



NATIONAL DRUG CONTROL STRATEGY

2011





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To the Congress of the United States

Every sector of our society is affected by drug use and the consequences of drug use. Drug use and its consequences hamper our Nation's ability to out-educate our global competitors and increase graduation rates. It lessens the ability of our workforce to be fully productive, and it takes the lives of too many fellow Americans.

My Administration's 2011 *National Drug Control Strategy* contains support for smart and cost-effective programs to reduce drug use and its consequences. There are new prevention initiatives to encourage young people to make good decisions. There are increasing numbers of evidence-based treatment programs for those with substance use disorders. There is a focus on smart criminal justice approaches that use our criminal justice system to break the cycle of drug use and crime by diverting non-violent offenders into treatment instead of prison. From pre-trial diversion to alternatives to incarceration, to re-entry efforts that fundamentally change how drug-related crime and substance-abusing offenders are addressed, these approaches reduce recidivism and help ex-offenders return to their communities. On our borders and around the world, we highlight our collaboration with international partners to stop drugs from reaching our shores and prevent proceeds of illicit drug sales from returning to traffickers.

This *Strategy* also builds on several legislative accomplishments passed with broad, bipartisan support from Congress over the past year. I was proud to sign two important pieces of legislation since the release of the Inaugural *Strategy*; the Fair Sentencing Act and the Secure and Responsible Drug Disposal Act.

The Fair Sentencing Act dramatically reduced the sentencing disparity between crack cocaine and powder cocaine violations. My Administration is committed to the fair and equal application of our Nation's laws. The Fair Sentencing Act marks the first time in 40 years that Congress has reduced a mandatory minimum sentence.

Prescription drug abuse is America's fastest-growing drug problem, and one largely fed by an unlikely source—Americans' medicine cabinets. The passage of the Secure and Responsible Drug Disposal Act of 2010 will save lives by providing patients with safe, environmentally sound ways to dispose of unused or expired prescription drugs.

By taking a balanced approach to drug policy, one that emphasizes both public health and public safety, we can help make our neighborhoods and communities even stronger. Together, we will make a real difference in addressing the many challenges posed by drug use and its consequences and create a brighter future for us all.

Barack Obama
The White House



Preface from Director Kerlikowske

In its inaugural *Strategy* published last year, this Administration embarked upon a new approach to the problem of drug use in the United States, an approach founded on scientific evidence and informed by extensive consultation with substance abuse experts, representatives of law enforcement, and our Federal, state, tribal, and local partners. This year, we continue our call for a balanced approach—one that draws upon prevention, treatment, recovery support, law enforcement, interdiction, and international partnerships—to achieve a 15 percent reduction in the rate of drug use and its consequences over 5 years.

This Administration's approach to addressing the multi-faceted challenges associated with drug use in this country is, necessarily, both detailed and complex. Its success depends upon realizing a number of accomplishments that will, collectively, make America's communities safer and its people healthier. This *Strategy* reports on the progress we have already made on many of the inaugural *Strategy's* commitments. Over the course of 2011, we expect significant progress on several other fronts. Those, in turn, will be presented in the 2012 *Strategy*.

Throughout this document, we highlight policies and programs at the Federal level; however, we also recognize the significant contributions of our state, local, and tribal partners. A basic tenet of the *Strategy* is that the Nation's drug problems require not only Federal attention, but also local partnerships to develop effective solutions. Prevention efforts are most successful when they involve multiple sectors of a community, such as schools, health and social service systems, law enforcement, faith communities, local businesses, and neighborhood organizations. While this *Strategy* is largely a blueprint for the Federal Government, I know from my experience as a police chief that it will also prove useful in guiding state and local decisions.

In this *Strategy*, as in all of our initiatives, we are focused on key topics where substantial short-term progress can make a significant difference in people's lives: prescription drug abuse, drugged driving, and prevention. Given the gravity and scope of the prescription drug abuse problem, which has been described by the Centers for Disease Control and Prevention as a public health epidemic, the Administration has developed and is implementing the Nation's first Prescription Drug Abuse Prevention Action Plan. We are also coordinating a national response to the problem of drugged driving, and we remain committed to and focused on ensuring drug use prevention efforts are plentiful and based on science.

Likewise, we have identified key populations that struggle with substance abuse, including military personnel, veterans, and their families; people in the criminal justice system; families, with particular emphasis on women and children; and college and university students.

Our goals are ambitious and our challenges numerous, but I am confident that our work and the work of our many partners will reduce drug use and lessen the damage it inflicts on our country. I am grateful for the support of Congress in addressing these challenges, and ask for continued support and collaboration as we implement this *Strategy*.

R. Gil Kerlikowske
Director, Office of National Drug Control Policy



Introduction

In May of 2010, President Obama released the Administration's inaugural *National Drug Control Strategy*. Based on the premise that drug use and its consequences pose a threat not just to public safety, but also to public health, the 2010 *Strategy* represented the first comprehensive rebalancing of Federal drug control policy in the nearly 40 years since President Nixon declared illicit drugs "public enemy number one."

