developed by the Delaware Department of Corrections, the Decide Your Time Program[106] placed new probationers and parolees with positive drug tests on intensive supervision employing swift and certain consequences for non-compliance with the terms of their probation or parole. The field experiment assessed the recidivism rates among participants in the Decide Your Time Program compared to those on standard probation or parole. In contrast to other testing and sanction models, the Decide Your Time protocol was implemented and operated by front line probation officers instead of a judge. The field experiment has been completed and the final report will be released in summer 2015.

Action Item: Consider Mechanisms for Assessing and Intensifying Community Corrections (4.3.B)

BJA recently expanded its "Smart Probation" Initiative to help probation and parole agencies implement swift, certain, and fair sanctions protocols for supervision violations. Now called the "Smart Supervision Initiative," this program is funded by the Second Chance Act.[107] In 2014, BJA made seven awards to state agencies in Florida, Georgia, Maine, and Washington, and to local agencies in Alameda County, California; Maricopa County, Arizona; and Noble County, Indiana.

Action Item: Align the Criminal Justice and Public Health Systems to Support Justice Involved Individuals with Substance Use Disorders (4.3.C)

In 2014, SAMHSA funded adult and juvenile drug courts, tribal healing-to-wellness courts, and a recently developed mental health/substance use disorder treatment court model for co-occurring mental health and substance use disorders. SAMHSA has focused on addressing substance use disorders earlier in the justice process. New grants supporting these programs will be awarded in 2015.

Action Item: Address Co-occurring Disorders Using a Community-Based Response (4.3.D)

SAMHSA worked to integrate treatment for substance use disorders and co-occurring mental health disorders into its justice programming. CSAT and the Center for Mental Health Services jointly funded 17 grants to support the establishment of Behavioral Health Treatment Court collaboratives. This public health and public safety initiative supports partnerships between courts and community treatment and recovery service providers to address the substance use and mental health needs of justice-involved individuals. For example, Craighead County, Arkansas will use the grant to improve collaboration among its existing "problem-solving" courts (drug court, mental health court, and driving while intoxicated [DWI] court) to ensure program participants can access community-based treatment resources for co-occurring mental health and substance use disorders.

Action Item: Improve and Advance Treatment in Prisons for Substance Use Disorders (4.3.E)

The Federal BOP continues to expand and improve treatment services, as well as develop additional treatment protocols for individuals with opioid use disorders. In May 2014, BOP approved a field trial involving the use of an injectable, long-lasting form of the medication naltrexone at three Federal facili-

ties. The field trial began in September 2014, and based on the results, BOP will determine whether to expand this protocol to other facilities.

In April 2014, BOP completed the expansion of its Bureau Electronic Medical Record (BEMR) system, which now includes mental health, drug treatment, and general health records. This comprehensive expansion will streamline record retention and improve overall patient care.

BJA's Residential Substance Abuse Treatment Program Training and Technical Assistance web site provides an interactive forum to discuss current issues in correctional substance use disorder treatment. The site recently added a virtual tour of the MAT pilot currently underway in Barnstable County, Massachusetts. These resources are in addition to monthly webinars on correctional treatment programming, reentry, and professional development for treatment providers and correctional officers.

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

Assisting in community reentry of justice-involved individuals has been among the most successful initiatives of the Federal Government. Under the auspices of the United States Attorney General's Federal Interagency Reentry Council, over 20 Federal agencies are working collaboratively to reduce legal and administrative barriers to housing, health care, education, employment, and public benefits; and to promote family reunification.[108]

Action Item: Expand Reentry Support and Services through the Second Chance Act and Other Federal Grants/Develop Adult Reentry Programs (4.4.A/B.)

Since 2009, BJA has supported reentry efforts in 49 states, awarding more than 600 Second Chance Act grants to promote comprehensive programs for individuals reentering their communities after incarceration. In 2014, 52 additional grants were awarded. In 2015, a formerly incarcerated person will serve as a Justice Fellow at the Office of Justice Programs to provide insight on the needs of justice-involved individuals. Additional information about Federal efforts can be found by visiting the National Reentry Resource Center.[109]

Additionally, efforts to improve reentry services in the juvenile justice system are underway. In 2014, OJJDP funded 17 grants to improve services for reentering youth and their families. These grants focus on reforming system-wide justice processes and supporting demonstration projects that test new approaches to youth reentry support.

Action Item: Facilitate Access to Housing for Formerly Incarcerated Individuals (4.4.C)

HUD is working with Federal partners to remove barriers to housing for people reentering their communities, particularly where policies and regulations impede reunification of families. HUD and OJJDP are working together to provide access to legal services for justice-involved youth within public housing communities. These services will help young people seal or expunge their criminal records to improve their employment and educational opportunities.

Action Item: Provide Work-Related Training and Assistance to Reentering Formerly Incarcerated Individuals (4.4.D)

The Department of Labor is working to expand and improve its job-readiness training for formerly incarcerated individuals. It has awarded multiple grants to reentry programs that help justice-involved individuals obtain employment. One such grantee, the Dannon Project in Birmingham, Alabama, offers life-skills development programs, job-readiness training, and certification programs, such as a construction management certification program.[110]

Action Item: Encourage States Receiving Federal Funds for Corrections Programs to Provide Assistance to BJS in Conducting Annual Recidivism Studies (4.4.E)

The Administration solicited assistance from states to build a more robust study of annual recidivism data. Based on the information received, the Bureau of Justice Statistics released the report, Recidivism of Prisoners Released in 30 States in 2005: Pattern from 2005 to 2010[111] in April 2014. The report showed that 67.8 percent of state prisoners released in 2005 in these 30 states were rearrested within three years of release, and 76.6 percent were rearrested within five years. While the high percentage of individuals being rearrested after release from prison is a concern, it reinforces the need to continue Federal, state, local, and tribal justice system reform efforts.

Principle: Improve Treatment for Youth Involved with the Juvenile Justice System

Although there is still a significant need to expand treatment services for adolescents, more Federal, state, local, and tribal agencies are working to improve access to substance use and mental health treatment for justice-involved youth. Additional programming and practices that employ evidence-based alternatives to incarceration and supportive services are helping justice-involved young people return to their communities and grow into productive adults.

Action Item: Develop and Disseminate More Effective Models of Addressing Substance Use and Mental Health Disorders among Youth in the Juvenile Justice System (4.5.A)

OJJDP funded multiple initiatives to improve juvenile justice reentry efforts, including treatment for substance use disorders. Funded by the Second Chance Act, one planning initiative supports demonstration pilots to improve services available to youth before and after they leave the juvenile justice system. For example, jurisdictions may choose to provide supportive services that include adolescent treatment, education or employment support, or family therapies. The National Reentry Resource Center will work with six grantees (Miami Gardens, Florida; New York, New York; and the states of Georgia, Illinois, Mississippi, and Ohio) on demonstration projects.

Further, SAMHSA has been working with the MacArthur Foundation to hold policy academies on issues affecting juvenile justice systems. In 2014, state and tribal juvenile justice teams met to discuss evidence-based reform strategies, and to develop plans on implementing diversion programs that include treatment for mental health and substance use disorders, and trauma. The MacArthur Foundation is funding follow-up studies that examine the outcomes of their reform efforts.

48

Advocate for Action: Julie Scofield, Washington, D.C.

Julie Scofield joined the National Alliance of State and Territorial AIDS Directors (NASTAD) as its first Executive Director in 1993. Under her leadership, NASTAD has grown from a staff of 1 to a highly respected national HIV and hepatitis organization of over 40 staff.

Since the beginning of Ms. Scofield's tenure, NASTAD has focused on the role of substance use in the transmission of HIV (and later HCV), health outcomes for persons living with HIV and hepatitis who use drugs, and the structural and policy barriers to address the prevention, care, and treatment needs of persons who inject drugs. NASTAD provides technical assistance to state health departments, and advocates for a science-based public health approach to address the needs of people who inject drugs. Throughout the 1990s, NASTAD issued resolutions in support of needle exchange programs and pharmacy sales of sterile syringes to help prevent blood-borne pathogen transmission. Currently, NASTAD focuses on providing technical assistance to health departments on HIV, hepatitis, and overdose prevention in support of its 2011 statement of commitment on promoting injecting drug user health.

Before joining NASTAD, Ms. Scofield served as legislative assistant in the New York Office of Federal Affairs during the Administration of the late Governor Mario M. Cuomo. She represented the state on science and technology and health issues, including HIV/AIDS policy and funding before Congress and the Administration from 1987 to 1993.

Chapter 5: Disrupt Domestic Drug Trafficking and Production

The unlawful trafficking and distribution of both illegal and diverted legal drugs in our communities are a threat to public health and public safety. Reducing drug trafficking and drug use and its consequences depends on the collaborative efforts of Federal, state, local, and tribal law enforcement agencies. Federal support for interagency law enforcement drug task forces is critical to leveraging limited resources. Improvements in law enforcement subject and event deconfliction and improvements in information-sharing among agencies can facilitate strategic deployment of law enforcement resources and coordination among law enforcement agencies and the intelligence community.

The threats posed by trafficking and use of illicit drugs continue to be serious and demanding challenges to the United States. While progress has been made in disrupting domestic drug trafficking and production, transnational criminal organizations (TCOs) have historically demonstrated the ability to adjust operations when challenged. These drug trafficking organizations (DTOs) and their criminal activity can be found throughout the United States. They exploit the Northern border with Canada and the Southwest border with Mexico and use domestic public and tribal lands to grow marijuana. Great strides have been made to counter domestic production of drugs like methamphetamine. However, even with increased seizures, countering Mexico-produced methamphetamine along the Southwest Border continues to be a challenge. Heroin availability is increasing because of sustained production in Mexico.[112] Moreover, marijuana availability continues to increase due to continued high levels of production in Mexico along with domestic cultivation.[113]

Law enforcement agencies collaborate with Federal, state, tribal, and local partners to address the expanding range of interrelated challenges along the Mexican and Canadian borders. These challenges range from drug and human smuggling into the United States, Mexico, and Canada, to the transit of arms and bulk cash, and money laundering across these borders. Law enforcement agencies have been successful in identifying interior corridors of drug movement within the U.S. However, illicit proceeds still cross the border in both directions, along with members of gangs and other organized crime groups, traffickers, facilitators, and couriers. Additionally, DTOs and TCOs consistently use novel techniques to launder their money. Law enforcement will continue to work to disrupt these emerging trends.

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

Multi-jurisdictional task force teams that implement strategies to pool resources and share information are the backbone of counterdrug enforcement efforts. This focuses limited resources on significant threats and strengthens their ability to identify and destabilize interconnected national and transnational criminal networks. HIDTAs will continue to coordinate and collaborate with other drug enforcement task forces through a variety of methods, including: law enforcement coordinating committees, the DOJ's Organized Crime Drug Enforcement Task Forces (OCDETF) case initiation and coordination meetings, and miscellaneous training opportunities. Information sharing and deconfliction will remain priorities for law enforcement agencies and support to tribal law enforcement will continue.

Action Item: Maximize Federal Support for Drug Law Enforcement Task Forces (5.1.A)

Federal policymakers have taken a number of steps to appropriately align Federal drug enforcement efforts with the efforts of state, local, and tribal partners. During FY 2013, the OCDETF program met the milestone of maintaining participation of state and local law enforcement agencies in at least 90% of active OCDETF investigations.

In 2013, HIDTA-funded initiatives disrupted or dismantled 3,135 drug trafficking organizations, removing significant quantities of drugs from the market and seizing over $780.1 million in cash and $349.3 million in non-cash assets from drug traffickers ($1.1 billion total).[114] As of September 12, 2013, the OCDETF Fusion Center had disseminated 10,116 products[115] to drug law enforcement task forces during the first three quarters of FY 2013. This is an increase of 60% over the number of products (6,306) disseminated during the same period (Q1-Q3) in FY 2012.

Action Item: Improve Intelligence Exchange and Information Sharing (5.1.B)

Systematic collection, analysis, and secure dissemination of accurate and timely intelligence are critical to thwarting the activities of criminal organizations. For example, multi-agency, prosecutor-led Panama Express (PANEX) offers intelligence exchange and information sharing that has contributed to numerous ongoing Consolidated Priority Organization Target (CPOT) investigations. PANEX is an [OCDETF co-located Strike Force operation involving United States Coast Guard (USCG), DEA, Homeland Security Investigations (HSI), Internal Revenue Service, the Federal Bureau of Investigation, and the Joint Inter-Agency Task Force South (JIATF-South). These entities share intelligence and operational resources to target the largest illicit drug traffickers operating in the Eastern Pacific and Caribbean regions that ship multi-ton quantities of cocaine destined for U.S. consumption.

At the Nation's borders, the Border Enforcement Security Task Forces (BEST) have expanded to 37 locations in 16 states and Puerto Rico. Since its inception in 2005 through July 2015, BEST's have collectively initiated over 15,300 investigations, obtained over 10,300 convictions that have resulted in the seizure of over $218.3 million, 1.7 million pounds of narcotics, and over 20,000 weapons.[116]

Due to increased reporting to the El Paso Intelligence Center's (EPIC) National Seizure System (NSS) and increased awareness in the Domestic Highway Enforcement (DHE) program, 8,058 incidents were reported as traffic stops to EPIC in 2013. These stops resulted in 14,139 seizures and highlight the importance of intelligence from border/source enforcement and transit/destination investigation activity to law enforcement efforts to address drug trafficking.

Action Item: Ensure State, Tribal, and Local Law Enforcement Access to Federal Information on Mexico-Based Traffickers (5.1.C)

Current intelligence on Mexico-based traffickers must be readily available to state, local, and tribal law enforcement. The Strategy's goal was to manage a 15% increase in the number of state and local law enforcement officers using the DEA's De-Confliction & Information Coordination Endeavor (DICE) intelligence system. In FY 2014, DEA surpassed the established goal by achieving a 28% increase in state and local law enforcement officer DICE accounts created.[117] The Financial Crimes Enforcement Network (FinCEN) continues to produce proactive targeting reports on compromised Money Services Businesses

(MSBs) and subsequently publishes finished intelligence and analytical products. Additionally, FinCEN continues to work with regulatory partners to conduct examinations of MSBs for non-compliance, and assesses civil money penalties as appropriate.

Action Item: Assist Tribal Authorities to Combat Trafficking on Tribal Lands (5.1.E)

Seven HIDTA programs continue to collaborate with tribal nations on enforcement operations and training. 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 Arizona HIDTA. The NATIVE initiative is now a fully funded operation in the Arizona HIDTA. NATIVE is a cooperative Federal and Tribal task force operating to address smuggling operations throughout the Tohono O'odham Nation. NATIVE includes law enforcement personnel from the Tohono O'odham Police Department, U.S. Immigration and Customs Enforcement's (ICE), HSI, and the Bureau of Indian Affairs Drug Enforcement Division.

Through its numerous offices along the Southwest and Northern borders, HSI continues to work with tribal law enforcement agencies. The HSI Shadow Wolves[118] continue to work with the Tohono O'odham Police Department on the Southwest border on various cases involving missing children, homicides, and kidnapping. On the Northern border, the St. Regis Mohawk Tribal Police directly participate in information sharing efforts through the New York State Intelligence Center (NYSIC), the state's primary intelligence fusion center, and EPIC.

Action Item: Ensure Comprehensive Review of Domestic Drug Threat (5.1.F)

ONDCP collaborates with its intelligence community colleagues to ensure that national policy makers are provided with the best possible domestic all-source counterdrug intelligence analysis. In support of this endeavor, DEA completed and distributed the National Drug Threat Assessment in June 2014. ONDCP will continue to collaborate with DEA and other intelligence, law enforcement, and domestic health agencies on the development of future iterations of the National Drug Threat Assessment.

Principle: The United States Must Continue to Secure Its Borders

Previous versions of the *National Southwest Border Counternarcotics Strategy* have incorporated several over-arching goals and objectives and the next iteration of the strategy will continue to build on earlier successes. Specific emphasis will again be placed on improving information and intelligence sharing; securing the land, air and maritime avenues of approach into the United States; controlling the illegal flow of bulk cash and weapons into and out of the United States; cooperating with the Government of Mexico; and establishing or expanding drug prevention, treatment and recovery programs.

Action Item: Implement the Southwest Border Counternarcotics Strategy (5.2.A)

Illicit drug activities along the United States southwest border—the transport, transshipment and distribution of illegal drugs; the flow of proceeds from the sale of illegal drugs in the form of bulk cash or other methods; and the movement of firearms to criminal organizations engaged in the illegal drug trade—continue to pose a serious threat to national security and to the safety and well-being of our Nation's citizens. The 2013 *National Southwest Border Counternarcotics Strategy* was developed to address those threats. The same focus, commitment, and energy will continue with the development and publication of the 2015 *National Southwest Border Counternarcotics Strategy*.