This 2010 *Strategy* continues to serve as the Administration's blueprint to reduce drug use and its associated consequences in the United States. It describes specific actions that Federal departments and agencies are taking to achieve the Administration's two main drug control goals: curtailing illicit drug consumption in America and reducing the consequences of drug abuse that threaten our public health and safety. It also highlights the development and implementation of evidence-based prevention and intervention practices and policies supported by Federal partnerships with state, local, and tribal jurisdictions and other stakeholders.

The actions enumerated in the 2011 *Strategy* will build on the 2010 *Strategy* and on several major drug policy milestones achieved over the last year. On August 3, 2010, President Obama signed into law the Fair Sentencing Act of 2010, a significant and long-overdue piece of criminal justice reform, which reduces the disparity in the amounts of powder cocaine and crack cocaine required for the imposition of mandatory minimum sentences. This act eliminates the mandatory minimum sentence for simple possession of crack cocaine in Federal cases. It also increases penalties for major drug traffickers. On October 12, 2010, the President signed into law the Secure and Responsible Drug Disposal Act of 2010, which will help communities combat the Nation's prescription drug abuse epidemic by providing states and localities the authority to collect unused prescription drugs for safe disposal. Both of these legislative accomplishments are the result of support from both Democrats and Republicans, illustrating how combating drug use and its consequences continues to be a bipartisan effort.

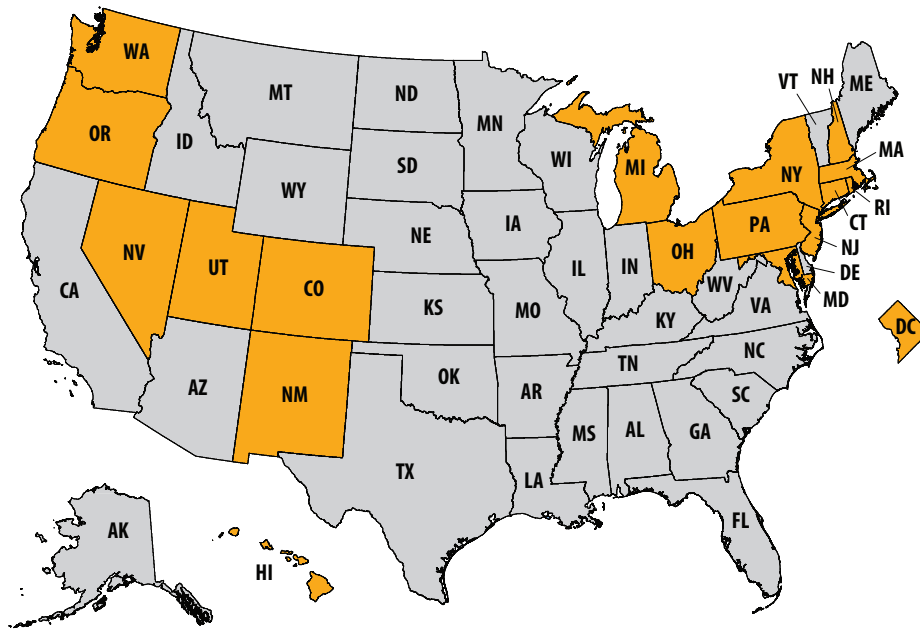
As Americans work together to address our Nation's shared challenges, the health, well-being, and safety of our citizens continue to serve as the basis for strengthening our economy and our country overall. A healthy, productive, and drug-free workforce fosters competition and innovation within our neighborhoods, towns, and communities. Addressing our Nation's drug problem will also ensure that our fellow citizens can contribute to our shared successes and America's future generations will continue to lead the world in innovation and ingenuity.

Framing the Problem

The Obama Administration's approach to the drug problem is borne out of the recognition that drug use is a major public health threat, and that drug addiction is a preventable and treatable disease. Whether struggling with an addiction, worrying about a loved one's substance abuse, or being a victim of drug-related crime, millions of people in this country live with the devastating consequences of illicit drug use. Overall, the economic impact of illicit drug use on American society totaled more than \$193 billion in 2007, the most recent year for which data are available.¹ Drug-induced deaths now outnumber gunshot deaths in America, and in 17 states and Washington, D.C., they now exceed motor vehicle crashes as the

leading cause of injury death.² In addition, 1 in every 10 cases of HIV diagnosed in 2007 was transmitted via injection drug use, and drug use itself fosters risky behavior contributing to the spread of infectious diseases nationwide.³ Furthermore, studies of children in foster care find that two-thirds to three-quarters of cases involve parental substance abuse.⁴ Also, low-achieving high school students are more likely to use marijuana and other substances than high-achieving students.⁵ Finally, Americans with drug or alcohol use disorders spend more days in the hospital and require more expensive care than they would absent such disorders. This contributes to almost \$32 billion in medical costs per year⁶—a burden that our communities, employers, and small businesses cannot afford to bear.

Figure 1. 17 States with More Drug-Induced Deaths than Deaths from Motor Vehicle Accidents, 2007



Source: CDC, WONDER online databases [<http://wonder.cdc.gov/cmfi-icd10.html>] (August 19, 2010).