Caribbean Border Counternarcotics Strategy

DTOs and other TCOs operating 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) exploit the region as both a destination and a transshipment point for cocaine shipped from South America through Central America, Mexico and the Caribbean to the continental United States. While cocaine trafficking through the Eastern Caribbean has increased, that represents only a small percentage of the total flow from South America.[119] This increase in cocaine trafficking and associated violent crimes and public health consequences from drug use contribute to social problems in Puerto Rico and the U.S. Virgin Islands.[120]

In 2014, ONDCP developed its first biennial *Caribbean Border Counternarcotics Strategy*. The *Caribbean Border Counternarcotics Strategy* articulates the Administration's plans to substantially reduce the flow of illicit drugs and drug proceeds into and out of the Caribbean border with a focus on reducing drug related violence. It 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 development of the *Strategy* was done in close consultation with Federal officials and officials representing Puerto Rico and the United States Virgin Islands.

Action Item: Implement National Plan for Southbound Interdiction of Currency and Weapons (5.2.C)

Trans-national organized criminals generate an enormous amount of money through their illicit drug activities. The money enables them to sustain and often expand operations. Additionally, the funds provide them with the flexibility to change their methods of operation in the face of law enforcement tactics.

In close coordination with law enforcement, including ICE-HSI and U.S. Customs and Border Protection (CBP), FinCEN on August 11, 2014, issued a Geographic Targeting Order (GTO) that requires enhanced cash reporting by armored car services and other common carriers of currency at the San Ysidro and Otay Mesa Ports of Entry in California. The GTO requires transporters of currency, including armored car services, to file CMIRs upon crossing the land border between Mexico and the United States (regardless of the existing exemption for certain overland shipments of currency) and identify the originator of the currency. Information gathered pursuant to the GTO will provide U.S. law enforcement unprecedented ability to identify precisely who is moving money into and out of the United States.

During FY14, FinCEN produced a number of analytic reports detailing the workings of emerging payment systems such as virtual currency and reloadable prepaid cards. In addition, FinCEN analyzed virtual commerce platforms such as darknet marketplaces, where drugs and other illicit goods and services are increasingly sold. FinCEN shared these analytic findings with law enforcement and regulatory customers who received copies of the reports via the FinCEN BSA access portal. In addition, FinCEN provides in-person and webinar training on these subjects to its law enforcement and regulatory customers on the SWB and worldwide.

Additionally, in FY 2014, CBP officers at the ports of entry seized 740 firearms that were being unlawfully exported; seized $37.7 million in outbound currency and monetary instruments; and arrested over 4,300 persons for violations of U.S. laws (excluding immigration laws).[121]

Action Item: Implement the *Northern Border Counternarcotics Strategy* (5.2.D)

Published in 2012, the Obama Administration's inaugural *National Northern Border Counternarcotics Strategy (Northern Border Strategy)* provided a blueprint for preventing the illegal trafficking of drugs across the U.S.–Canada border. The *Northern Border Strategy* details how TCOs on both sides of the border exploit the international boundary to transport drugs and smuggle proceeds from illegal drug sales.

The updated 2014 *Northern Border Strategy* provides an overview of current counternarcotics efforts and identifies strategic objectives to substantially reduce the flow of illicit drugs and drug proceeds along the Northern border. The 2014 *Northern Border Strategy* makes some significant changes and additions, including items that address: drug trafficking in the Bakken oil field region of North Dakota and Montana; the emerging threat posed by synthetic drugs; eliminating public corruption; enhancements to the financial investigations section; the use of virtual currency and electronic payment devices to purchase illicit drugs and goods; and trade-based money laundering schemes. Additionally, there are significant enhancements to the section that details our cooperative efforts with our Canadian counterparts. ONDCP will work with the interagency partners to implement and track progress of the strategy's action items.

Action Item: Deny Use of Ports of Entry and Routes of Ingress and Egress Between the Ports (5.2.E)

Precipitated by a changing operational environment along our Nation's border, CBP continues to update its approach to secure the border through expanded use of integrated and targeted enforcement operations. CBP utilizes joint targeting teams, task force initiatives, unified commands, and community engagement in its efforts to secure the border. TCOs responsible for the majority of the cross-border smuggling and associated crime are specifically targeted by CBP.

Additionally, the U.S. National Guard is testing DoD reconnaissance systems that were in use for operations in Afghanistan. These reconnaissance systems may be used to observe isolated airstrips and drop zones, and to track movement along drug trafficking corridors.

The Integrated Cross-border Maritime Law Enforcement Operations (ICMLEO), also known as Shiprider, is a bi-national initiative between the Royal Canadian Mounted Police and the USCG that has expanded the capabilities and reach of law enforcement officials across the shared maritime border and at ports of entry and routes of ingress and egress between U.S. and Canadian ports. Working together, armed Canadian and U.S. law enforcement officers transit back and forth across the border to interdict cross-border criminal activity in shared waterways.

Principle: Focus National Efforts on Specific Drug Problems

An emerging trend in methamphetamine production has necessitated the adoption of new enforcement tactics to curb the smuggling of this drug. "Liquid methamphetamine," is a finished methamphetamine

dissolved in a liquid solvent and evaporated, resulting in powder methamphetamine that is then crystallized. As law enforcement identifies trends such as this, agencies will continue to address new threats through robust interagency efforts, training, and information sharing. ONDCP and DOJ are co-chairing a Federal interagency task force on heroin that addresses enforcement, treatment, and prevention.

Action Item: Counter Domestic Methamphetamine Production and Ice Conversion (5.3.A)

While the majority of methamphetamine available in the United States is produced in Mexico,[122] the presence of Small Capacity Production Laboratories (SCPLs) and methamphetamine hydrochloride ("ice") conversion laboratories poses a serious threat. Although SCPLs generally yield small amounts (1 to 3 grams per laboratory), the method of production is extremely volatile and can result in fires and explosions, threatening the safety of law enforcement and the community. Likewise, methamphetamine hydrochloride ("ice") conversion laboratories, most of which are located in residential areas, rely on the use of acetone, a common but highly flammable solvent. DEA continues to dedicate enforcement, intelligence, and other resources to prevent the manufacture of methamphetamine, and to disrupt the trafficking and transportation of methamphetamine. Its efforts include training state and local law enforcement officers on the detection, processing, and clean up of clandestine laboratories that produce methamphetamine and other illicit drugs.

Action Item: Identify Interior Corridors of Drug Movement and Deny Traffickers Use of America's Highways (5.3.B)

Our Nation's roads and highways continue to be a conduit for drug traffickers to move large amounts of drugs, currency, weapons, and other illicit contraband. The HIDTA DHE program works to deter this threat. The DHE strategy is based on collaborative, intelligence-led policing to enhance law enforcement efforts on interstate highways specifically identified as drug trafficking corridors. In FY 2014, DHE task forces confiscated $328.3 million worth of drugs, and disrupted or dismantled 56 drug trafficking organizations. Drug related cash seizures totaled $60.5 million and other drug related assets seized were valued at over $3.4 million.[123]

The EPIC System Portal (ESP) continues to be an invaluable tool for DHE. Users can access the DHE community of interest section through the Department of Homeland Security's (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. DHE Coordinators host over 100 Information Sharing Corridor Web Meetings per year from the nine highway regional corridors. Currently, there are 603 vetted users from state, local, federal law enforcement officers and analysts. Over 5,525 searchable corridor drug trafficking documents have been posted, including 896 images in the concealment database, 2,775 Hot Sheet trend posts since April of 2014, and 293 Information Bulletins from HIDTA, Fusion Centers, and EPIC. The DHE HSIN "hot sheet" is a vetted posting board that allows for sharing of drug trafficking trends, HIDTA and EPIC bulletins and other interstate and organized crime trends. Additionally, "emerging trend" webinars were hosted on topics including the connection between khat and terrorism, law enforcement use of social media, credit card skimming, Caribbean narcotic influences, and human trafficking.

Action Item: Address Illicit Marijuana Cultivation and its Threat to Public Safety and the Environment (5.3.C)

The illicit cultivation of marijuana poses a serious threat to our Nation's public lands. Cannabis cultivation results in the chemical contamination and alteration of watersheds; diversion of natural water courses; elimination of native vegetation; wildfire hazards; poaching of wildlife; and harmful disposal of garbage, non-biodegradable materials, and human waste. In California, where much of the illicit cultivation of marijuana in the United States occurs, the threat is severe, particularly as the state is in its third year of an unprecedented drought. California's Department of Fish and Wildlife reports that a marijuana plant consumes about 900 gallons of water per plant (6 gallons daily over its 150-day growing cycle).[124] In 2013, more than 2.7 million marijuana plants were eradicated by law enforcement in California—over their growing cycle, these plants would have consumed 2.4 billion gallons of water, which is equivalent to the annual water usage of 34,000 Californians. In addition, California's drought has made its rural lands extremely vulnerable to fire. In recent years, trespass marijuana growers have caused several destructive fires, including the La Brea fire in 2009 that burned nearly 90,000 acres in Santa Barbara County. During the 2014 fire season, a marijuana grower was responsible for the Bully fire near Redding, CA. This fire burned more than 12,000 acres; destroyed 20 structures; cost more than $20 million to contain; and claimed the life of a man who was unable to escape the flames.[125]

ONDCP has worked with its Federal, state, local, and tribal partners to address the threat posed by marijuana cultivation on public and tribal lands. ONDCP convenes the Public Lands Drug Control Committee (PLDCC), a Federal interagency group that coordinates programs to support marijuana eradication operations, investigations, and related intelligence and information sharing. In September 2014, the PLDCC formed a Science Subcommittee that will coordinate a unified research agenda across the public lands agencies to define and quantify the threat posed by illegal marijuana cultivation on public lands. This group of researchers is currently developing a 'white paper' to synthesize existing research. This paper will provide information to potential partner agencies and allies outside government, including environmental groups and civic organizations, and will address best practices to ensure officer safety.

An Emerging Threat: THC Extraction Laboratories

The increase in popularity of concentrated cannabis products such as hash oil comes with increased danger associated with the illegal laboratories that produce these products. Solvent extraction with n-Butane remains the most common method of THC isolation and is extremely dangerous. In 2014, 131 THC extraction labs (commonly known as Butane Honey Oil (BHO) labs) were seized in California.[126] Of these, 46 caused fires or explosions. Colorado experienced 32 THC extraction lab explosions and 30 related injuries in 2014.[127]

In January 2014, a BHO lab explosion in an apartment complex in the Sacramento area displaced 140 people. In June 2014, a BHO lab exploded at an apartment building in Redding, CA, making ten apartments uninhabitable. Burns caused by BHO lab explosions can be very severe. Since 2011, at least 68 patients have been treated at Shriners Hospital for Children or the University of California-Davis Medical Center for burns caused by BHO lab fires. On average, these victims had burns to 28 percent of their bodies and remained hospitalized for nearly a month.[128] Recovery from a large burn requires at least a year, and the resulting scars are permanent. Financial costs for burn care are staggering: hospital treatment costs for severely burned patients can be $15,000 or more per day, so a 28-day stay can cost over $400,000.[129]

Action Item: Target Indoor Marijuana Production (5.3.D)

Increasingly, marijuana growers are modifying their methods to evade detection by law enforcement and the public. In recent years cultivation operations have moved away from outdoor grows on public lands to indoor grow sites. According to DEA's Domestic Cannabis Eradication/Suppression Program, the number of plants seized from indoor cultivation operations nationwide increased from 302,080 in 2012 to 396,620 in 2014.[130] This shift makes detection more challenging and complicates eradication efforts, particularly in states where the legalization of recreational marijuana or of medical use of marijuana has complicated law enforcement efforts to secure necessary search warrants. To address this growing threat, Federal law enforcement, in coordination with state and local agencies will aggressively deploy resources as efficiently as possible to eradicate indoor marijuana and dismantle the organizations that produce dangerously large quantities.

Action Item: Partner with Local Law Enforcement Agencies to Combat Street, Prison, and Motorcycle Drug Gangs (5.3.E)

In April 2014, the National Gang Intelligence Center (NGIC) published the 2013 National Gang Report (NGR). The NGR is produced every two years. It discusses current and emergent violent criminal gangs in the United States and concludes that gangs rely on street-level drug distribution and trafficking as their primary source of revenue. The purpose of the report is to educate law enforcement on all matters related to gangs. NGIC analysts also train state, tribal, local, and federal gang investigators across the nation.

In FY 2014, the FBI's Safe Streets and Gang Unit provided training to gang task force officers with up to two years of experience on a Safe Streets Task Force. The Safe Streets Task Force is comprised of local and Federal agencies responsible for investigating gang activity, violence, and gun crimes. The officers were trained on asset forfeiture, confidential human source operations, undercover operations, shooting reviews, discovery, FBI databases, case administration, and Special Operations Division capabilities and resources.

The FBI's Violent Crime and Gang Section is attempting to quantify and qualify the results and improvements within a community through law enforcement action and targeted social services and community renewal efforts. The FBI works with state and local law enforcement partners, in conjunction with municipal governments, regulatory agencies, community organizations, and academic institutions. Through a partnership with Temple University, several publications are in progress that will quantify community impact and police strategies to address gang violence. This initiative is based on the DOJ's "Weed & Seed" program, in which law enforcement "weeds" out criminal activity while social and community services partners attempt to "grow" a safe and productive community.

Action Item: Disrupt Illicit Financial Networks by Exploiting Cash Seizures and Targeting Money Laundering Organizations and Facilitators (5.3.F)

The Bulk Cash Smuggling Center (BCSC), in partnership with the ICE Forensic Lab continues to exploit fingerprint evidence from packaging and other evidence found during bulk cash encounters. BCSC provides real-time intelligence, investigative support, and expertise to address the illicit transportation and

smuggling of bulk cash. The Executive Branch, as called for in the 2011 *Strategy to Combat Transnational Organized Crime*, is working with Congress to strengthen money laundering laws, particularly through the closure of the beneficial ownership gap that has been exploited by criminal groups to protect their illicit proceeds. In FY 2014, ICE seized more than $93 million in currency and monetary instruments, affected 643 criminal arrests, and obtained 328 indictments and 292 convictions for bulk cash smuggling offenses.[131] The National Guard is developing a cadre of instructors qualified to teach Threat Finance Courses and will coordinate with HIDTAs to disseminate the training at no cost. Courses include instruction on how money moves, what patterns to look for, interagency roles and investigation techniques.

Prepaid Access Devices (PADs) present a significant challenge to all levels of law enforcement. Although PADs function in a substantially different manner from debit and credit cards, they are often marked similarly, which can make them difficult to identify. In recent years, PADs have been used in lieu of bulk cash smuggling operations by TCOs.

Action Item: Interdict Drug Trafficking through Mail and Parcel Services (5.3.G)

Laboratories and Scientific Service Directorate (LSSD) is the scientific arm of CBP. Operation Safeguard was established to evaluate the type, volume, and quality of declared pharmaceutical products being shipped in international mail packages. Operation Safeguard now includes participation from numerous other agencies, including the U.S. Postal Inspection Service (USPIS) and the FDA. A majority of what is seized is counterfeit, stolen/diverted, or otherwise illegal in the United States with links to known TCOs. Through LSSD, CBP continues to conduct Operation Safeguard on a monthly basis with participation from the DEA, FDA, and USPIS.

In addition, CBP continues to manage Operation Safeguard at international mail facilities. This includes the physical inspection of over 100 packages per day for a minimum of three consecutive days each month. Additional operations take place at express consignment facilities. The use of the Automated Targeting System (ATS) for international mail is on track, pending agreements with foreign postal agencies. The ATS allows CBP to target high-risk air cargo shipments inbound to the United States that may require additional physical screening under the appropriate regulatory framework and protocols. The use of ATS for express consignment carriers is currently operational.

Action Item: Establish Interagency Task Force on Drug Endangered Children (5.3.H)

The inaugural 2010 *National Drug Control Strategy* called on DOJ to initiate a Drug Endangered Children Task Force. This task force is focused on gathering and producing educational resources (model protocols, programming, promising practices, and downloadable checklists) to aid law enforcement, child welfare workers, health and education professionals, and children's advocates working with drug-endangered children. The newly revised National Alliance for Drug Endangered Children webpages provide updated resources for organizations that work with children in hazardous situations, including those born with Neonatal Abstinence Syndrome (NAS). Additionally, a new resource for law enforcement was released in August 2014: the International Association of Chiefs of Police, in partnership with BJA, released *Safeguarding Children of Arrested Parents*, a guide to working with crime-endangered children.

Developing Solutions to New Jersey's Opioid Epidemic

DEA New Jersey Division, HIDTA New York and New Jersey, and the Partnership for a Drug-Free New Jersey organized the Do No Harm symposiums to address New Jersey's opioid epidemic. These symposia brought together healthcare practitioners from across the state to discuss and develop solutions to this public health crisis.

In 2014, a total of five symposia were held based on the goals set forth in the Administration's *Epidemic: Responding to America's Prescription Drug Abuse Crisis*. This plan focused on educating healthcare providers; the link between overprescribing and development of a substance use disorder; appropriately prescribing controlled medications; the importance of safe and legal prescription drug disposal; and the value of participating in the New Jersey prescription drug monitoring program (PDMP).

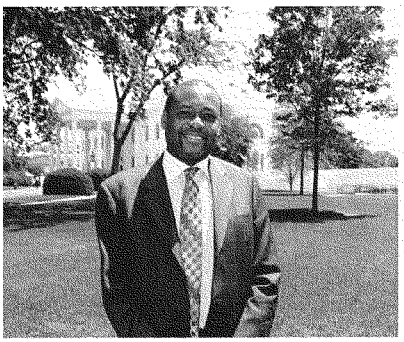
Several physicians in attendance said that they learned the benefits of PDMPs and would use the system more. Throughout the series, hundreds of physicians registered for the New Jersey PDMP at a mobile PDMP registration table.

Perhaps most importantly, many of the 1,000 healthcare providers who attended a Do No Harm symposium reported that they would change the way they work with their patients. Specifically, healthcare providers reported learning important tips on how to identify patients who might be diverting drugs or who have a substance use disorder. Healthcare providers also mentioned the importance of educating their co-workers and staff about the scope of this issue; and reported plans to revise their prescribing protocols and expand the use of non-pharmaceutical methods of pain management.[132]

Action Item: Coordinate Interagency Response to Emerging Drug Related Criminal Activity in Locations with Limited Law Enforcement Resources (5.3.J)

The economic boom associated with the oil and gas development in the Bakken Region of North Dakota and Montana continues to place a strain on the area's infrastructure and security. In conjunction with the Domestic Policy Council, ONDCP has worked with our Federal, state, tribal, and local partners to address emerging threats in the Bakken region. In August 2014, ONDCP released its updated and expanded *Northern Border Strategy,* which includes a section dedicated to drug trafficking in the Bakken region and our efforts to address this threat. Also, in late 2013, ONDCP designated Williams County, ND, which lies at the heart of the Bakken region, as part of the HIDTA program. In addition, Federal agencies jointly launched "Project Safe Bakken," an initiative that will address crime and target drug trafficking organizations and criminal enterprises operating in the Bakken region and surrounding communities.

Advocate for Action: Dr. Arthur C Evans, Jr., Pennsylvania



Policymaker, clinical and community psychologist, and health care innovator, Arthur C. Evans Jr., Ph.D., is Commissioner of Philadelphia's Department of Behavioral Health and Intellectual Disability Service.

Dr. Evans has brought a new approach to his agency's system of serving a wide range of individuals with complex needs. The transformation of the $1 billion Philadelphia system into a recovery-oriented, outcome-focused system of care has helped the city develop effective public health strategies. Meanwhile, Dr. Evans has emphasized data-driven approaches to improve system performance. The transformation of the Philadelphia service system has improved outcomes for people accessing services and resulted in fewer inpatient admissions, visits to crisis centers, and millions of dollars in savings that the city has reinvested in other community-based services. His work as Commissioner continues his lifelong commitment to serving people who are underserved and ensuring that effective, high-quality health care is accessible to all.

Dr. Evans has been recognized nationally for his work in behavioral health care policy and the transformation of service delivery systems. In 2013, he received the American Medical Association's top government service award in health care, the Dr. Nathan Davis Award for Outstanding Government Service. Dr. Evans was also recognized by Faces and Voices of Recovery and presented with the Lisa Mojer-Torres Award. He has served on the faculty of the Yale University School of Medicine and currently holds a faculty appointment at the University of Pennsylvania School of Medicine.

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

The United States continues to face a serious challenge from the large-scale smuggling of drugs and precursor chemicals from abroad. The significant flow of heroin and methamphetamine across the U.S. Southwest Border, combined with continuing movement of cocaine and marijuana, are indicators of the scale of the challenge we face. Federal agencies, in close collaboration with our international partners, are working to help reduce the supply drugs by supporting poppy and coca crop eradication; alternative development; air, sea, and land interdiction; law enforcement operations and investigations; and an array of interagency efforts including enhanced threat finance coordination and expanding the use of threat finance cells to deny the illicit proceeds of the drug trade to TCOs.

The leadership of organizations that manufacture and traffic illicit drugs into our communities are largely based abroad. To improve the health and safety of our society, and to help reduce violence and corruption in partner nations, we work closely with authorities in the countries where these organizations operate and support the drug control efforts of major drug source and transit countries. Through technical exchanges and aid, the U.S. helps partner nations build capability and capacity to dismantle transnational criminal groups, eradicate drug crops, and interdict drugs, money, and precursor chemicals.

Interdiction not only removes dangerous drugs from the supply chain but also can provide important information and investigatory leads to help identify, target, and dismantle the primary criminal organizations that supply illicit drugs to the United States. This work also benefits our international partners. Drug trafficking networks severely threaten the security and prosperity of many countries in the Western Hemisphere and other regions. Dismantling these groups allows affected nations to develop stronger institutions better able to withstand the corrosive and corruptive effects of the trafficking organizations. It also addresses the impunity of criminals and corrupt officials - a top priority for improving security in regions like Central and South America.

Like the United States, counties around the world are concerned about the impact of drug use on their citizens and especially on their youth. U.S. international efforts also focus on expanding prevention, treatment, and recovery initiatives and on promoting criminal justice reforms, including alternatives to incarceration, through collaboration with partner nations, multilateral organizations, such as the United Nations Office of Drugs and Crime (UNODC) and the Organization of American States Inter-American Drug Abuse Control Commission (OAS/CICAD), and non-governmental organizations. Promoting access to evidence-based treatment for substance use disorders, sentencing reform, alternatives to incarceration, and other humane and effective interventions and policies helps improve not only the health and wellness of individuals around the world, it helps strengthen communities and reduce the global impact of drugs.

Principle: Collaborate with International Partners to Disrupt the Drug Trade

A key mechanism that enables us to reduce the availability of drugs from abroad is the investigation of the major international drug trafficking organizations, which makes disruption and dismantlement of complex trafficking organizations possible. It is not just that major drugs of abuse including cocaine, heroin, and methamphetamine are produced outside the United States—much of the core operating structure is based abroad, often in more than one country. Cartel senior leadership, key operatives, and significant portions of illicit financial networks are all abroad. Thus, our effectiveness is almost entirely based on our ability to work together with our key international and multilateral partners.

Action Item: Conduct Joint Counterdrug Operations with International Partners to Interdict Drugs and Support Disruption of Transnational Criminal Organizations (6.1.A.)

Collaboration with partner nations remains a cornerstone of efforts to disrupt transnational criminal organizations. DEA initiatives such as vetted units and combined investigations with partner nations are essential. Assets such as USCG Airborne Use of Force–equipped helicopters aboard Allied vessels are also vital. Combined operations such as OPERATION MARTILLO and OPERATION ANVIL, which include U.S. and partner nation activities, have had a positive impact on disrupting illicit air and maritime trafficking in the Western Caribbean and Eastern Pacific littoral routes. OPERATION BAHAMAS, TURKS and CAICOS (OPBAT) is another international effort that helps reduce and deter drug trafficking. As illicit traffickers shift their routes, U.S. and partner nation efforts must rapidly adapt and evolve to address new challenges. Throughout 2015, we will work with Mexico to address the increasing threat of heroin produced in and distributed from Mexico and will continue to work with Central American nations to reduce the impact of illicit trafficking on regional security. Implementation of the DHS Southern Border and Approaches Campaign Plan, which was designed to enhance border security and reduce illegal migration, will, along with the other counternarcotics actions outlined in this chapter, help to reduce the flow of drugs into the United States in 2015.

Action Item: Work with OAS/CICAD to Strengthen Counterdrug Institutions in the Western Hemisphere (6.1.B.)

In 2014, the United States actively participated in fora organized by OAS/CICAD. At these meetings, and through the Department of State's Bureau of International Narcotics and Law Enforcement Affairs (INL) funded OAS/CICAD projects around the Hemisphere, the United States continued to support a range of evidence-based prevention, treatment, public health, criminal justice, law enforcement, and supply reduction interventions. In 2014, OAS/CICAD completed the sixth round of the Multilateral Evaluation Mechanism (MEM), which assesses implementation of counternarcotics programs and provides recommendations for improvement to members. The MEM helps to drive improvements in anti-drug efforts through its objective reports and the "peer pressure" that comes with this widely supported hemispheric process. ONDCP and the Department of State also participated in the Demand Reduction and the Alternatives to Incarceration meetings, which focused on promoting best practices and expanding host nation capacity. DOJ, DEA, and DHS participated in CICAD working groups on anti-money laundering, chemicals and pharmaceuticals, and maritime interdiction, all of which develop guides and model

regulations and legislation for use by OAS countries. In 2015, CICAD will continue its work, supported by the United States, to implement counternarcotics initiatives that advance the U.S. drug policy priorities.

Action Item: Work with Partners in Europe, Africa, and Asia to Disrupt Drug Flows and Counter Illicit Networks in the Trans-Atlantic and Trans-Pacific Regions (6.1.C.)

Developments around the world underscore the increasingly international drug market: French authorities seized a 1.4 ton shipment of cocaine in February 2014 that DEA forensic analysis shows originated primarily from Peruvian-grown coca; Pacific nations are concerned over rising methamphetamine production in Philippine mega-labs; and Southwest Asian heroin is increasingly transiting Africa for onward shipment to North America and Europe. United States European Command's Joint Interagency Counter Trafficking Center, which is located close to trafficking routes and within proximity to European Union law enforcement organizations, will continue in 2015 to provide regional synchronization and appropriate support to U.S. and partner nation agencies to help disrupt flows in the region. In Africa, initial counternarcotics efforts will remain focused on West Africa to address illicit trafficking. The West Africa Cooperative Security Initiative will be synchronized across the U.S. agencies and with international partners with specific benchmarks and objectives.

Action Item: Coordinate with Global Partners to Prevent Synthetic Drug Production and Precursor Chemical Diversion (6.1.D.)

Access to precursor chemicals used to manufacture heroin, cocaine and amphetamine-type stimulants continues to challenge U.S. and international drug control efforts. In 2014, DEA worked with its global partners to confront the diversion of precursor chemicals used to manufacture heroin, cocaine, and methamphetamine, and New Psychoactive Substances. For example, DEA continued collaborations with International Narcotic Control Board (INCB) initiatives to target precursor chemicals and establish partnerships with the chemical industry, including three special projects: Cohesion, Prism, and ION, and two online communication systems: PENS and PICS. DEA also engaged in meetings on precursor chemicals at the annual Commission on Narcotic Drugs (CND) and other international and regional fora. In 2015, DEA also led the EU-US Joint Follow-Up working group on drug precursors. Also in 2015, the United States agencies will continue to work with INCB, UNODC, and other partners to prevent the diversion of precursor chemicals and production of synthetic drugs. For example, in partnership with DEA, JIATF West will continue to help track precursor chemical shipments and increase our understanding of the movement of these chemicals.

Action Item: Expand Global Demand Reduction Initiatives (6.1.E.)

To help reduce the global demand for drugs, improve individual and community health, and encourage economic stability and prosperity, the United States supports demand reduction programs in over 100 countries. In 2014, Federal agencies continued to promote evidence-based prevention, treatment, and recovery services in regions in the world that have not had adequate access to demand reduction interventions. For example, the U.S. National Guard works with 68 foreign governments to share best practices on reducing the demand for drugs through a partnership program with each of the 50 United States. NIDA and the Department of State operate the Hubert Humphrey Fellowship program to further

the research and development of evidence-based programs to support the prevention, treatment, and recovery of substance use disorders worldwide. State INL is funding the development of the UNODC International Standards on Treatment of Substance Use Disorders, which will be released for global implementation in 2016. INL is also supporting the Colombo Plan, UNODC, and the OAS in training the Universal Treatment and Prevention Curricula in over 40 countries. The Colombo Plan also continues to provide training and technical assistance for the treatment of children with substance use disorders in South Asia with INL support. In 2015, Federal agencies will continue collaborations with international partners to share research practices and experiences, and continue to emphasize the value of coordination among public health and law enforcement agencies.

Action Item: Support the Implementation of the *Strategy to Combat Transnational Organized Crime* (6.1.H.)

Large-scale TCOs are increasingly involved in a range of illegal activities, although illicit drugs are often the primary fuel for these organizations' wealth, power, and influence and result in the corruption and destabilization of vulnerable nations and vital institutions. In 2011, the President released the *Strategy to Combat Transnational Organized Crime*, a commitment to build, balance, and integrate U.S. efforts against the expanding national security threat posed by TOC. Under this framework, actions have been taken throughout 2014 to advance the goals of both the *Strategy to Combat Transnational Organized Crime* and the *National Drug Control Strategy*. These include sanctions to block the property of significant TOC networks, posting reward offers for information that leads to the conviction of key transnational criminals, and establishing an interagency working group to ensure the coordination of U.S. actions against those TOC networks that present a high national security threat. Further whole-of-government efforts to target the primary international organized crime threats to the U.S. will continue in 2015.

Action Item: Address International Production and Trafficking of New Psychoactive Substances (6.1.I.)

NPS such as synthetic cannabinoids, have become a global phenomenon. In fact, the number of identified NPS has already exceeded the number of all illegal drugs and pharmaceuticals controlled through the three international drug control treaties.[133] Over the past several years, the United States has seen more than 230 NPS.[134] The use of these substances has caused significant health and safety problems in the United States and abroad. As these substances are produced in laboratories overseas, the U.S. Government is working closely through the international drug control regime as well as with key partner nations, bilaterally, through the UN and the G-7, to address this global threat. Both in 2014 and in early 2015, CND adopted U.S. initiated resolutions to promote global cooperation on synthetic drugs and to push for tighter international control of the growing number of NPS smuggled into the United States and other countries. The U.S. government will continue to work very closely with key international partners where NPS are produced and with partner nations that are also directly impacted by the threat posed by NPS throughout 2015.

Action Item: Collaborate with UNODC and the Commission on Narcotic Drugs to Address Key Global Challenges (6.1.J.)

The United States actively participates in the CND to promote public health interventions for substance use disorders, alternatives to incarceration and other policy reforms within the framework of the three UN Drug Control Conventions and to support ongoing drug enforcement and supply reduction priorities. The UNODC, a UN agency based in Vienna, Austria, organizes the CND and works year round on key global drug issues. At the 2014 CND, the United States promoted a number of reform-focused policies and interventions including alternatives to incarceration, overdose prevention, drugged driving, international drug prevention, and effective law enforcement and diplomatic responses to the threat posed by NSP. Also at 2014 CND, the United States sponsored the first international resolution on the importance of recovery. In 2015, as the United States and partner governments prepare for the UN General Assembly Special Session (UNGASS) on Drugs in 2016, the United States will again promote an ambitious U.S. agenda in UN fora and continue to support UNODC programming in priority areas.

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; this and the hazards posed by violent, well-funded drug production and trafficking organizations require significant governance capacity to be addressed effectively. This is true in the United States as well as in partner nations where transnational organized criminal groups may base key parts of their operations. The U.S. seeks to work bilaterally and multilaterally to build robust law enforcement, security, and public health institutions that can effectively address drug related threats.

Action Item: Strengthen Strategic Partnerships with Mexico (6.2.A.)

U.S.-Mexico bilateral security cooperation continues to progress as a result of strong, multi-layered institutional ties, coupled with the development and implementation of the Mérida Initiative and of other bilateral activities. Between 2014 and 2015, the U.S. and Mexico held a series of bilateral meetings and increased exchanges on an array of demand and supply reduction issues of concern to both countries, including the increased production of opium in Mexico and trafficking of methamphetamine and cocaine through Mexico.[135] In 2015, the U.S. and Mexico began collaboration on a new bilateral project to increase Mexican law enforcement capacity to investigate, safely process, and dismantle clandestine drug laboratories.[136] U.S.-Mexico drug policy efforts will remain focused on interventions to address these priority issues including disrupting organized criminal groups, institutionalizing the rule of law, creating a 21st century border, and building strong and resilient communities. These efforts are designed to strengthen citizen security in both countries. As Mexico continues to be a major producer of and supplier to the U.S. market of heroin and methamphetamine, and is the most significant transit route for cocaine from South America bound for the United States, U.S. government agencies will continue to strengthen counternarcotics engagement with Mexico in 2015.

Action Item: Support Implementation of Afghanistan Post 2014 Counternarcotics Objectives (6.2.B.)

With the transition of security responsibility to the Government of the Islamic Republic of Afghanistan (GIRoA) complete, the GIRoA will now take the lead to dismantle drug trafficking organizations and to target CPOT list and drug kingpin personnel in Afghanistan with U.S. support. The United States has clearly articulated U.S. support for the Afghan people, including shared commitments to address the illicit drugs industry and drugs-corruption nexus. The U.S. counterdrug law enforcement agencies will advise in the development of Afghan solutions, maintain the capabilities of vetted units, and support the Afghan Special Mission Wing. The U.S. will continue to develop the justice and governance infrastructure and will invest in alternative development and livelihood programs. Agencies and departments will make every effort, when able, to focus efforts on the centers of the drug industry in Afghanistan, the provinces of Kandahar and Helmand.

Action Item: Support the Law Enforcement and Criminal Justice Capacities of Countries in the Western Hemisphere to Sustain Progress against Illicit Drug Production and Trafficking (6.2.C.)