Despite significant gains over the past decade, recent survey results have shown troubling increases in drug use in America. Young adults between the ages of 18 and 25 have the highest rates of current drug use at nearly 20 percent. Each day, an estimated 4,000 young people between the ages of 12 and 17 use drugs for the first time.⁷ Additionally, more high school seniors now use marijuana than tobacco, and non-medical use of prescription or over-the-counter drugs remains unacceptably high, accounting for 6 of the top 10 substances used by 12th graders in the year prior to the survey.⁸

While these results inspire a call to action, they are not unexpected. Data from the last 2 years show young people's attitudes towards drugs are weakening, particularly toward marijuana and prescription drugs.⁹ When youth attitudes weaken, increases in use are never far behind.

The 2011 *Strategy* continues efforts to coordinate an unprecedented government-wide public health approach to reduce drug use and its negative consequences in the United States while maintaining

strong support for law enforcement. Experience shows we can continue to make progress in reducing drug use by supporting balanced and evidence-based drug control strategies. Data show that, despite recent increases in drug use, the percentage of Americans using illicit drugs is half the rate it was 30 years ago, cocaine production in Colombia has dropped by almost two-thirds since 2001, and increasing numbers of non-violent offenders are being diverted into treatment instead of jail. Previous national efforts to reduce smoking, drunk driving, and other public health threats have shown that sustained and balanced approaches can work to significantly improve public health and safety. The Administration's *National Drug Control Strategy* provides a roadmap to build on these past successes.

Policy Priorities

In addition to the overarching drug policy outlined above, we are focused on three areas where substantial short-term progress can make a significant difference in people's lives—prescription drug abuse, drugged driving, and prevention.

Reducing Prescription Drug Abuse (Also discussed in Chapters 1, 5, 6, and 7)

Prescription drug abuse is the Nation's fastest-growing drug problem. While prescription drugs have important benefits when used properly, they are also increasingly abused by teens and young adults. According to the Centers for Disease Control and Prevention (CDC), more than 27,000 people died from drug overdose deaths in 2007. These deaths primarily involve prescription drug pain relievers. The rate of overdose deaths from such drugs has risen five-fold since 1990 and has never been higher. Prescription drugs are now involved in more overdose deaths than heroin and cocaine combined.¹⁰

Because prescription drugs are legal, they are easily accessible and are most frequently acquired through friends and family members. Further, some individuals who misuse prescription drugs, particularly teens, mistakenly believe these substances are safer than illicit drugs because they are prescribed by healthcare professionals and legally sold by pharmacies.

Although we must carefully balance the need to minimize abuse of pharmaceuticals with the need to maximize safe and legitimate access to these products, the Administration has made reducing prescription drug abuse a national priority. This *Strategy*, along with the Administration's recently released plan (titled, *Epidemic: Responding to America's Prescription Drug Abuse Crisis*) provides a blueprint for reducing prescription drug abuse by supporting the expansion of prescription drug monitoring programs, encouraging community prescription take-back initiatives, recommending disposal methods to remove unused medications from the home, supporting education for patients and healthcare providers, and reducing the prevalence of illegal prescribing practices and doctor shopping through enforcement efforts. The complete plan can be found here:

<http://www.whitehousedrugpolicy.gov/prescriptiondrugs/>

Addressing Drugged Driving (Also discussed in Chapters 1 and 5)

Similar to the highly successful efforts to prevent drunk driving, drugged driving demands a national response. According to the National Highway Traffic Safety Administration (NHTSA), roughly one in eight weekend, nighttime drivers tested positive for illicit drugs.¹¹ In 2009, drivers who were killed in

motor vehicle crashes (and subsequently tested and had results reported), one in three tested positive for drugs.¹² One in eight high school seniors self-reported that in the last 2 weeks they drove a car after using marijuana.¹³

To help shed light on this threat, the President declared December 2010 National Impaired Driving Prevention Month and called on all Americans to recommit to preventing the loss of life by practicing safe driving practices and reminding others to be sober, drug free, and safe on the road. In follow-up to the activities called for in this *Strategy*, drugged driving will be addressed domestically by raising public awareness in partnership with national non-governmental organizations, local law enforcement, and courts; providing technical assistance to states considering per se laws; developing an online version of NHTSA's Advanced Roadside Impaired Driving Enforcement Program; and improving testing methods for impaired drivers.

Preventing Drug Use Before it Begins (Also discussed in Chapter 1)

Scientific evidence makes clear that drug prevention is the most cost-effective, common-sense approach to promoting safe and healthy communities. Youth who refrain from drug use have better academic performance.¹⁴ Communities enjoy reduced drugged driving and, therefore, safer roads. Employers experience lower absenteeism, resulting in more productive workplaces.^{15,16,17} Drug use prevention efforts also impact HIV transmission rates by decreasing injection drug use, creating safer home environments by reducing the number of drug-endangered children, and revitalizing neighborhoods through coalition-based efforts.^{18,19,20}

Americans from every walk of life suffer from drug addiction, especially with the increasing abuse of prescription drugs. The next generation deserves every opportunity to succeed in life, and effective prevention gives them much better odds.

Special Populations

While drug addiction respects no geographic, ethnic, economic, or social boundaries, there are some specific populations with unique challenges and needs in addressing their substance abuse issues. Throughout this *Strategy*, the Administration is proposing new policies and practices that will improve the way the Federal government responds to the special populations described below.

College and University Students

About 40 percent of college students report binge drinking (defined for men as five or more drinks in a row on at least one occasion in the past 2 weeks and for women as four or more drinks).²¹ Other drug use, including marijuana and prescription drug abuse, is also of concern. One study at a large university reported that 34 percent of students had used a prescription stimulant medication during times of academic stress, believing that these drugs increased reading comprehension, cognition, and memory.²² Substance use by college students also contributes to numerous academic, social, and health-related problems. In one national study of 14,000 college students, 29.5 percent reported missing a class because of alcohol use and almost 22 percent who drank in the year prior reported falling behind in their work.²³ In another national study examining the consequences of binge drinking among college students 10 years post-college, binge and frequent drinking was associated with academic attrition, early departure from college, and lower earnings in post-college employment.²⁴

Women and Families

Seeking treatment for drug addiction poses hurdles specific to women because many treatment programs are designed for and used mostly by men and many women must weigh competing family concerns against the need for substance abuse treatment. Because many traditional treatment programs do not allow for the inclusion of children, a woman may be torn between the need to provide child care and the need for treatment. Involvement with the child welfare system also complicates a woman's decision to seek care, because admitting to a substance abuse problem may lead to involvement with the criminal justice system and the loss of custody of children.

Girls have caught up to boys in their initiation of the use of illicit drugs and alcohol.²⁵ Teenage girls' drug use is frequently tied to self-esteem issues, depression, and peer pressure, but often prevention and treatment programming do not address these risk factors.²⁶

Military, Veterans, and Their Families

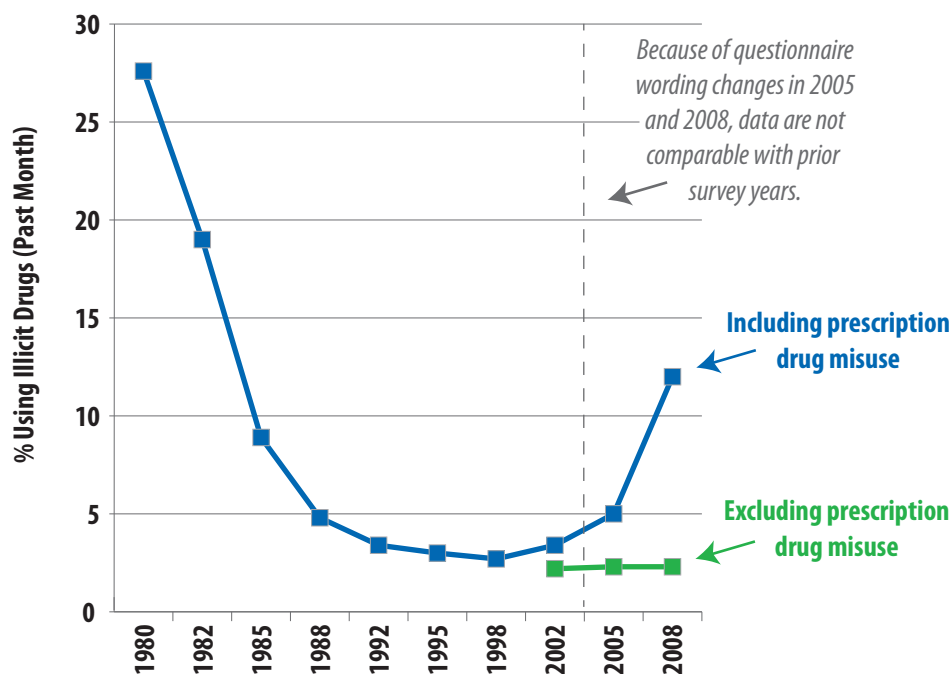
Far too many brave men and women who have risked their lives in service to our country are now suffering from physical, mental health, and substance abuse problems. A 2008 Department of Defense (DOD) survey revealed that 11.9 percent of active duty military personnel reported current illicit drug use, including non-medical use of prescription drugs. Largely due to regular testing, the use of illicit drugs such as marijuana, cocaine, heroin, and methamphetamine is rare among active duty military. The percentage reporting prescription drug misuse (11.5%) is more than double that of the civilian population in the age group 18-64 (4.4%).²⁷

In response to the increased concern about misuse of prescription medications, DOD has established a Pharmacovigilance Center. By taking advantage of technological advances, DOD is able to monitor possible medication misuse and assess the effectiveness of policies, formulary decisions, risk reduction measures, and point of care initiatives within the DOD system. However, diversion, drug sharing, and prescriptions obtained outside the DOD system, which may have contributed to the increase in prescription misuse in recent years, are not captured through the Pharmacovigilance Center. DOD will partner with the Office of National Drug Control Policy (ONDCP) to further enhance their ability to identify misuse by exploring data sharing with state prescription drug monitoring programs.

Additionally, the Justice Department's most recent survey of incarcerated Veterans found that an estimated 60 percent of the 140,000 Veterans in Federal and state prisons were struggling with a substance use disorder, while approximately 25 percent reported using drugs at the time of the offense.²⁸ The Veterans Health Administration (VHA) has made three special populations the target of particular VA substance use disorder prevention and treatment efforts: service members who have returned from Iraq and Afghanistan and are eligible for VHA services; patients receiving care in Mental Health Residential Rehabilitation Treatment Programs; and patients suffering from Post Traumatic Stress Disorder.