During 2014, there were several high level bilateral discussions between the United States and Central American partners to discuss how to address common threats. These discussions led to Guatemala, Honduras, and El Salvador creating T*he Alliance for Prosperity* and to the development of a new, complementary *U.S. Strategy for Engagement in Central America.* Both plans emphasize the need for a comprehensive approach to addressing regional threats. The *Strategy*, approved in 2014, establishes three key pillars—prosperity, governance, and security—and clarifies that without prosperity and governance, there cannot be any lasting security. In line with the *Strategy*, U.S. sponsored law enforcement operations throughout Central and South America and the Caribbean in 2015 will continue to involve key partners, help build capacity, and directly address the serious drug-related security threats to the hemisphere. Ongoing initiatives, including the Caribbean Basin Security Initiative (CBSI) and the Central American Regional Security Initiative (CARSI), are now integrated with efforts to create prosperity and more accountable and effective institutions.

Action Item: Promote Alternative Livelihoods for Coca and Opium Farmers (6.2.E.)

The United States Agency for International Development (USAID) continued to lead U.S. Government efforts in support of alternative development projects in Colombia, Peru, and Afghanistan. In Peru, the partnership between the U.S. Government and the Humala Administration has resulted in a proactive and ambitious strategy that seeks to find alternatives to the drug trade. In Afghanistan, USAID efforts continue with Alternative Development and Alternative Livelihood programs aimed at strengthening the licit economy. Moving forward, USAID, to the extent the security situation allows, will increase in 2015 the productivity of high-value crops through extension and field demonstrations, supporting agribusiness, creating jobs, and enhancing the productivity and quality of orchard and vineyard perennial crops.

Action Item: Leverage Capacities of Partner Nations and Help Coordinate Programs in the Western Hemisphere (6.2.G.)

One of the most positive developments in Western Hemisphere counternarcotics efforts is the growing role of key allies in the region to provide training and assistance to other countries, at times funded and assisted by the United States. Colombia, in particular, has used its hard-earned expertise in policing to train and advise other police forces not just in the region, but around the world. Mexico is increasingly assisting partners in Central America on a range of issues related to drug production, trafficking, and related organized crime. For example, Mexico has been working with Guatemala on a southern border strategy to enhance security and awareness of the movement of persons and contraband between the two countries. In 2015, the Department of State will continue to support these vital efforts by our key regional partners and will identify additional partners in the region to work with on border control, joint operations, and other mutually beneficial programs.

Action Item: Address Challenges in Colombia and the Andean Ridge (6.2.H.)

Pressure on criminal organizations that produce and distribute cocaine in Colombia must be sustained in order to preserve and build upon a decade of enhanced citizen security in Colombia. Plan Colombia and its follow-on programs have allowed for a persistent government pressure in coca growing regions and have resulted in gains in interdiction, eradication, and the capture and extradition of high-value targets; these successes have helped reduce violence and increase foreign investment and development. Coca crop cultivation and production estimates for 2014 indicating expanding coca cultivation[137] in Colombia and the decision in May 2015 by the Government of Colombia to suspend aerial eradication necessitates that the United States to continue to work closely with the Government of Colombia on manual eradication and drug interdiction operations and expanding alternative development programs. Another rising challenge is in Peru. Although Peru has increased counterdrug efforts since 2011, exceeding its eradication goals in both 2013 and 2014, it faces a significant challenge from coca production in the Apurimac, Ene, and Mantaro River Valley (VRAEM).[138] The U.S. will work with Peru to increase the presence of the state in these non-state controlled spaces while helping to ensure the consolidation of the gains Peru has already made.

Action Item: Ensure Development of Partner Nation Interdiction Capability Remains a Priority (6.2.I.)

Few partner nations in the Western Hemisphere are able to operate air and maritime assets effectively and consistently offshore, where smugglers are most exposed. Building partner nations' capacity to patrol, govern, and defend their air and maritime domains is an important effort in support of the new Central American engagement strategy. It also requires synchronizing country and regional initiatives, including devising a steady progression of standardized air, land, and maritime forces. The Departments of State, Defense, and Homeland Security will continue in 2015 to develop partner nation capacity to synchronize country and regional initiatives by executing individual and combined interdiction activities. Partner nations should be encouraged in 2015 to work regionally and to take advantage of the growing maritime capability in countries such as Colombia and Panama.

Action Item: Strengthen Legitimate Financial Systems (6.2.J.)

Financial systems in both developed and developing nations are vulnerable to exploitation by criminal groups seeking to launder their proceeds from drug trafficking or other illegal activities. However, a body of knowledge exists on how to build resilient financial systems that are more resistant to such abuses and can detect inappropriate abuses. U.S. agencies, including the Departments of Treasury, Justice, Homeland Security, and State, are working bilaterally with partner nations, and through multilateral mechanisms, such as the Financial Action Task Force, UNODC, and OAS, to strengthen financial systems through training, technology, information sharing, engagement and close partnership with various sectors, most intensively the banking and financial industry. These efforts are an increasing priority for the United States, and U.S. agencies will accelerate work in this area over the next year.

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 networks of drug trafficking organizations. To reduce the supply of drugs, it is necessary to identify these networks, determine their most vulnerable points, and dismantle them by attacking multiple vulnerabilities simultaneously. This requires concentration and prioritization of interagency and international efforts; from interdictions in international waters and apprehensions at ports-of-entry, to coordinated multi-national investigations of transporters and money launderers, to extraditions of large scale drug traffickers. A focus on vulnerabilities will enable us and our international partners to disrupt and break up trafficking groups, their facilitators, and support systems.

Action Item: Improve Our Knowledge of the Vulnerabilities of Transnational Criminal Organizations (6.3.A.)

Actionable intelligence is the key to successful, targeted operations to disrupt transnational criminal groups. The intelligence, law enforcement, foreign affairs, and defense communities will continue to explore creative means to improve collection and analysis of relevant information, as well as to increase information-sharing among U.S. Government agencies and trusted foreign partners. The interagency community, recognizing that drug trafficking and TOC remain national intelligence priorities, will continue to work closely with international partners, to expand intelligence sharing on TOC networks and to pursue analysis of key networks' operations and organizations to determine both their weaknesses and where actions against them will have the most impact.

Action Item: Disrupt Illicit Drug Trafficking in the Transit Zone (6.3.B.)

Interdicting criminal operatives transporting illicit drugs and precursors in the transit zone reduces the availability of drugs in the United States, removes significant sources of instability and corruption from partner nations, and is eliminating key disruptor of criminal networks that produce and distribute illicit drugs. In September 2014, the Coast Guard released its Western Hemisphere Strategy that identifies three priorities for the maritime domain: Combating Networks, Securing Borders, and Safeguarding Commerce. To implement the Strategy, the USCG dedicated additional focus and assets to Drug Transit Zone interdiction operations, and invested in the people and platforms necessary to carry out an

offensive focus that targets TOC networks. Maritime interdiction is especially valuable because larger quantities of illicit drugs and precursor chemicals are removed from the supply chain compared to other interdictions later in the trafficking process. In addition, U.S. interdiction in international waters subjects can, in many instances, subject criminals to swift, direct entry into the U.S. criminal justice system. Exploiting the intelligence available during an interdiction has proven invaluable for identifying, investigating, penetrating, and combatting TCOs. Sustaining a strong law enforcement presence in the transit zone provides the capacity and specialized skills needed to effectively interdict criminal operatives and preserve evidence in a manner that best supports the eventual incarceration of major traffickers. DoD will continue its mission of detection and monitoring the flow of drugs to the United States, in support of law enforcement interdiction efforts.

The Methamphetamine Challenge to the United States

According to reporting from the ONDCP/HIDTA funded National Methamphetamine and Pharmaceuticals Initiative (NMPI), domestic labs and lab sites identified within the United States have dropped from over 15,000 in 2010 to less than 7,000 in 2014 (as of the end of October 2014).[139] Increased retail restrictions on the sale of pseudoephedrine, state and local enforcement efforts, and the increased availability of methamphetamine produced in Mexico and smuggled across our Southwest Border may have contributed to this reduction.

Although past efforts to control international diversion of pseudoephedrine and ephedrine and combination products containing these substances, have been relatively effective, methamphetamine manufacturers in Mexico have changed production methods to the "P2P method," which uses chemicals other than ephedrine or pseudoephedrine. Even if some of the constituent chemicals are on a watch list, interdiction efforts can be evaded through mislabeling or outright smuggling. These substances are coming into Central America and Mexico in large quantities, and turned into methamphetamine in these countries for consumption in the United States.

Southwest Border seizure trends and other indicators suggest an increase in the availability and consumption of methamphetamine in the United States:

- Seizures of methamphetamine along the Southwest Border from Mexico have increased more than seven-fold between 2008 (2,237 kilograms) and 2014 (16,750 kilograms).[140]
- Methamphetamine prices per pure gram decreased more than 70 percent between the third quarter of calendar year 2007 and the fourth quarter of calendar year 2012; during that time, methamphetamine purity increased almost 130 percent.[141]
- Domestic availability and demand indicators are now beginning to show modest increases in methamphetamine consumption that warrant close attention.[142, 143]

To address this issue, the Administration is taking several steps. Specifically, the Federal agencies are engaging with China and India, two of the main precursor source countries, to improve international controls of precursor chemicals. We are also working multilaterally with the UNODC and the INCB to tighten international control mechanisms to prevent the diversion of precursor chemicals from legitimate international commerce. The Administration is working to improve the capacity of Mexico and Central American

nations to detect and seize diverted precursors. DEA is also working closely with Mexican law enforcement to better identify and destroy super labs, and to disrupt and dismantle the organizations that produce and traffic methamphetamine. Moreover, the U.S. is providing training and technical assistance to Central American nations to improve precursor disposal capabilities in the region. Partner nations without a safe way to discard seized chemicals may reduce their efforts at detection and seizure.

Action Item: Target Transnational Money Laundering Networks to Deny Drug Trafficking Organizations Illicit Financing and Money Laundering Capabilities (6.3.C.)

During 2014, U.S. law enforcement and intelligence agencies continued to aggressively identify and target the illicit financial activities and money laundering networks used by drug trafficking and transnational criminal organizations. Multi-agency OCDETF investigations conducted by DEA, ICE HSI, the Internal Revenue Service's Criminal Investigation (IRS-CI), and the FBI identified a number of businesses located in the Los Angeles Fashion District that are alleged to have been involved in laundering illicit drug proceeds for Mexico's Sinaloa Cartel; this resulted in the simultaneous arrests and seizures of more than $100 million in U.S. currency in September 2014.[144] Treasury's Office of Foreign Assets Control has designated numerous individuals and entities linked to Mexican drug cartels pursuant to the Foreign Narcotics Kingpin Designation Act, while DEA and ICE-HSI have sustained focus on bulk currency interdictions and seizures. Treasury's FinCEN continued its ongoing efforts within the Egmont Group to enhance global capabilities and international cooperation among FIUs. FinCEN also continued to exchange information with other countries' Financial Intelligence Units in support of illicit drug investigations and strategic intelligence projects. ICE HSI Transnational Criminal Investigative Units (TCIUs) facilitate information exchange and rapid bilateral investigation of money laundering and bulk cash smuggling and other illicit activities. Currently, there are over 200 foreign law enforcement officers that comprise the TCIUs operating in Colombia, Dominican Republic, El Salvador, Honduras, Panama, Guatemala, Jamaica, and Spain, with expansion to Mexico planned for next year. In 2015, U.S. agencies will increase their focus on the illicit financial networks used by heroin and methamphetamine manufacturing and trafficking organizations that operate in Mexico and Central America.

Action Item: Target Cartel Leadership and their Networks (6.3.D.)

U.S. Federal agencies and partner nations pool their sources of information and investigatory leads to disrupt, pull apart, and exploit the vulnerabilities of criminal organizations and the networks that are responsible for drug trafficking and money laundering. The United States and Mexico, along with other partner nations, will continue to cooperate to dismantle drug trafficking organizations operating in both countries and to arrest cartel leadership. Notable arrests over the past year include Fernando Sánchez Arellano, Héctor Beltrán Leyva, and Vicente Carrillo Fuentes. These successes degrade the capacity of the cartels to operate efficiently, destabilize their organizations, and create additional opportunities to disrupt their trafficking organizations. Information sharing among the intelligence, law enforcement, and defense agencies enables U.S. law enforcement to effectively disrupt and dismantle drug trafficking organizations, thereby sustaining the cycle of success. The U.S. Government in 2014 continued to identify the issues of drugs and TOC as national intelligence priorities, and conducted studies on the

transportation and illicit finance operations of illicit trafficking groups. In 2015, Departments and agencies will intensify information sharing with key partner nations, especially in Mexico, Central America, and the Andean Ridge, to disrupt major drug manufacturing and trafficking organizations.

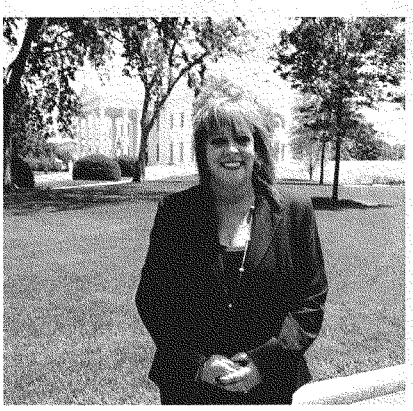
Action Item: Implement New Transit Zone Performance Measures (6.3.E)

In 2014, as part of a broad effort to identify a wider array of metrics to assess illicit drug trafficking activities, the interagency implemented measures developed by the 2013 TIC Goals and Performance Measures Working Group. In 2015, ONDCP will review and develop strategic metrics targeting all major drugs, including cocaine, heroin, methamphetamine, and precursor chemicals.

Action Item: Review and Align U.S. Resource Allocation for Transit Zone Interdiction (6.3.F)

Illicit trafficking is a significant threat to U.S. national security and regional stability. Significant resources are required to apprehend criminals moving illicit drugs and precursors over land and through international waters. ONDCP will support alignment of U.S. assets, employment of non-traditional resources, and synchronization of capabilities to sustain the network of intelligence, law enforcement, diplomatic, military, criminal justice, and logistical capabilities that drives criminal justice successes and improves regional stability and rule of law.

Advocate for Action: Denise Mariano, New Jersey



Denise Mariano's advocacy efforts have varied, but her goal remains the same: to keep other children from walking the same path as her son, who struggled with a substance use disorder for four years, and to keep other families from having to watch their children walk down that path. Her efforts began with education and prevention in her hometown via The Herren Project's Project Purple Initiative, now embraced county-wide. As a result of her work, communities are collaborating, education programs are being restructured, and, most importantly, fewer parents are saying "not my kid."

Ms. Mariano is a member of the Partnership for Drug-Free Kids' "National Parent Partner" program, which develops evidence-based resources for parents on www.drugfree.org. She is a key part of the Parent Support Network, providing resources and support for families across America who have kids with substance use disorders.

Ms. Mariano was trained as a peer-to-peer parent coach for the Partnership to offer support for parents who have "been there" with their own children or are currently struggling with a child's drug use. She also was selected as a 2013 National Council on Alcoholism and Drug Dependence-NJ Advocacy Leader for her ongoing advocacy efforts in New Jersey.

Together with her regional team, Ms. Mariano is raising the profile on solutions to addiction issues throughout New Jersey. She is an integral member of the Morris County Task Force on Opiates. The Task Force is a collaborative effort of the Morris County Department of Human Services and the County Coalition for a Safe and Healthy Morris, whose mission is to deter the misuse of opioid medications and the use of heroin, reduce the stigma surrounding substance use disorders, enhance access to treatment, and prevent overdose deaths through education, advocacy, and collaboration.

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

Research and data analysis are critical to science-based policy decisions and making progress in any area of government activity. Labor, commerce, and health are a few of the fields in which the federal government has invested considerable resources in surveys, analysis, and reporting. The Consumer Price Index, current unemployment statistics, and National Vital Statistics are examples of recurring, statistical measures that serve as a foundation for tracking critical issues in today's American society.

Similarly, ONDCP encourages departments and agencies to prioritize statistics and data in their programmatic execution in order to better support drug policy decision-making. Of special concern are data on drug-related emergency department visits and drug use among criminal-justice involved populations, specifically among arrestees. Federal data collection systems among both populations were recently terminated and replacements are urgently needed.

Substance use prevalence is measured through various surveys. Currently, the most extensive survey of illicit drug use in the United States is the NSDUH, a representative annual sample of approximately 70,000 Americans living in households and other types of group quarters. This instrument provides extensive substance use information for tobacco, alcohol, and marijuana.

The 2013 NSDUH results showed approximately 20 percent of Americans age 12 and older were current users of cigarettes, approximately 20 percent were binge alcohol users, and approximately 8 percent were current users of marijuana. In contrast, the 2013 NSDUH prevalence rates for other substances were much lower: cocaine (0.6%); heroin (0.1%) and stimulants, including methamphetamine (0.5%).[145] The Arrestee Drug Abuse Monitoring (ADAM) program surveyed arrestees, a population with a much higher frequency of illicit drug use than the U.S. household population. For example, in the 2013 ADAM sample of 5 U.S. urban counties the rate of marijuana use ranged from 34 percent in Atlanta to 59 percent in Sacramento.[146] While the ADAM program was discontinued in 2014 and DAWN[147] in 2011, a new survey has been introduced called the National Hospital Care Survey.