Enhancing the psychological and behavioral health of military families was the first identified priority in the Presidential report, *Strengthening our Military Families*, which is designed to provide a comprehensive strategy to improve and expand substance abuse prevention, treatment, and recovery services available for active duty Armed Forces, the National Guard, and the Reserves.

Figure 2. **Drug Use Among Active-Duty Military Personnel,* 1980-2008**



*Department of Defense services only (Army, Navy, Marine Corps, and Air Force).

Sources: Bray, et al., 2002 Department of Defense Survey of Health Related Behaviors Among Military Personnel (November 2003) and Bray, et al., 2008 Department of Defense Survey of Health Related Behaviors Among Active Duty Military Personnel (September 2009).

Goals and Baselines

The 2010 *Strategy* called for a balanced approach of prevention, treatment, law enforcement, interdiction, and international partnerships to achieve a 15-percent reduction in the rate of youth drug use over 5 years, as well as similar reductions in chronic drug use and drug-related consequences such as drug-induced deaths and drugged driving.

Within its seven chapters, last year's *Strategy* articulated seven objectives that support the overall goals and presented 106 specific action items whose implementation is necessary to achieve the *Strategy*'s goals and the Administration's vision of a balanced approach to drug policy in the United States. The *Strategy* provided both a brief description of the action items and, for each item, a list of the agencies responsible for their implementation. Following the release of the *Strategy*, ONDCP, working with interagency partners, developed a process to track and ensure successful implementation of the 106 action items and designed a Performance Reporting System (PRS) for gauging the overall effectiveness of the *Strategy*.

INTRODUCTION

The 2011 *Strategy* reports progress toward achievement of the many action items enumerated in the 2010 *Strategy* for which there are specific accomplishments to document. The full list of Action Items can be found at <http://whitehousedrugpolicy.gov/strategy>. Action Items addressed in this *Strategy* are marked throughout the document.

Appendix One contains tables and short narrative descriptions for the *Strategy*'s two main goals and their seven sub-measures. For all the goals and sub-measures, 2009 data are used as the baseline, although in some cases, 2009 data are not yet available. The PRS will track progress and report annually on the *Strategy*'s seven strategic objectives. In addition, a report on the design of the PRS will be released under separate cover.

The 2011 *Strategy* is a recommitment to the goals, objectives, and activities in the Administration's inaugural *Strategy*, which set forth the foundation and direction of President Obama's drug policy. This *Strategy* will continue to ensure continuity, accountability, and transparency in the Administration's efforts to reduce drug use and its consequences.

National Drug Control Strategy Goals to be Attained by 2015

Goal 1: Curtail illicit drug consumption in America

- 1a. Decrease the 30-day prevalence of drug use among 12- to 17- year- olds by 15%
- 1b. Decrease the lifetime prevalence of 8th graders who have used drugs, alcohol, or tobacco by 15%
- 1c. Decrease the 30-day prevalence of drug use among young adults aged 18-25 by 10%
- 1d. Reduce the number of chronic drug users by 15%

Goal 2: Improve the public health and public safety of the American people by reducing the consequences of drug abuse

- 2a. Reduce drug-induced deaths by 15%
- 2b. Reduce drug-related morbidity by 15%
- 2c. Reduce the prevalence of drugged driving by 10%

Data Sources: SAMHSA's National Survey on Drug Use and Health (1a, 1c); Monitoring the Future (1b); What Americans Spend on Illegal Drugs (1d); and Prevention (CDC) National Vital Statistics System (2a); SAMHSA's Drug Abuse Warning Network drug-related emergency room visits, and CDC data on HIV infections attributable to drug use (2b); National Survey on Drug Use and Health and National Highway Traffic Safety Administration (NHTSA) roadside survey (2c)