To offset losses in illicit drug use data, this Administration has been seeking to improve existing data systems and identify alternatives. Some of these efforts include:

- **National Hospital Care Survey.** SAMHSA and the National Center for Health Statistics, and the Food and Drug Administration (FDA) are working collaboratively to implement a new survey, National Hospital Care Survey. This survey integrates DAWN and two other hospital-based surveys—the National Hospital Discharge Survey and the National Hospital Ambulatory Care Survey—into a single, more cost efficient survey. The new survey will involve trade-offs between more detailed information on drug-involved patients and less specific information on the range of drugs involved.
- **The Community Drug Early Warning System (CDEWS).** This system exploits urine specimens that have already been collected by criminal justice agencies, tested for a limited drug screen, and are ready to be discarded. CDEWS sends these anonymous specimens to a laboratory that

retests them for an expanded panel of more than 30 drugs. The drug panel is current with the latest synthetic cannabinoids and cathinones.

- **Vital Statistics.** Mortality information is a critical measure of the consequences of opioids, however, collection of such data by state and local coroners and medical examiners is not always standardized and complete. There is large variation in the completeness of reporting of drugs for overdose deaths based differences in state death reporting systems. DOJ and the National Institute of Standards and Technology (NIST) have teamed to respond to a National Academy of Science study promoting the advancement of forensic science. Justice issued solicitations in 2013 dedicated to the development of highly discriminating, accurate, reliable, cost-effective, and rapid methods for consistently identifying, analyzing, and interpreting physical evidence.
- **Administrative Data.** In support of the Administration's initiative to more fully understand administrative data, ONDCP and other Federal drug control agencies are increasingly analyzing data routinely collected by government programs and non-governmental organizations as part of their business functions. These data, while often not based upon representative samples, are often much larger in sample size than population surveys and are often available in a timelier manner. With appropriate understanding of their limitations, they can be quite useful to policymakers in assessing emerging trends.

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

Multiple data sets are required by policymakers to understand the illegal, covert activities related to drug use and trafficking. These need to be routinely and consistently reported in a timely manner to be useful for informing policymakers. Adjustments to existing data systems must be made judiciously considering the trade-offs between improving some aspect of the data and breaking the trend.

Action Item: Enhance the Drug Abuse Warning Network Emergency Department Data System (7.1.A.)

SAMHSA's DAWN provided national and local-area estimates of drug-related emergency department (ED) visits, and drug-related mortality until its termination in 2011. To replace DAWN, SAMHSA developed a revised drug surveillance system known as SAMHSA's Emergency Department Surveillance System (SEDSS). SEDSS is being implemented through a partnership with CDC's National Center for Health Statistics (NCHS) and FDA to collect data on drug-related emergency department visits as part of NCHS's new National Hospital Care Survey (NHCS). SAMHSA will use the data on drug-related ED visits to provide products similar to those provided by legacy DAWN. SAMHSA continues to work with NCHS on issues of hospital recruitment to ensure availability of data by 2016, and estimates that reports based on 2015 SEDSS data will be available in 2016.

Action Item: Improve the National Survey on Drug Use and Health (7.1.B.)

The NSDUH provides policymakers with the most detailed picture of drug use and related issues among the U.S. population 12 and older. NSDUH data are used by the government to assess the progress the

Nation is making in achieving the goals of the *Strategy and the Prescription Drug Abuse Prevention Plan.* It is also used by researchers to study such issues as medical marijuana, drug-related risk and protective factors, and the prescription drug abuse epidemic. A significant redesign of the NSDUH has been completed over the past three years and will be implemented in 2015. Enhancements to the survey include questions to better characterize the non-medical use of prescription drugs and to provide estimates of the use of synthetic drugs.

Action Item: Sustain Support for the Drug and Alcohol Services Information System (7.1.C.)

The Drug and Alcohol Services Information System is composed of three data sets: (1) the Treatment Episode Date Set (TEDS), containing data on substance abuse treatment admissions, by state; (2) the National Survey of Substance Abuse Treatment Services (N-SSATS), containing administrative data on the Nation's treatment providers (these data are used to populate SAMHSA's Substance Abuse Treatment Locator); and (3) the Inventory of Substance Abuse Treatment Services (I-SATS), a listing of the Nation's treatment providers. These data sets provide policymakers and the public with critical information regarding the Nation's treatment system, including the name, location, and specialty of providers (I-SATS); characteristics (e.g., source of payment, staffing, number of clients) of the providers (N-SSATS); and the number and characteristics of clients in treatment (TEDS). SAMHSA will continue to work with ONDCP to sustain DASIS and increase the speed with which makes the data are made available.

Action Item: Better Assess Price and Purity of Illicit Drugs on the Street (7.1.D.)

Critical information can be determined by forensic analyses of drug specimens obtained through seizures and undercover purchases. Price and purity can be indicative of pressures on the retail market. Analysis determining the source country of the drugs can inform policymakers of the changing threat and where resources are needed to reduce availability. After investigating several methods for improving these data, DEA has expanded their drug purchase program to conduct probes in a variety of cities to broaden their understanding of domestic drug flow and regional difference in the retail market. DEA's National Forensic Laboratory Information System centralizes collection of local, state, and Federal forensic drug analyses. This program sometimes collects on purity analyses conducted by participating labs to provide insights into local market trends. DEA will continue to dedicate resources toward forensic analyses and data integration to assess local street-level drug prices and purity levels to make these data a useful gauge of drug market responses to supply-and-demand reduction policies.

Action Item: Strengthen Drug Information Systems Focused on Arrestees and Incarcerated Individuals (7.1.E.)

Studying drug use among the criminal justice population provide invaluable data on chronic drug use prevalence. The ADAM program estimated the prevalence of drug use and related information among booked arrestees in selected U.S. counties and was the only Federal drug survey to include a biologic indicator (urine sample) of recent drug use. NIJ conducted ADAM from 1998 through 2003; ONDCP began conducting the program (as ADAM II) in 2007; however, due to budget constraints, 2013 was the last year for which ADAM data was collected. In 2014, ONDCP published the findings from the 2013 ADAM data collection.

In 2013, ONDCP implemented a pilot program, CDEWS, to reassess urine samples collected from individuals under the supervision of the criminal justice system (e.g., drug courts, parolees, and probationers) in the Washington, D.C. and Richmond, Virginia areas. The reassessment tested for drugs that were not originally tested for by the various criminal justice programs. Results suggest that significant proportions of individuals tested positive for synthetic cannabinoids.[148] ONDCP funded a second round of CDEWS, with results to be published in 2015, and recently funded a third round, which will collect data in new locations and include specimens collected on juveniles.

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

All data systems have their limitations, but these challenges can sometimes be overcome through focused analyses. For example, drug use prevalence surveys provide insights into the frequency of drug consumption, but little on the amount of drugs consumed. Asking drug users about the amount consumed does not provide a useful measure because of purity fluctuations and purchase volume variability, as well as recall limitations. Most users, however, know their expenditure habits for drugs. Combining these data with drug price/purity information provides an analytical estimate that is useful to policymakers.

Action Item: Develop and Implement Measures of Drug Consumption (7.2.A.)

Economic analyses of drug use and drug markets are essential to assessing the effectiveness and cost-effectiveness of drug control policies and programs. Estimating the magnitude of drugs consumed by Americans is a critical measure for understanding market dynamics and putting drug demand and supply reduction estimates in perspective. In early 2012, ONDCP published annual consumption estimates through 2010, based on the latest available data. An update, taking these estimates through 2013, is planned for 2015.

Action Item: Transition Drug Seizure Tracking to the National Seizure System (7.2.B.)

Tabulation of drug seizures is the foundation for reporting statistics on the trends, activities, and patterns related to drug supply reduction policy. It also can help inform about potential increases in certain types of drug use to aid in effective treatment responses. Since the 1980's, federal drug seizures were tabulated by the Federal-wide Drug Seizure System (FDSS). In 2002, advances in communications and technology permitted the development of an improved drug seizure collection system, which was the NSS, housed at EPIC. The NSS expanded the seizure collection by eliminating weight thresholds and integrating state and local law enforcement data. Over the past years, EPIC has integrated historical FDSS data into the NSS, improved the user portal, and plans on more intuitive analytical and reporting tools including geospatial mapping.

Action Item: Enhance the Various Data that Inform Our Common Understanding of Global Illicit Drug Markets (7.2.C.)

Increased participation by international partners, including Canadian and Australian agencies, contributed to a more comprehensive evaluation of global cocaine flow in the most recent edition of the Interagency Assessment of Cocaine Movement (IACM). The Federal government continues to work to

improve two of the key pillars of the IACM: its methodology for its annual assessments of illicit drug production, and the Consolidated Counterdrug Database (CCDB), which documents cocaine and other illicit drug and drug precursor chemicals movement events. To that end, the counterdrug community is completing a DoD-led interagency study on CCDB to identify actions to create a more comprehensive picture of drug movement, while increasing efficiency. DEA's scientific studies of illicit crop yield and illicit drug lab efficiency, known as Operation Breakthrough; the Cocaine Signature Program; Heroin Signature Program; Methamphetamine Profiling Program; and Heroin Domestic Monitor Program remain critical to providing policymakers with the best information available on the drug threat to the United States. Despite budget constraints, the US Government needs to maintain these key data sets to enable critical research, assessment, and evaluation to continue.

Action Item: In Coordination with Our International Partners, Improve Capacity for More Accurately, Rapidly, and Transparently Estimating the Cultivation and Yield of Marijuana, Opium, and Coca in the World (7.2.D.)

Drug markets are continually changing and are truly globalized. Each of the major drugs have different market dynamics and price, purity, availability and use in each region of the world. Understanding these dynamics is vital for organizing and prioritizing policy responses. Each drug varies in terms of trends and degree of threat to the United States and other countries. Poppy cultivation in Afghanistan rose 7 percent in 2014 to over 211,000 hectares, the highest since 2007, in Mexico it was 17,000 hectares producing approximately 26 metric tons of heroin. In Peru, the largest producer of cocaine across the Andean Ridge, potential production of pure cocaine increased 7 percent to 285 metric tons. In Colombia, there has also been an increase for a second year in a row; from 185 to 245 metric tons of pure cocaine production potential in 2014.[149] The ability to gather and access these numbers, to include production of drugs such as methamphetamine, MDMA, and other synthetics allows the U.S. to adjust policy, strategy and ONDCP guidance to Departments. In coordination with ONDCP, agencies will work together to gather the pertinent data, conduct yield studies and provide support to senior leadership and Congress to better inform efforts across the interagency and with our partner nations. Operation Breakthrough must continue its valuable work in 2015 conducting studies of illicit crop cultivation, production potential, and laboratory efficiencies. International exchange of this type of information has expanded significantly, especially as a result of collaboration with the UNODC, the European Monitoring Center for Drugs and Drug Addiction, and bilateral exchanges with the United Kingdom and other nations. Together this information increasingly enables us to model more accurately the global drug challenge and more effectively develop solutions. U.S. agencies will expand these efforts to promote collection and sharing of critical drug data.

Principle 3: Measures of Drug Use and Related Problems Must be Useful at the Community Level

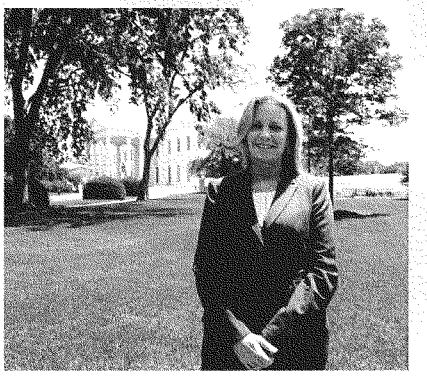
When initiating new data collection initiatives may be costly, exploiting community data sources can provide a useful alternative. For example, DEA created a program to connect state and local forensic laboratories by collecting the drug analysis results. This program, the National Forensic Laboratory Information System (NFLIS), collects state and local forensic laboratory data to provide the following

benefits: estimating national and regional trends in drug use and trafficking, identifying emergent substances such as synthetic cannabinoids, and deducing geographic differences in drug availability measured.

Action Item: Develop a Community Early Warning and Monitoring System that Tracks Substance Use and Problem Indicators at the Local Level (7.3.A.)

Phase I was completion of an interagency agreement with the USDA that funded Michigan State University for 10 pilot sites; surveys and analysis; community feedback meetings with toolkits provided. Phase II is to be completed 9/30/2015 with a second interagency agreement with USDA for MSU. The National Drug Early Warning System (NDEWS) is a complementary community indicators effort funded by NIDA and initiated in 2014. NDEWS plans to establish a system of harmonized community indicators for tracking drug trends and emerging drugs nationally, using both traditional data collection strategies as well as social media and web scans. NDEWS, operated in partnership with the University of Maryland, will serve as a coordinating center to generate information about emerging drug concerns and their public health consequences so that rapid, informed, and effective public health responses can be developed. NDEWS is envisioned to be the successor to NIDA's Community Epidemiology Working Group (CEWG). CEWG was a network of local researchers from more than 20 areas in the U.S. that provided ongoing community-level surveillance of drug abuse through analysis of available quantitative and qualitative data in semi-annual meetings.

Advocate for Action: Joanne Peterson, Massachusetts



Joanne Peterson is Founder and Executive Director of Learn to Cope (LTC), a non-profit peer-led support network established in 2004. Her journey started as a young girl growing up with siblings who experienced issues with mental illness and addiction. Years later, when she discovered that her own son's prescription drug misuse had led to an opioid use disorder, she was motivated and empowered to use her voice to bring about change. Ms. Peterson started Learn to Cope to offer families the kind of support, education, resources, and hope that would have benefitted her family. Today, her son is in long-term recovery.

Funded by the Massachusetts Department of Public Health, Learn to Cope staff collaborate with communities across Massachusetts to spread messages of prevention, education, awareness, and advocacy. With nearly 7,000 members on a private online forum and 16 chapters throughout the state, the group offers families peer support. Through collaboration with the state health department, Learn to Cope became the first parent network in the country to provide the overdose-reversal medication naloxone and training to family members at all Learn to Cope meetings. Today, 46 of the 160 Learn to Cope facilitators are trained and certified to provide LTC families with overdose education and nasal naloxone kits at each chapter. Through Learn to Cope, families who attend meetings receive training and the lifesaving medication to reverse a loved one's opioid overdose. Since December 2011, LTC members have successfully reversed 40 opioid overdoses in Massachusetts. With the growth and expansion of Learn to Cope, Ms. Peterson has been called upon by high-level government officials, law enforcement, and educators to assist in their efforts to address the opioid misuse epidemic.

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

Since releasing the 2011 *Prescription Drug Abuse Action Plan*, entitled "Epidemic: Responding to America's Prescription Drug Abuse Crisis", the Administration has remained committed to addressing the prescription drug crisis and its many health and social consequences. America is awash in prescription opioids. Approximately 18 billion opioid pills were dispensed in 2012,[150] enough to give every American 18 years or older 75 pills.[151] Because patients do not always use all of their prescribed medicines, pills are available for nonmedical use by those seeking their effects as drugs of abuse. Survey data suggest that many nonmedical prescription opioid users initially obtain them from friends or family.[152] Those who obtain prescription drugs through a health care provider are just as vulnerable to overdose as those who obtain prescription opioids through illegal sources.[153] As users become tolerant to the effects of these medicines, they need more over time to get the same effect. Research shows chronic users are more likely than less frequent users to pay for these drugs from dealers.[154] Chronic users with a need for stronger medicines and larger doses often spend large sums of money to obtain sufficient opioids to avoid painful withdrawal symptoms.[155] Because of their growing dependence on prescription opioids, such individuals may be tempted for economic reasons to try these drugs intravenously or to try cheaper non-prescription opioids like heroin.[156]

The consequences of the twin prescription drug and heroin epidemics are tragic. From 1999 to 2013 drug poisoning deaths involving opioid medications have accounted for nearly 175,000 fatalities in the United States.[157] Over the same period fatal overdose rates involving opioid medicines rose 264 percent.[158] Prescription opioids are not the only dangerous substances, however. During this same period the rate of deaths involving heroin rose 286 percent[159] and the rate of deaths involving one type of anti-anxiety medicines, benzodiazepines, grew 514 percent.[160] Prescribers are warned against combining opioids and benzodiazepines because together their effects are magnified. Deaths involving co-use of these substances are growing even more quickly than deaths involving only one of these medicines. From 1999 to 2013 the rate for deaths involving both benzodiazepines and prescription opioids rose by 819 percent.[161] Although deaths certainly occur in patients who have used diverted drugs, at least one study[162] shows that almost half of those whose deaths involved a prescription drug had received a prescription in the prior 60 days for at least one of the substances implicated in their death, suggesting the need for a renewed policy emphasis on changing prescriber behavior.

Along with fatalities, other serious medical consequences of non-medical use of prescription drugs include non-fatal overdose which can require hospital treatment; newborns showing signs of withdrawal from drugs taken by their mothers during pregnancy, a condition called neonatal abstinence syndrome, often referred to as NAS; and substance use disorders, which can require specialty substance use disorder treatment. People who use prescription opioids non-medically and who transition to injection drug use compound the risk of developing a chronic major blood-borne health condition, such as HIV and HCV infections, from contaminated injection supplies and equipment. As of June 30, 2015 the Indiana State Department of Health documented 174 HIV positive patients related to an outbreak in a rural county.[163] Most of these cases were linked to injectors using the extended-release formulation of the

prescription opioid oxymorphone, an opioid which when taken orally is approximately three times as potent as morphine.[164, 165]

We are beginning to make measurable progress addressing some elements of the prescription drug epidemic. For example, the rate of current nonmedical opioid use among young adults in 2013 (3.3 percent) was lower than the rates in 2012 (3.8 percent) and in 2002 to 2010 (ranging from 4.1 to 5.0 percent).[166] Additionally from 2010 to 2013 deaths involving prescription opioids dropped 2%.[167] Unfortunately overdose deaths involving heroin increased 172% during that same period.[168]

Heroin

Heroin is an opioid. It belongs in the same drug class as most opioid-based medicines and it activates similar neurotransmitters as these pain medications. Heroin use and possession in the United States is illegal except in limited research contexts. Compared to the non-medical use of prescription opioids, heroin use is relatively rare. In 2013, approximately 11 million people reported past year nonmedical use of prescription opioids while only approximately 681,000 people reported past year heroin use.[169] However, nonmedical prescription opioid use is a strong risk factor for heroin use.[170] Additionally heroin is of particular concern because it is contributing strongly to the growth in overdose death rates[171] just as the trend of prescription drug overdose deaths is beginning to level off. Research indicates that about 80 percent of recent heroin initiates report beginning their use of opioids with prescription drugs. However, less than 4 percent of recent initiates of nonmedical use of prescription opioids transition to heroin within 5 years of their initiation of nonmedical prescription opioid use.[172] This more than likely represents the progressive nature of many substance use disorder illnesses, which require continued use of opioids to avoid withdrawal symptoms that interfere with functioning, and either ever higher doses or more potent drugs as the body adapts to use. Although rising heroin use rates are a concern, new nonmedical prescription opioid users far outnumber new heroin users. According to the 2013 NSDUH, there were an estimated 169,000 people who first used heroin in the preceding year compared to 1.5 million who first used a prescription opioid non-medically.[173]

For these reasons, it is essential that stakeholders across the Federal government, in national organizations and at state, local and tribal levels continue to focus on controlling nonmedical prescription drug use improving controlled substance prescribing practices, and also identifying those with substance use disorders and engaging them in the evidence-based treatment most appropriate for their condition, generally MAT. The central means we have for halting and eliminating the heroin use trend is reducing rates of new and current nonmedical prescription opioid use.

Although Afghanistan is the world's largest producer of opium, recent DEA analyses of heroin seizures indicate that the majority of heroin consumed in the United States comes from Mexico.[174] Heroin seizures along the southwest border increased sharply (324%) from 2008 to 2013, suggesting a substantial increase in the amount of the drug entering the United States.[175] Estimates of Mexico's potential production of heroin rose from 26 metric tons in 2013 to about 42 metric tons in 2014.[176] Both governments are working together to address this threat through efforts to target drug labs, disrupt trafficking organizations, and reduce opium cultivation.

From a public health standpoint, heroin is:

- More likely to be a cause of death, when it is found, than many prescription opioids;[177]
- Being mixed with other substances such as fentanyl or fentanyl analogs[178] which are many times more potent than heroin;[179]
- Frequently injected and thus places users at high risk of blood-borne infections from sharing injection equipment, including HCV and HIV/AIDS which can be chronic, lifelong or expensive to treat conditions.

The association of heroin with intravenous injection drug use is well known. Injecting bypasses digestion and sends drugs rapidly to the brain so it can be a way to overcome the body's adaptation to the drug over time or to deliver a faster or more intense effect without using a higher dose. Like heroin, many prescription opioids also can be injected and research shows it is not uncommon for users to substitute prescription opioids or heroin for each other.[180] Indiana's recent HIV outbreak illustrates why it is essential for the medical community to address nonmedical prescription drug use early, before it advances to stronger medicines, injection or heroin. Although effective treatments exist for opioid use disorders it is preferable to engage opioid users in treatment while they are engaged only in oral non-medical opioid use before they are exposed to the greater risks posed by injection drug use.

Preventing intravenous drug use and related risky behaviors, such as sharing needle and preparation materials, is an Administration priority. This can help prevent the spread of infectious disease not only to other injection drug users but also to non-using partners, infants, and others. In 2000 the U.S. Surgeon General determined that syringe exchange services programs when offered as part of a comprehensive HIV strategy can play a critical role in preventing HIV among persons who inject drugs and can facilitate entry into drug treatment.[181] Unfortunately, Congress currently does not permit the use of Federal funds to support SSPs. Additionally, syringe exchange and/or purchase of clean needles are illegal in certain states. In response to the Indiana HIV Epidemic, the Governor of Indiana issued an emergency authorization for a time-limited pilot SSP. Access to safe products, including both abuse deterrent medicines and safer injection products, through efforts at the state and Federal level is essential for addressing the spread of infectious disease that can accompany local injection epidemics, whether the drug involved is heroin or a prescription opioid.

On June 19th 2014, ONDCP held a White House Leadership Summit on opioids and heroin.[182] Keynote speakers included former Attorney General Holder and Governor Shumlin of Vermont.[183] This meeting raised awareness of the need to redouble efforts with respect to the prescription opioid crisis to prevent more individuals from transitioning to heroin use. Twin strategies of promoting access to MAT for opioid use disorder treatment and naloxone for overdose prevention were identified as the two most promising public health solutions to the crisis. It also highlighted the fact that heroin is plentiful and inexpensive. Although the relationship is not fully understood, opioid users are price conscious[184, 185] and low price may tempt some to try heroin. Since the meeting the Federal government has engaged in several important efforts aimed at ensuring that any discussion of the prescription opioid problem also addresses heroin. For example,

- ONDCP's Interagency Workgroup on Prescription Drug Abuse Prevention has expanded to include all opioids including heroin. This group will continue to coordination efforts across the federal government especially with regard to overdose prevention and decreasing the new prescription drug users who may eventually become heroin users.

- Additionally the ONDCP Director's Treatment Coordination Workgroup which oversees drug treatment related activities across Federal agencies will be responsible for addressing heroin use disorder treatment, primarily through efforts aimed at expanding MAT, the most effective treatment for those with opioid use disorder.
- As mandated by Congress, DOJ has produced the 2015 National Heroin Threat Assessment and is jointly chairing a Federal task force on heroin with ONDCP, which will establish a coordinated response to the national heroin problem.

The four pillars of the 2011 *Prescription Drug Action Plan,*[186] education, monitoring, safe storage and disposal and enforcement remain critical elements of the *Strategy* which emphasizes prevention, early identification and treatment and recovery support for people with substance use disorders, and enhanced enforcement activities.

This year the Administration and our partners have made considerable progress addressing the pillars. Progress is reviewed below. Additionally, the Secretary of HHS committed to the Secretary's Opioid Initiative which targets three priority areas: prescribing practices, naloxone, and MAT. The Secretary's Initiative addresses the monitoring component of the pillars and prescriber education, but also includes two additional areas of focus reviewed below: changes to opioid prescribing practices to reduce opioid use disorders and overdose such as drug utilization review, and expanded use of naloxone to treat overdoses.[187] A third component of the Secretary's Initiative, the expanded use of MAT to treat opioid use disorders is discussed in chapter 3 of the *Strategy*. The remainder of the Policy Focus discusses plans for the remainder of the Administration including new actions to address the Secretary's Initiative and planned activities on medical consequences of opioid use disorders such as opioid exposed infants.

Pillar 1: Education

The 2011 *Prescription Drug Abuse Action Plan* discussed education of patients, providers, youth, and parents as essential to raise awareness about the dangers of nonmedical opioid and for reducing availability of opioids which may be diverted. Because prescribers are the source for prescription opioids, that has been our priority with respect to this pillar. Federal partner progress is reviewed below.

Educate Health Care Providers About Opioid Pain Medicine Prescribing

Research shows that most people who engage in non-medical prescription pain medicine use obtain these medicines either from a prescriber or from a friend or family member who obtained it from a prescriber.[188] Additionally, prescribers typically receive little education during formal training on safe prescribing or alternatives to opioids for pain management.[189, 190] Therefore, retraining the prescribing workforce is critical.

Since 2011, the Administration has supported development and implementation of a number of free and low-cost education programs to accomplish this retraining. NIDA and ONDCP jointly released online course modules known as NIDAMED in 2012 and these are available at no cost through September of 2015. To date, over 55,819 tests were taken on a module concerning managing pain patients who use

drugs, and 51,654 tests were taken on a module concerning safe prescribing for pain.[191] Additionally, SAMHSA's CSAT met its goals of providing live continuing medical education (CME) courses to more than 1,500 practitioners, by the end the 2014 fiscal year.[192] The SAMSHSA programs also provided training to providers in at least 3 states showing high prevalence of prescription drug abuse and 5 states total.[193] CSAT also continued its partnership with Boston University School of Medicine offering an online CME prescriber course on safe and effective opioid prescribing for chronic pain.

In 2012, the FDA approved a Risk Evaluation and Mitigation Strategy for extended release and long-acting opioid pain medicines (ER/LA REMS). The ER/LA REMS requires makers of this class of opioid analgesics to make training available to prescribers. The makers of ER/LA opioid analgesics are meeting this obligation by funding independent grants to continuing education providers who develop and implement low-cost or free continuing education programming to train prescribers based on agreed upon elements of safe prescribing known as the "blueprint".[194] In addition, prescribers are strongly encouraged to use other tools developed for the REMS such as counseling patients about safe use, serious risks, storage, and disposal; emphasizing the importance of patients and caregivers reading the medication guide and considering the use of other tools such as patient-prescriber agreements. In September of 2014 the American Council on Continuing Medical Education (ACCME) reported that approximately 16,000 ER/LA opioid analgesic prescribers had completed REMS-compliant training. FDA continues to monitor the uptake of these educational programs. A database of continuing education programs funded by the makers of the ER/LA opioid analgesics REMS is available online.[195]

Although pharmaceutical manufacturers are required to financially support the REMS courses by offering funding for the course development via unrestricted grants, prescriber participation is voluntary which means the program depends on the interest of prescribers to take the course. It does not address short-acting (immediate-release) opioids which are also often implicated in non-medical use and overdose.[196] That is why the *2011 Prescription Drug Abuse Prevention Plan* contains an action item requiring continuing education for all controlled substance prescribers tied to DEA controlled substance registration.

Pillar 2: Monitoring

The 2011 *Prescription Drug Abuse Action Plan* outlined a number of important efforts with respect to prescription drug monitoring. Both enhancements to the system and new efforts related to drug utilization and review (a form of monitoring) are discussed below.

Enhance Prescription Drug Monitoring Programs and Expand Information Sharing among State Systems and to Electronic Health Records

Significant progress has been made toward strengthening PDMPs—the second pillar of the Administration's Plan. PDMPs are state-run electronic databases that track the prescribing of certain prescription medications, and can involve prescriber and pharmacies monitoring of risky substance use, which may signal conditions of concern or provide assurance of appropriate medical use. Today, 49 states and one U.S. territory (Guam) have an operational PDMP; and in 2014, the District of Columbia passed legislation authorizing the creation and operation of a PDMP.[197, 198] Additionally, 30 states now allow for interstate data sharing that facilitates the exchange of PDMP information across state lines.[199]

Available evidence suggests that PDMP data may be effective in guiding appropriate clinical decision-making, reducing drug seeking behavior, and impeding the diversion of controlled substances.[200] However, PDMPs are unlikely to reach their full potential in reducing prescription drug misuse and abuse and diversion if they are not utilized. In many states with operational PDMPs, participation is voluntary by healthcare providers and accessing them is complicated. This results in low rates of use. States such as New York, Kentucky, and Tennessee, where healthcare providers must access the PDMP before prescribing controlled medications to a new patient, are the exception. According to Tennessee's PDMP Law, effective in 2013, prescribers in the state must now access the PDMP before prescribing opioids to a new patient. High utilizers (persons receiving opioids from 5 prescribers or 5 pharmacies in a 90-day period) decreased 33 percent from 2011 to 2013 after the law went into effect requiring prescribers to consult the PDMP.[201]

The Federal government has invested significant resources toward efforts to make PDMPs more user-friendly so healthcare providers can access them quickly and easily. The Office of the National Coordinator for Health Information Technology (ONC) and SAMHSA supported a series of pilot studies, completed in 2012 and 2013, which explored ways HIT such as EHRs and health information exchanges could be connected to PDMPs to improve healthcare providers' access.[202] The pilots enabled healthcare providers to effortlessly check the PDMP from their EHR without having to sign into multiple systems; thus increasing the likelihood that providers reviewed patient controlled substance prescription history prior to prescribing.

Additionally, between 2012 and 2013, SAMHSA awarded a total of 16 grants to states to support wide-spread expansion of the PDMP-HIT integration pilots and improve interstate PDMP data exchange.[203] CDC is evaluating the 2012 grantees to identify best practices and the impact of the integration efforts. In 2013, ONC and SAMHSA launched a new effort to establish technical standards to enable seamless data exchange between PDMPs and HIT systems.[204] Healthcare providers often use a different computer system to access the PDMP other than the HIT system routinely used for clinical activities. Standards increase the effectiveness and impact of PDMPs by enabling the information contained within the databases to be delivered directly to healthcare providers.

Under the BJA-administered Harold Rogers Prescription Drug Monitoring grant program, 15 site-based awards were made in FY 2014 for states to implement or enhance a PDMP program or strategy to address prescription drug abuse, misuse, and diversion within their communities. Since inception of the grant program in FY 2002, grants have been awarded to 49 different states and 1 U.S. territory to support their efforts to plan, implement, or enhance a PDMP. The program allows for state discretion to plan, implement, or enhance a PDMP to accommodate local decision-making based on state laws and preferences, while encouraging the replication of demonstrated best practices. In recent years, the program expanded to include tribal participation in drug monitoring activities, and support to states and localities to assemble responsive, collaborative efforts between public health and public safety professionals to pilot innovative ways to use PDMP and other data to inform prevention, treatment, and enforcement efforts. For example, Maryland used the funding to form overdose fatality review (OFR) teams comprised of multi-agency, multi-disciplinary stakeholders who review information on individuals who died from drug and alcohol related overdose. The OFR teams meet monthly to review medical examiner data as

well as other local-level data to identify overdose risk factors and missed opportunities for prevention/intervention and to recommend policies or programs to prevent future deaths.[205]

In 2014, the CDC began its "Boost for State Prevention" program to advance the most promising prescription drug overdose prevention strategies in 5 states—Kentucky, Oklahoma, Tennessee, Utah, and West Virginia - and it will be expanded in FY2015 to 16 states and is planned in the President's FY-16 budget to be expanded to all 50 states.[206] The initial grantee states are beginning to implement innovative activities such as analyzing PDMP data to identify prescription drug abuse hot spots. Maximizing PDMPs is one of the priority areas of the initiative. Other activities included in this initiative are advance innovative public insurance programs to prevent opioid abuse, and rigorous state policy evaluations to advance our understanding of the most effective prevention strategies. In September 2015, CDC will launch a major expansion of its state-based program, Prescription Drug Overdose: Prevention for States. Under this new program, 16 states will receive awards ranging from $750,000 to $1 million a year for four years to address the epidemic on multiple fronts. With an emphasis on addressing problematic prescribing practices, states will use the funding to enhance and maximize PDMPs, implement effective prevention in hard hit communities; improve prevention practices for insurers and health systems; evaluate prevention policies; and respond to new and emerging crises.

The Administration remains committed to improving the public health and safety benefits realized by PDMPs by expanding their use within the Federal healthcare system. On February 11, 2013, VA published its interim final rule allowing VA sites to contribute veterans' data to the state PDMP.[207] Since then, the VA has developed and installed software to enable VA pharmacies to transmit their data to PDMPs. As of April 2015, 66 VA facilities were sharing information with PDMPs in their respective states.[208] VA providers have also begun registering and checking the state databases.

While PDMP reporting is not required by IHS facilities, many tribes have declared a public health emergency and elected to participate with the reporting initiative. Currently, IHS is sharing its pharmacy data with PDMPs in 21 states.[209] Additional efforts have been undertaken to establish PDMP accounts for IHS providers so they can access PDMP data on their patients, with accompanying training in the use of the data.

VHA does not currently require prescribers to check the PDMP prior to prescribing. Significant investments in the VHA EHR System are needed for PDMP integration to ensure VHA prescribers can check state PDMPs through the VHA system they are already using.