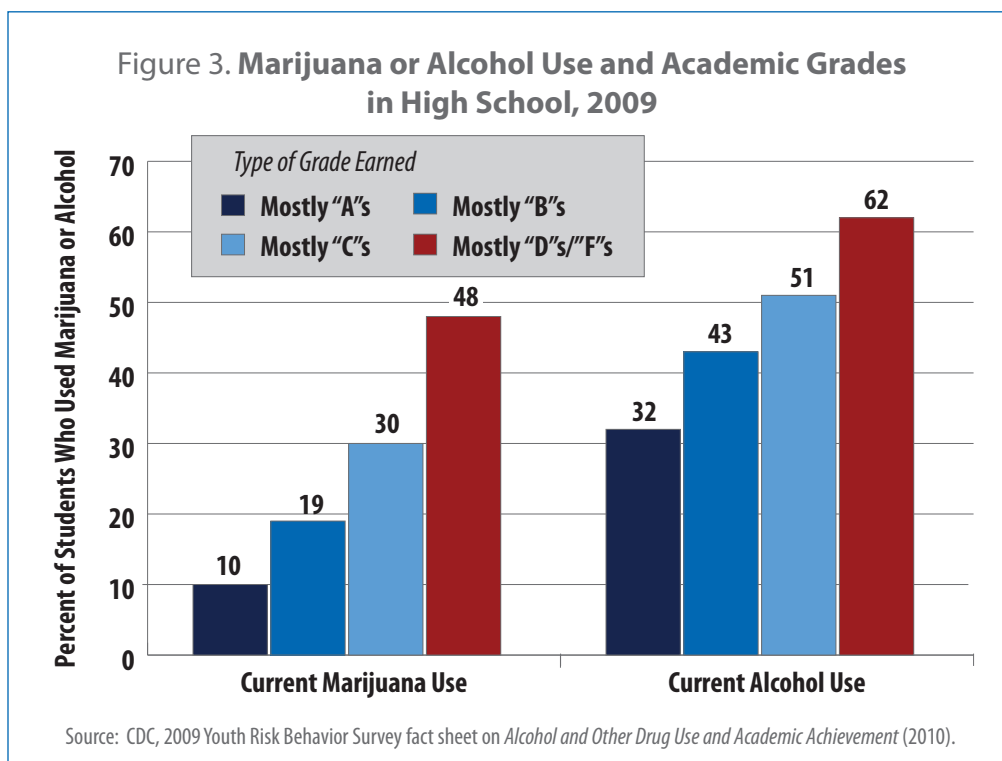


Chapter 1. Strengthen Efforts to Prevent Drug Use in Our Communities

Drug and alcohol use affects health outcomes, job opportunities, family life, military preparedness, and academic outcomes. Findings from several national surveys show that teen marijuana use may be increasing and that the perceived risk of marijuana use is decreasing. Historically, research demonstrates that drug use among youth increases when the perceived danger of using drugs decreases.²⁹

Therefore, now more than ever, it is critical to focus resources and efforts on preventing use before it ever starts. This is not only common sense, but is cost-effective: For every dollar invested in prevention, up to 10 dollars in treatment for alcohol or other drugs can be saved.³⁰

The consequences of substance use on academic performance are significant and demonstrate why we must invest in prevention efforts. For example, the CDC found that 9th to 12th graders who received grades of mostly Ds and Fs were twice as likely to be current alcohol users, five times more likely to be current marijuana users, and 13 times more likely to be current cocaine users, compared to students receiving A grades.³¹ In a study of first-year college students who used marijuana five or more times in the past year, nearly 25 percent were found to meet the diagnostic criteria of abuse or dependence. Of these students, 24 percent regularly put themselves in physical danger when under the influence, 40 percent reported concentration problems, and 14 percent reported missing class due to their drug use.³²



Risk factors specific to substance use (e.g., truancy, deviant peers, school failure) must be considered when designing prevention programs. Effective drug prevention is comprehensive and includes a combination of evidence-based interventions and environmental strategies and policies to enforce the consequences for substance-related offenses; reduce the access to substances; and decrease the likelihood of use.

A basic tenet of the *Strategy* is that the Nation's drug problems require not only Federal attention but also local partnerships to develop effective solutions. Prevention efforts are most successful when they involve multiple sectors of a community, such as schools, health and social service systems, law enforcement, faith communities, local businesses, and neighborhood organizations.

The National Prevention Council

As part of the Affordable Care Act, on June 10, 2010 the President signed an Executive Order creating the National Prevention, Health Promotion, and Public Health Council (the National Prevention Council). Chaired by the Surgeon General, the Council consists of senior officials from 17 Federal departments and is charged with providing coordination and leadership among all executive departments and agencies with respect to prevention, wellness, and health promotion practices.

To do so, the National Prevention Council is developing a National Prevention and Health Promotion Strategy with input from the public and other interested stakeholders. Planned for release in spring 2011, this Strategy provides the foundation for our Nation's prevention efforts and will address seven priority areas aimed at addressing the leading causes of death, including drug abuse and excessive alcohol use.

Goals and performance measures for the National Prevention Strategy's section on drug abuse and excessive alcohol use were informed by those established in the *National Drug Control Strategy*, thus ensuring compatibility with the Administration's existing plan to reduce drug use and its consequences. Further information about the National Prevention Council can be found at <http://www.healthcare.gov/center/councils/nphpphc/index.html>

Principle 1. A National Prevention System Must be Grounded at the Community Level

The Drug Free Communities Support Program

ONDCP's Drug Free Communities (DFC) Support Program is a critical component of the Nation's drug prevention infrastructure. It is built on the premise that Federal and state assistance for prevention is most effective when supporting programs that originate in, and are developed by, communities. To this end, the DFC program provides resources to community-based coalitions to develop data-driven strategic plans that increase community collaboration that reduce youth substance use. In August 2010, ONDCP, in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA), awarded DFC grants totaling \$85.6 million to 741 communities.

DFC coalitions connect with the community at a "grassroots" level to help identify and respond to their unique local drug problems by using environmental strategies aimed at addressing community factors that may contribute to youth substance use. These strategies may include addressing school policies

related to possession of drugs on campus and limiting the number of alcohol retailers near parks, schools, or other places that youth congregate. By working together, coalitions can create changes that reduce the social and health consequences of drug use by limiting access to illegal substances and by changing social and cultural norms that promote such risky behaviors. The DFC approach is effective and sustainable long after grant funds are provided—an outcome not achieved by programs that do not seek to create environmental change.