With funding from CDC and FDA, the PDMP Center of Excellence at Brandeis University developed the Prescription Behavior Surveillance System (PBSS), which collects de-identified PDMP data from participating states.[210] The data are being used in novel ways to measure trends in controlled substance prescribing and dispensing as well as indicators of medical and non-medical use, diversion, and inappropriate prescribing and dispensing. The Federal government, for example, has used the system to monitor new opioid products entering the market. The information within PBSS is also used to target and evaluate the effectiveness of state interventions aimed at reducing prescription drug abuse.

Additional Monitoring Activities

Drug Utilization Review is a practice pharmaceutical benefit managers and others who pay for medicines use to examine prescription data for patterns or trends that suggest a patient might be at risk for health problems or to manage care. CMS has established a Medicare Opioid Overutilizer program under which prescription drug plans in Medicare part D to review patient opioid use and to notify prescribers by mail and phone when they suspect a plan member may be at risk of receiving opioids from too many providers or pharmacies. In some cases, plans may use a case management process to help ensure providers arrive at appropriate prescribing decisions.[211]

Medicaid and private insurers often use a second practice, Drug Utilization Review and Restriction (DURR) in which if a patient is identified at high risk following prescription history review, the insurer restricts the patient to receive services from a single primary care provider and/or a single pharmacy and refuses to reimburse claims made through other locations or providers. To date, at least 46 states and the District of Columbia Medicaid agencies use such programs.[212] At least one study has shown that states using these programs reduce high levels of controlled substance prescribing compared with states not using such programs.[213] DURR is not explicitly permitted by Medicare Part D Statute and would require a legislative change to enable its use by prescription drug plans in that program; the FY 2016 President's Budget included a proposal that would allow CMS to establish such a program.

VA has been a leader in reducing overuse and abuse of prescription opioids through the Opioid Safety Initiative. Despite seeing more overall outpatients, nearly 115,000 fewer Veteran patients are receiving opioids as of 2015 than in mid-2012. When Veteran patients require opioids for their medical needs, more Veterans now than in the past are receiving lower dosages to make sure the opioid prescriptions are safe but effective. In mid-2012, there were 59,499 Veteran patients receiving greater than or equal to a 100 morphine equivalent daily dose (MEDD); as of mid-2015, there are 45,768 patients receiving greater than or equal to a 100 MEDD, a reduction of 23%. In addition, VA is exploring cutting-edge alternative therapies to treat pain and reduce the need for opioids.

Pillar 3: Disposal

Drug diversion contributes to non-medical opioid use. Proper storage and safe disposal are important as a means to secure opioids in the home and prevent them, as well as unwanted or unused opioids from being used for nonmedical reasons.

Increase Prescription Return/Take-Back and Disposal Programs

From 2010 to 2014, DEA prescription drug take-back events collected over 4.9 million pounds (2,411 tons) of drugs.[214] In September of 2014, the DEA held its ninth official Drug Take-Back Day.[215] Events occurred at 5,495 collection sites, including sites in the 50 states, the District of Columbia, Guam, Puerto Rico and the US Virgin Islands and collected a total of 309 tons of drugs.[216] On October 9th 2014, DEA's final Rule on the Disposal of Controlled Substances[217] authorized by the Secure and Responsible Drug Disposal Act of 2010[218] went into effect.

Drug Deactivation Systems

Provided they meet the DEA rule's standard for disposal that drugs are rendered "non-retrievable" by the disposal method, ONDCP supports of innovative disposal methods such as drug deactivation. These systems may be helpful for disposal in locations where incineration is not permitted or take back is not within easy driving distance. In 2013, NIDA sponsored a Small Business Innovation Research contract solicitation[219] requesting proposals to develop system that would provide a simple way to safely inactivate and contain unwanted prescription drugs, thereby minimizing the potential for diversion or accidental exposure, and providing a safe and environmentally responsible way to properly dispose of pharmaceuticals. A disposal product was developed which exemplifies how the drug control interagency partners work together to use federal funds to address policy issues and how U.S. small business innovators can address public health and safety needs.

Disposal Regulations

The new disposal regulations expand the options available to safely and securely dispose of potentially dangerous controlled substance prescription medications on a routine basis including options for take back programs by authorized collectors and law enforcement.[220]

The regulations authorize certain DEA registrants (manufacturers, distributors, reverse distributors, narcotic treatment programs, retail pharmacies, and hospitals/clinics with an on-site pharmacy) to modify their registration with the DEA to become authorized collectors. All authorized collectors may operate a collection receptacle at their registered location, and collectors with an on-site method of destruction may operate a mail-back program. Anyone (not just authorized collectors) can hand out the pre-printed, pre-addressed mail-back packages in which patients and their caregivers can send their unused drugs to the mail-back program operators. Retail pharmacies and hospitals/clinics with an on-site pharmacy may operate collection receptacles at long-term care facilities.

Law enforcement continues to be able to collect controlled substance prescription drugs from patients or their caregivers, including by holding take-back events. Any person or entity - DEA registrant or non-registrant—may partner with law enforcement to conduct take-back events. Patients also may continue to use the guidelines for the disposal of pharmaceutical controlled substances listed by the FDA and the Environmental Protection Agency (EPA). Any method of patient disposal valid prior to these new regulations continues to be valid.

DEA, ONDCP and state experts have begun the process of increasing awareness and educating the public and communities about the new rule. In September and October of 2014, DEA conducted trainings for its diversion field agents in 20 different field divisions and headquarters. DEA, ONDCP and experts from the Alameda County California Superintendent's office held a webinar for community agencies on the new rule. Over 800 people registered for the program and 436 viewed it live. The webinar is archived on the ONDCP website as a resource for interested parties.[221] DEA has also trained registered distributors, reverse distributors, pharmacies, and multiple practitioner groups and associations regarding the disposal regulations. In September 2015, DEA will provide disposal training to registered manufacturers, importers, and exporters. Alameda County Supervisors developed a unique ordinance which permitted the county to charge industry for program support but resulted in a lawsuit against the county by the manufacturers.[222]

The U.S. District Court for the Northern District of California found for Alameda County, and on appeal, the Ninth Circuit Court of Appeals affirmed. This year, the U.S. Supreme Court refused to hear an appeal on this matter. Based on the decision of the Ninth Circuit upholding its constitutionality, the Alameda ordinance may become a useful model for other locales interested in funding disposal programs.[223] Additionally the VHA is offering disposal options to Veterans in alignment with the new regulations.[224] DOD has also begun to offer drug disposal opportunities at DOD facilities. In the next year ONDCP, EPA, DEA and HHS will develop and implement a plan for engaging communities to increase safe disposal. State and local governments remain essential players in expanding prescription drug disposal.

Pillar 4: Enforcement

Although nonmedical prescription drug use is a public health problem, the 2011 *Prescription Drug Abuse Action Plan* recognized that unscrupulous prescribers, illegal pharmacies and those who illegally divert opioids for criminal gain or fraud should be addressed through enhanced enforcement activities.

Assist States to Address Diversion and Pill Mills

Over the past several years, Federal, state and local law enforcement have undertaken significant enforcement actions against pill mills and pain clinics that practice outside the bounds of many clinical practice guidelines. Enforcement, together with legislative efforts to address pill mills, have led to some notable changes in health outcomes. Florida is a noteworthy example. In 2011, Florida enacted HB 7095, which banned physician dispensing, and changed wholesale distribution and reporting, pharmacy license regulations, physician standards of care, Department of Health (DOH) pharmacy inspections, and violation penalties. Initial analyses by the CDC indicate declines in the prescribing of drugs, especially those favored by Florida prescribing dispensers and pain clinics; from 2011 to 2012 overdose death involving those drugs declined 23 percent.[225] NIJ funded a comprehensive policy analysis of HB 7095 that is using information collected via interviews with physicians and Drug Enforcement Strike Force personnel, DOH and crime records to determine whether HB 7095 altered practices and identify useful aspects of this legislation. NIJ's research findings are anticipated in spring 2016.

One challenge to such efforts are increases in the number of clinics in border states where there has been high enforcement. For example, in the wake of legislative and enforcement efforts in Florida, DEA reports that Georgia now has over 150 registered clinics, many of which DEA data shows continue to serve patients without regard to practice standards.[226] Kentucky has also heightened enforcement, and DEA now estimates that Tennessee has over 300 clinics.[227] DEA and state authorities have been addressing this threat through a combination of enforcement actions, legislation, and education.

DEA also provides presentations at regional and national law enforcement conferences across the United States. These presentations inform the law enforcement community of the regional and national trends of diversion and abuse of controlled substance pharmaceuticals. As an active participant in the NMPI, DEA provides information to federal, state, local, and tribal law enforcement officials.

Drive Illegal Internet Pharmacies Out of Business

On October 15, 2008, the President signed into law the Ryan Haight Online Pharmacy Consumer Protection Act of 2008, often referred to as the Ryan Haight Act. This law amends the CSA by adding a series of new regulatory requirements and criminal provisions to stop the proliferation of so-called "rogue Internet sites" that unlawfully dispense controlled substances by means of the Internet. The Ryan Haight Act applies to all controlled substances in all schedules.

This law became effective April 13, 2009.[228] As of that date, it is illegal under Federal law to deliver, distribute, or dispense a controlled substance by means of the Internet unless the online pharmacy holds a modification of DEA registration authorizing it to operate as an online pharmacy. Thus, any person who knowingly or intentionally dispenses a controlled substance by means of the Internet that does not have a modification of DEA registration allowing such activity is in violation of 21 U.S.C.§841(h)(1) and subject to potential criminal prosecution and (in the case of DEA registrants) loss of DEA registration.

Since the passage of the law the National Association of Boards of Pharmacy has been tracking internet sites that do not require a prescription.[229] In the year following the law's passage the percentage of sites offering controlled substances dropped from 41% to 8%.[230]

Crack Down on Rogue Pain Clinics that Do Not Follow Appropriate Prescription Practices

Through enforcement actions and the Ryan Haight Act, many of the domestic illegal Internet pharmacies identified through DEA-led investigations have been shut down. However, many establishments involved with pain management practicing far outside the scope of acceptable medical practices have emerged. Currently, these "rogue pain clinics" are now a source of controlled substance pharmaceuticals which can be diverted or which may be used by patients who are receiving substandard care and who may be at great risk because of inappropriate prescribing and oversight. DEA, in coordination with other Federal, State, and local agencies, investigates rogue pain clinics through expanded Tactical Diversion Squads and shuts down, via administrative actions, those who violate safe prescribing practices.[231]

When illegitimate pain clinics close because of state policy changes, as was the case in Florida, a provider vacuum can occur in the market. Clinics may increase in neighboring states to supply those who are drug dependent who previously obtained medicines from closed clinics. Tennessee, Georgia, and Alabama have all seen increased activity in the wake of Florida's success. DEA estimates at least 80 clinics located across Georgia continue to prescribe in manners inconsistent with medical guidelines.[232] In an effort to address the influx of new clinics in Georgia, the Atlanta Tactical Diversion Squad is gathering and collecting intelligence information to identify, target, investigate, and assist in the effective prosecution of those associated with these pain clinics.[233] This approach is used throughout the United States to prosecute pain clinics operating indiscriminately. As of June 30, 2015, there are 66 operational TDS groups throughout 41 states and territories.[234]

DEA continues to review pharmacy applications, especially in Florida where many non-pharmacist owned pharmacies closed. Since 2010 DEA saw 136 pharmacy registrations surrendered in Florida and 411 across the United States.[235] They also saw in that same timeframe 436 pharmacy applications withdrawn in Florida and 756 withdrawn across the entire United States.[236]

In addition to these efforts, the FBI has established a headquarters based team, the Major Provider Response Team (MPRT), to review intelligence on improper corporate policies relating to the promotion and utilization of pharmaceutical products. The MPRT communicates with FBI field offices on review findings to assist in investigation initiation determinations and to provide investigative assistance on priority investigations. In FY2014, FBI conducted over 500 reviews, including pharmaceutical related findings.[237]

Additional Overdose Prevention Progress

Equip Healthcare Providers and First Responders to Recognize and Manage Overdose

The *2010 Strategy* identified a need to help healthcare providers and first responders recognize and manage overdose. Since then, Federal, state, industry, and private stakeholders have joined together to address overdose through education and expanded access to overdose antidotes. The medicine naloxone is an opioid overdose antidote. Efforts in the past four years efforts include:

- Improving awareness of and access to overdose antidotes for first responders, especially law enforcement;
- New antidote product development in easier to administer formulations:
- Disseminating information to prescribers, patients, caregivers and the public about overdose risk and ways to counter it and working with states and municipalities to enact policies (e.g., Good Samaritan laws and policies to encourage third party naloxone use) that will permit use of naloxone by caregivers, law enforcement and first responders and encourage those who might use naloxone to save a life and obtain emergency follow-up care for the victim.

Law Enforcement and First Responder Naloxone Access

The Administration's commitment to treat drug use disorders as a public health concern is exemplified by efforts concerning overdose education and naloxone distribution. A pilot project, started in 2010 in Quincy, Massachusetts and profiled in the 2013 *Strategy*, has snowballed into a national movement. By January 2015 multiple governors or state attorneys generals (New York, New Jersey and Vermont) had begun the process to equip state law enforcement with the lifesaving opioid antidote, naloxone (Narcan).[238, 239, 240] As of May 2015, naloxone programs for law enforcement have begun in at least one municipality in the following states: California, Delaware, Connecticut, Georgia Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, Washington, and Wisconsin.[241]

Additional Federal activities this year have included a Memorandum by the U.S. Attorney General in July 2014 urging Federal law enforcement agencies to identify, train and equip personnel who may interact with a victim of a heroin overdose; a release by the DOJ of a DOJ Naloxone Toolkit for law enforcement; and an August Executive Action by President Obama directing DoD First Responders to carry naloxone. CBP has initiated a pilot naloxone program in seven ports of entry in various parts of the country. CBP

trained employees in use of naloxone and plans to evaluate the effectiveness of the program in the future.

Overdose Prevention Activities with Healthcare Providers and Patients

Federal agencies that provide healthcare are also engaged. Action steps include:

- Inclusion of naloxone in DOD/VHA Guidelines for managing Suicide Risk[242]
- Creation of naloxone Policy for VHA Prescribers.
- Provision of naloxone by VHA to veterans who may be at risk for overdose via prescribed naloxone through the VHA mail order pharmacy or at the medical center pharmacy.
- Permitting the use of block grant dollars to purchase naloxone and conduct overdose education activities by SAMHSA for at risk populations (e.g., for patients in opioid use disorder treatment or actively using drugs).

VHA is now collecting reports of overdose reversals from its sites. The most recent report through July 26, 2015 was that 6,539 naloxone kit prescriptions had been filled across 128 medical centers that had dispensed at least 1 kit and 87reversals having been voluntarily reported.[243]

Research shows overdoses decrease with naloxone to the extent that communities are saturated with the medicine.[244] One promising avenue for expanding access to naloxone states are exploring is collaborative practice agreements. A collaborative practice agreement allows patients to obtain medicine from a pharmacy without first being seen by a prescriber under certain circumstances. Washington[245] and Rhode Island[246] are both examples of states that allow patients to obtain naloxone from a pharmacy without a prescription under a standardized protocol with education and informed consent given by the pharmacist as part of a formal agreement with a prescriber. The pharmacist then notifies the collaborating physician in writing that the patient has been dispensed naloxone. These programs allow patients to use insurance to cover costs of naloxone and can help get more overdose education and naloxone into the hands of people where many overdoses occur. Standing order programs and pharmacist as prescriber programs can also expand naloxone availability.

Developing New Antidotes

Currently naloxone is approved by FDA for use by injection, although it is often used through an unapproved nasal route of administration by adding an atomizer device and putting liquid into the nose. The Federal government funded development of two naloxone products that, if approved, will permit delivery by the nasal route. These products are anticipated to increase use of naloxone and increase market competition and thereby decreasing costs.

Prescription Drug and Heroin Use During Pregnancy

NAS is a withdrawal syndrome some babies experience after exposure to drugs used by their mothers during pregnancy. In 2012, NAS began to gain media and political attention after research documented a nearly threefold increase in such babies affected by withdrawal in the U.S. and states began efforts to address this phenomenon in their overburdened hospitals.[247] Concern also was raised over total

hospital charges due to NAS, which had increased from $190 million in the year 2000 to $720 million in 2009.[248] The same study shows the Medicaid contribution grew from $130 million to $560 million. Updated analyses show a nearly five-fold increase in national incidence of NAS from 2000 to 2012.[249] Another study using data representing about 20 percent of all infants admitted to neonatal intensive care units (NICU) in the United States found that in 2013 NAS infants made up 27 of 1000 admissions and accounted for 4% of total NICU days.[250]

Research shows that NAS can have origins in the use of legitimate medical prescriptions or treatment for substance use disorders as well as in the use of non-medical drugs like heroin. In addition, the majority of people report the prescription pain relievers they use non-medically are obtained from friends and relatives either purchased or obtained for free sometimes without asking.[251] This suggests that NAS rates may be altered by reducing excessive prescribing and opioid diversion.

Among women who are pregnant, illicit drug use is low, reported by 5.4 percent, and the highest rate of illicit drug use is seen in the youngest women, or those between the ages of 15 and 17 (14.6 percent),[252] suggesting we must do more to help younger women at risk for drug use during pregnancy. Research shows that while the proportion of pregnant women entering treatment has been stable, proportionately more pregnant women with opioid use disorders are entering substance use disorder treatment than were seen prior to the opioid use epidemic, [253] suggesting that even women with serious substance use disorders find their way to care. This research also shows approximately two thirds of these women do not receive the standard of care for pregnant opioid users, MAT with methadone or buprenorphine.

Reducing new non-medical prescription drug use is essential for decreasing the number of infants born with NAS. Two pillars of the 2011 Prescription Drug Abuse Action Plan are especially relevant to this: prescriber education and monitoring. Prescriber education on safer opioid prescribing is required in only six states. Increasing the prescriber education requirements will create a more informed workforce that will take measures to reduce unnecessary prescribing and consider alternatives to opioid prescribing for pain relief opioids in women of childbearing age where clinically appropriate including non-pharmacological therapeutic options.

Expanding PDMPs to help prescribers identify active substance use and, where necessary, create linkages to treatment can also help address NAS. Only a small number of states mandate use of PDMPs. However where they do, evidence is starting to show decreases in the percentage of patients who obtain pain medicines from multiple providers and pharmacies.[254] Research shows certain types of medicines – especially long acting ones - are closely tied to NAS incidence.[255] By consulting the PDMPs, providers can know well in advance about possible prescription drug exposure for medicines known to put infants at greater risk. OB/GYNs can and should make use of PDMPs as a way to understand patient drug use and the risks for having a NAS birth, even if they are not prescribing controlled substances.

Policies to address opioid exposure in infants born to mothers with opioid use disorder should focus on ensuring prenatal care and stability for mothers and babies including using MAT where medically indicated.

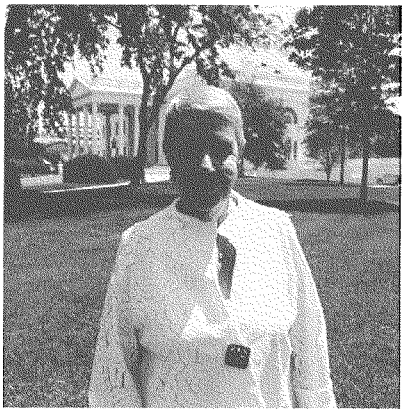
Although MAT is known to cause NAS in some infants, MAT is the standard of care for opioid use disorder in pregnant women. Policies to address opioid exposure in infants born to mothers with opioid use disorder should focus on ensuring prenatal care and stability for mothers and babies including using

MAT where medically indicated. ONDCP is working with state policy teams to expand MAT for opioid use disorders as the standard of care, especially during pregnancy. ONDCP is also working with health plans and pharmacy organizations to ensure adequate coverage for screening and treatment for substance use disorders.

ONDCP and our Federal partners have agreed to complete the following new action items by 2017 to help address maternal substance use and NAS rates.

- Develop/Establish/Update Online Resources on NAS and pregnancy on Federal partner agency websites (ONDCP Lead, HHS/CDC, ASPE, NIDA, FDA, SAMHSA as partners).
- Develop collaborative guidance for states, tribes, and communities on best practice solutions for child welfare and collaborating service providers working with opioid dependent pregnant women, their infants, and their families (HHS/SAMHSA and HHS/Administration for Children and Families (ACF)).
- Develop treatment guidelines for opioid-dependent pregnant women (HHS/SAMHSA).
- Focus the "Treating for Two" initiative on reducing unnecessary opioid risk during pregnancy (HHS/CDC).
- Publish guidelines for the use of opioids in treating chronic pain. The guidelines will target primary care practitioners and apply to patients age 18 and older with chronic pain outside end-of-life care. Special populations—such as pregnant women, given potential adverse maternal and infant outcomes associated with opioid use—will be addressed within the supporting text of recommendations when relevant and when they can be informed by the scientific literature (HHS/CDC lead).

Advocate for Action: Harriet Rossetto, California



Harriet Rossetto is a self-professed rebel spirit and misfit who has found her calling: helping broken souls and changing a broken system.

Thirty years ago, lost and despairing of finding her purpose in life, she was "called" to a small classified ad in the Los Angeles Times: "... person of Jewish background and culture to work with Jewish criminal offenders ... MSW required." At last, she had found her mission and her life's meaning. As a "Jewish Jail Lady," Ms. Rossetto was tasked with helping offenders with substance use disorders re-enter the community, but she quickly became frustrated by the lack of resources and the revolving door of recidivism.

With a one-time grant from the Federal Emergency Management Agency (FEMA), Ms. Rossetto bought an old house and called it Beit T'Shuvah—the house of Return and Redemption. Since then, it has grown from the original halfway house model to a nationally recognized faith-based recovery community serving people with substance use disorders and their families. Today, Beit T'Shuvah houses 140 residents and 100 employees (80 percent of whom are former residents) and continues to provide treatment to people who have limited or no financial resources.

Ms. Rossetto describes herself as addicted to redemption and feels that nothing is as moving as witnessing the transformation of the human spirit. She is married to Mark Borovitz, a former felon and recovering alcoholic, who was ordained as Rabbi Mark in 2000 and "adopted" Beit T'Shuvah.

Policy Focus: Drugged Driving

Americans are all-too familiar with the terrible consequences of alcohol-impaired driving. We are also becoming increasingly aware of the dangers of driving with distractions such as text messaging or talking on a cell phone. Working with DOT, National Transportation Safety Board (NTSB) and other Federal agencies, ONDCP is taking steps to highlight the growing problem of drugged 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.

The 2014 NSDUH, collected by SAMHSA, has determined 4.0 percent of people ages 16 or older reported driving under the influence of illicit drugs in 2013. This is a decrease from 4.4 percent in 2009.[256] However, the Roadside Survey of Alcohol and Drug Use by Drivers, conducted by NHTSA in 2013-2014, shows that weekend nighttime drivers testing positive for illegal drugs or medications has increased from 16.3 percent in 2007 to 20.0 percent in 2013-2014. The same survey found that drivers testing positive for alcohol declined by nearly one-third since 2007. As drinking and driving is falling, use of illegal drugs or medications that can affect road safety is climbing. One in four drivers tested positive for at least one drug that could affect safety, and this proportion represents a 23 percent increase from 2007.

The Administration continues to focus on four key areas to reduce 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. These areas will remain ONDCP priorities for the 2015 year.

The Administration is particularly concerned with the health and safety of America's youth. 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.[257] To best deliver prevention messages about drugged driving to teens, ONDCP partners with youth-serving organizations—including SADD and National Organizations for Youth Safety—who have student outreach in all 50 states.

Preventing Drugged Driving Must Become a National Priority Equivalent to Preventing Drunk Driving

Action: Collect Further Data on Drugged Driving

NHTSA completed analysis on the first large-scale case control crash risk study in the United States to include drugs other than alcohol in 2015. Designed to estimate the risk associated with alcohol- and drug-positive driving, Virginia Beach, Virginia was selected for this study. Data was collected from more than 3,000 crash-involved drivers and 6,000 control drivers who were not involved in crashes. Breath alcohol measurements were obtained from a total of 10,221 drivers, 9,285 drivers provided oral fluid samples, and 1,764 drivers gave blood samples over 20-months. THC was the drug most frequently used by drivers and was detected in 7.6 percent of crash-involved drivers. The study found that marijuana

users are more likely to be involved in accidents, but that the increased risk may be due in part because marijuana users are more likely to be in high-risk groups for becoming involved in crashes (e.g., young males).

Action: Increase Prevention of Drugged Driving by Educating Communities and Professionals

ONDCP, in collaboration with Federal partners, including the NTSB and NHTSA, focused on engaging nongovernmental organizations in raising awareness of drugged driving throughout the year. Traditional drugged driving prevention partners—including RADD: The Entertainment Industry's Voice for Road Safety, Students Against Destructive Decisions and National Organizations for Youth Safety—assisted in prevention efforts. New partners Youth to Youth International, Foundation for Advancing Alcohol Responsibility, and Family Career and Community Leaders of America also provided support.

In July 2014, then Acting Director Botticelli, NHTSA Regional Administrator Michael Witter, and NTSB Acting Chairman Hart joined researchers and community leaders in Columbus, Ohio for the RADD-ONDCP Ohio Teen DUID Summit. This one-day summit focused on sharing the latest drugged driving research and discussing how prevention messaging can involve drugged driving.

The year 2014 was the fifth year President Obama declared December "National Impaired Driving Prevention Month". During the month of December, ONDCP joined youth-serving organizations to host a teen Twitter chat to discuss drugged driving and prevention with youth from around the country. ONDCP sent more than 50 tweets about drugged driving during a one-hour period and more than 30 national partners joined the chat to learn more about drugged driving. Nearly twenty stakeholder organizations reported their plans to raise awareness of drugged driving as part of Impaired Driving Prevention Month.

Action: Provide Increased Training to Law Enforcement on Signs to Identify Drugged Driving

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 which provides an officer up to 60 days to complete the course.

ONDCP promoted the ARIDE program to law enforcement partners—including the International Association of Chiefs of Police, National Association of Police Organizations, the DOJ's Community Oriented Policing division, 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 online ARIDE program to law enforcement communities of interest and stakeholders.

Action: Develop Uniform Screening Methodologies for Drug-Testing Labs to Use in Detecting the Presence of Drugs

ONDCP supports the development of guidelines on toxicology laboratory standards to detect drugs in oral fluids to make on-site drug screening by law enforcement possible, and enhance how drug testing is carried out in the workplace. SAMHSA has finalized and proposed oral fluid testing guidelines. OMB is expected to release the proposed Mandatory guidelines in 2015 or early 2016.

List of Abbreviations

ACA	Patient Protection and Affordable Care Act
ACF	Administration for Children and Families (U.S. Department of Health and Human Services)
ADAM	Arrestee Drug Abuse Monitoring
AIDS	Acquired Immunodeficiency Syndrome
ARIDE	Advanced Roadside Impaired Driving Enforcement
ARS	Association of Recovery Schools
ATF	Bureau of Alcohol, Tobacco, Firearms, and Explosives (U.S. Department of Justice)
ATI	Above the Influence
ATR	Access to Recovery
ATS	Automated Targeting System
ATTC	Addiction Technology Transfer Center
BCSC	Bulk Cash Smuggling 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)
BTO	Butane Honey Oil
CADCA	Community Anti-Drug Coalitions of America
CARSI	Central America Regional Security Initiative
CBP	U.S. Customs and Border Protection (U.S. Department of Homeland Security)
CBSI	Caribbean Basin Security Initiative
CCDB	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
CJ-DATS	Criminal Justice Drug Abuse Treatment Studies
CME	Continuing Medical Education
CMS	Centers for Medicare & Medicaid Services (U.S. Department of Health and Human Services)
CND	Commission on Narcotic Drugs

CPOT	Consolidated Priority Organizational Target
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
CEWG	Community Epidemiology Working Group
DAWN	Drug Abuse Warning Network
DDRU	Designer Drug Research Unit
DEA	Drug Enforcement Administration (U.S. Department of Justice)
DFC	Drug Free Communities
DFE	Demonstration Field Experiment
DHS	U.S. Department of Homeland Security
DICE	DEA Internet Coordination Endeavor
DMI	Drug Market Intervention
DoD	U.S. Department of Defense
DOJ	U.S. Department of Justice
DOT	U.S. Department of Transportation
DTO	Drug Trafficking Organizations
EEOC	Equal Employment Opportunity Commission
EHR	Electronic Health Record
EPA	Environmental Protection Agency
EPIC	El Paso Intelligence Center
ERAD	Electronic Recovery and Access to Data
ER/LA	Extended-Release/Long-Acting
ESP	EPIC System Portal
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
FinCEN	Financial Crimes Enforcement Network (U.S. Department of the Treasury)
GTO	Geographic Targeting Order
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
HSIN	Homeland Security Information Network
HUD	U.S. Department of Housing and Urban Development
IACM	Interagency Assessment of Cocaine Movement
ICE	U.S. Immigration and Customs Enforcement (U.S. Department of Homeland Security)
ICMLEO	Integrated Cross-border Maritime Law Enforcement Operations
IHS	Indian Health Service (U.S. Department of Health and Human Services)
INCB	International Narcotics Control Board
INL	Bureau of International Narcotics and Law Enforcement Affairs (U.S. Department of State)
IRP	Intramural research program
I-SATS	Inventory of Substance Abuse Treatment Services
JIATF	Joint Interagency Task Force
JJ-TRIALS	Juvenile Justice Translational Research on Interventions for Adolescents in the Legal System
LSS	Laboratories and Scientific Services Directorate
MAT	Medication-Assisted Treatment
MEDD	Morphine Equivalent Daily Dose
MEM	Multilateral Evaluation Mechanism
MPRT	Major Provider Response Team
MSB	Money Services Business
MSI	Minority Serving Institutions
MTF	Monitoring the Future
NADCP	National Association of Drug Court Professionals

NAS	Neonatal Abstinence Syndrome
NASTAD	National Alliance of State and Territorial AIDS Directors
NATIVE	Native American Targeted Investigation of Violent Enterprises
NDEWS	National Drug Early Warning System
NFLIS	National Forensic Laboratory Information System
NGIC	National Gang Intelligence Center
NGR	National Gang Report
NHTSA	National Highway Traffic Safety Administration (U.S. Department of Transportation)
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIC	National Institute of Corrections
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)
NMPI	National Methamphetamine and Pharmaceuticals Initiative
NPS	New Psychoactive Substances
N-SSATS	National Survey of Substance Abuse Treatment Services
NSDUH	National Survey on Drug Use and Health
NSS	National Seizure System
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)
OJJDP	Office of Juvenile Justice and Delinquency Prevention (U.S. Department of Justice)
OFR	Overdose fatality review
ONC	Office of the National Coordinator for Health Information Technology
ONDCP	Office of National Drug Control Policy
OPM	Office of Personnel Management
PAD	Prepaid Access Devices
PBSS	Prescription Behavior Surveillance System
PDMP	Prescription Drug Monitoring Program
PEPFAR	President's Emergency Plan for AIDS Relief

PSA	Public Service Announcement
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)
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SCPL	Small capacity production laboratories
SEDSS	SAMHSA Emergency Department Surveillance System
SSP	Syringe Service Programs
STTR	Seek, Test, Treat, and Retain Initiative
TCG	Treatment Coordination Group
TEDS	Treatment Episode Data Set
TCO	Transnational Criminal Organizations
TOC	Transnational Organized Crime
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
USCG	U.S. Coast Guard (U.S. Department of Homeland Security)
USDA	U.S. Department of Agriculture
VA	U.S. Department of Veterans Affairs
VHA	Veterans Health Administration (U.S. Department of Veterans Affairs)
VRSS	Veteran Reentry Search Service
Y2Y	Youth to Youth

Notes

1. In 2013, an estimated 10 percent of Americans 12 and older who needed and perceived a need for treatment but did not receive it at a specialty facility responded that they did not seek such treatment because they were concerned "that receiving treatment might cause neighbors/community to have a negative opinion." Substance Abuse and Mental Health Services Administration. (2014). Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings (NSDUH Series H-48, HHS Publication No. (SMA) 14-4863). SAMHSA, Rockville, MD.

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70. The Indian Health Service's Tele-Behavioral Health Center of Excellence webinar trainings topic areas included Introduction to Addictions, Opioid Dependence; Chronic Pain and Depression; Anxiety and Chronic Pain; General Headaches; Migraine Headaches; Fibromyalgia; Chronic Pain and Neurology; Epidemiology of Chronic Pain; Pain Anatomy and Physiology; Medication Management for Pain; Federal and State Regulations; Non-Opioid Pain Medications; Clinical Interview of a Chronic Pain Patient; Screening for Misuse, Diversion, and Addiction; Physical Exam of a Chronic Pain Patient; Psychosocial Assessment of a Patient with Chronic Pain; Basics of Motivational Interviewing; Motivational Interviewing: A Taste of the Fundamentals, Part I; The Role of Nurses in Pain Management; Measurement and Management of Chronic Pain; The Role of a Pharmacist in the Management of Patients with Chronic Pain; Diagnosis & Treatment of Myofascial Pain; Acupuncture; Intensive Short Term Dynamic Psychotherapy (ISTDP); Cognitive Behavioral Therapy (CBT); Provider Self-Care and Coping; Introduction to PTSD and Chronic Pain; Prolonged Exposure as a Treatment for PTSD/SUD; EMDR; A Clinical Approach to Working with Substance Abuse and PTSD; Naloxone and Medically Assisted Treatment for Opioid Dependence; Methadone: An Introduction; Creating a Circle of Hope; Fetal Alcohol Spectrum Disorder: Diagnosis, Intervention, and Research; FASD and Addiction Treatment: Improving Outcomes; Typical and Atypical Brain Development (FASD); Substance Abuse, Part I; Substance Abuse, Part II.

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