To increase the program's outreach to special populations, the Program hosted two American Indian/Alaska Native (AI/AN) technical assistance sessions at Fiscal Year (FY) 2011 Applicant Workshops in San Diego and Washington, D.C. The workshops were designed to provide technical assistance specific to the challenges faced by applicants serving AI/AN populations. As of the FY 2010 funding, 10 percent of all DFC-funded coalitions serve tribal communities. (Action Item 1.2A)

The DFC program undergoes a national cross-site evaluation each year that uses data provided by its grantees. These data indicate that since January 2002, past 30-day use of alcohol, tobacco, and marijuana declined significantly in both middle school and high school-aged youth in areas served by DFC coalitions. Moreover, prevalence of 30-day use across all substances was lower for DFC high school students than among a nationally representative sample of high school students taking the Youth Risk Behavior Survey (YRBS). The differences between DFC and YRBS were statistically significant for alcohol in 2003, 2005, 2007, and 2009. Differences in prevalence of 30-day use were also statistically significant for marijuana in 2003, 2005, and 2007.

Reaching Out to Military Personnel and their Families

Studies show that individuals with post-traumatic stress disorders, such as returning active duty personnel and Veterans, are more susceptible to substance use.³³ The Administration recognizes the profound importance of ensuring the health and well-being of servicemen and women and their families. To help address these issues, DOD has developed and will work with other agencies to further improve prevention, resilience and community assistance programs. In 2011, ONDCP will use the DFC coalition model to help build the prevention capacity of communities with military families.

Promoting Successful, Safe, and Healthy Students

The Administration's reauthorization plan for the Elementary and Secondary Education Act recognizes that the children and young people most at risk for drug abuse and academic failure too often attend schools and live in communities that fall short in meeting their basic needs.

To address these resource-poor schools and communities, the Successful, Safe, and Healthy Students (SSHS) program will build on competitions under the Safe and Drug-Free Schools and Communities National Programs. SSHS will provide \$365 million in funding to increase the capacity of state educational agencies (SEAs), high-need local educational agencies (LEAs), and their partners to develop and implement programs and activities, including those focused on preventing drug use, alcohol use, bullying, harassment, or violence and promoting the physical and mental well-being of students.

Strategic Prevention Framework

SAMHSA's Strategic Prevention Framework-State Incentive Grant (SPF-SIG) program has also contributed to building a national prevention infrastructure. The SPF-SIG program helps states and communities implement effective prevention programs using a data-driven, strategic planning process. This program requires most funding be directed to community-level organizations such as coalitions. In 2010, SAMHSA awarded 10 new SPF-SIG grants totaling \$10.6 million, bringing the current total number of SPF-SIG awardees to 49 states, 8 jurisdictions, 19 tribes, and the District of Columbia. In total, the program has reached more than 800 communities.

In the President's FY 2012 Budget, the elements of this successful program are being required within a State Prevention Grant program as well as a Behavioral Health Tribal Prevent Grant program to help support all states and tribes implement a data-driven local approach to preventing substance abuse.

Findings from an evaluation of the first cohort of SPF grantees (2006) show positive changes in a number of outcomes over the course of 12 months: 42 percent of grantees showed improvements in perception of risks of drug use by both youth and adults; 68 percent of grantees had improvement of disapproval rates of peer substance use by 12- to 17- year-olds; 74 percent of grantees showed improvement of past 30-day drinking rates by youth ages 12 to 20 years; and 68 percent of grantees improved in past 30-day drug use rates among both youth and adults.³⁴ The majority of interventions were evidence-based, and nearly half were environmental strategies.

The President's FY 2012 Budget reflects plans to establish a new Substance Abuse State Prevention Grant (SASPG), which will bring the SPF-SIG approach to scale across the Nation. Specifically, the SASPG will provide enhanced prevention funding to ensure every state and territory makes prevention of substance abuse a priority and does so using data-driven strategic planning.

The National Youth Anti-Drug Media Campaign

The National Youth Anti-Drug Media Campaign (*Media Campaign*) is frequently the only media message to counter the barrage of pro-drug messaging to which young people are exposed. There is a common misperception among many parents and youth that prescription drugs are less dangerous when abused than illegal drugs because they are approved by the Food and Drug Administration (FDA). This misperception, coupled with increased direct-to-consumer advertising, which has been linked to overutilization and is the most rapidly increasing form of pharmaceutical marketing, makes effective educational programs even more vital to combating prescription drug abuse.^{35,36}

In June 2010, the *Media Campaign* launched a redesigned "Above the Influence" (ATI) Campaign with a broadened focus on those substances most often abused by teens. (*Action Item 1.2B*) ATI has become one of the most widely recognized youth brands in the country, and 80 percent of teens are aware of ATI advertising.

In addition to new national-level prevention messaging, the *Media Campaign* works directly with communities to amplify the effects of the national ATI Campaign and to encourage youth participation in the ATI initiative through the help of on-the-ground partner organizations, such as DFC coalitions, Boys & Girls Clubs, Students Against Destructive Decisions (SADD), Y's (formerly YMCAs), Girls, Inc., and

ASPIRA, a national nonprofit organization devoted solely to the education and leadership development of Puerto Rican and other Latino youth.

This new multi-tiered approach allows the *Media Campaign* to reach teens across the country with a highly visible national advertising presence while providing resources that can be localized to meet the needs of individuals and local youth-serving organizations. In this way, ATI is helping provide a voice to the majority of teens who choose to be above the influence of drug and alcohol use.

Evidence for the effectiveness of the ATI Campaign recently appeared in a study published by the peer-reviewed journal *Prevention Science*. This independent scientific analysis, funded through a grant by the National Institute on Drug Abuse (NIDA), concluded that “exposure to the ONDCP [ATI] campaign predicted reduced marijuana use.” The analysis showed that those youth who reported exposure to the ATI Campaign were less likely to begin use of marijuana compared to those not exposed to the ATI Campaign—a finding consistent with the *Media Campaign’s* own year-round Youth Ad Tracking Survey results.

The *Media Campaign* also runs an Anti-Meth Campaign each year to prevent and reduce methamphetamine use in areas of the country most severely affected by methamphetamine, as well as among specific populations with higher incidence of use, including American Indians and Alaska Natives.

“Above the Influence:” Engaging Local Communities

The National Youth Anti-Drug Media Campaign relaunched its ATI youth brand, with broad prevention messaging at the national level—including television, print, and Internet advertising—as well as more targeted efforts at the local level. Since the relaunch, results from the *Media Campaign’s* year-round tracking study of teens between the ages of 14 and 16 show a significant increase in teens’ awareness of ATI messages. More important, teens who either were exposed to, or interacted with, ATI had significantly stronger anti-drug beliefs than teens who were not exposed or did not interact with it.

To foster youth participation at the community level, the *Media Campaign* has partnered with more than 40 youth-serving organizations in more than 20 communities³⁷ across the country and provided technical assistance and training to more than 500 community organizations through conference workshops and webinars, with the objectives of:

- Actively engaging youth at the local level to allow them to inform and inspire the campaign;
- Providing local youth-serving organizations with a recognized, national platform to further their specific goals and initiatives; and
- Providing localized advertising across the more than 20 communities—including posters and bus shelter ads featuring artwork created by teens and customized banners in 1,150 high schools—to generate additional awareness.

Campaign partners include DFC grantees, the Boys & Girls Club of America, the Y, Girl’s Inc., ASPIRA, and SADD.



Prevention Prepared Communities

Effective prevention requires the collaboration of multiple service systems in a community. Education, child welfare, juvenile justice, health care, and behavioral health care are just a few of the systems required to ensure a comprehensive prevention infrastructure. Unfortunately, resources from these systems are often scattered and difficult to coordinate, resulting in a patchwork of services that do not meet a community’s needs.

In 2010, a Federal interagency team developed a proposal for a competitive grant program called Prevention Prepared Communities (PPC) to provide Federal support to locally based prevention systems. Proposed in the President's FY 2011 and FY 2012 Budgets, this \$22.6 million project is designed to lay the foundation for a national, evidence-based, community-oriented prevention system. A collaborative effort of the Department of Health and Human Services (HHS), the Department of Education (Education), the Department of Justice (DOJ), and ONDCP, PPC will provide local communities and states with resources to implement a comprehensive array of programs to reduce the multiple risk factors associated with the onset and progression of substance use and associated mental, emotional, and behavioral problems among youth. (Action Item 1.1B)

Strengthening Communities along the Southwest Border

To address the fragmentation of prevention programs along the Southwest border, the *2011 National Southwest Border Counternarcotics Strategy* will dedicate a section to coalition building, research on culturally appropriate interventions, and workforce development. Currently there are 17 DFC coalitions within 100 miles of the Southwest border. The actions planned by these coalitions include expanding the reach of the DFC Support Program to border communities and continued operation of Forces United, an innovative program supported by the California Border Alliance Group, part of the network of 28 ONDCP-funded High Intensity Drug Trafficking Areas (HIDTAs). Forces United brings military organizations (such as the National Guard) together with existing community-based organizations and programs to work collectively on local drug prevention efforts. Specifically, this involves using military personnel as positive role models to help disseminate information about drug use and its negative consequences. These personnel conduct educational forums, participate in various prevention initiatives in schools and other community settings, and deliver Parent Connection, a program developed and conducted by the California National Guard that is designed to improve parenting skills.

In addition, HHS will continue to support U.S. counties along the border with Mexico by providing customized, culturally appropriate training and technical assistance for state and local prevention providers and practitioners.

To further support border communities, the DOJ will implement Latino360, a Spanish language drug prevention program designed to mobilize community members against the threat of methamphetamine.

Community Coalition Support along the Southwest Border

The consumption, smuggling, and distribution of illicit drugs along the U.S.-Mexico border erodes societies, endangers families, and provides illicit earnings that fuel corruption, crime, and violence. Illicit drugs and the drug culture lure children away from school and adults away from legitimate work. On February 25, 2010, the Declaration of Drug Demand Reduction Cooperation was signed at the 8th U.S.-Mexico Bi-National Drug Demand Reduction Policy Meeting held in Washington, D.C. The Declaration underscored the concept of mutual responsibility and acknowledged the duty to take action domestically, bilaterally, and regionally to reduce drug use.

In December 2010, ONDCP sponsored two bi-national cross-border coalition-building workshops in partnership with HHS, the Community Anti-Drug Coalitions of America (CADCA), the Army National Guard, the Southwest Border HIDTAs, the Department of State, and the Government of Mexico. Workshops were held in San Diego, CA, and El Paso, TX, and attended by representatives from both sides of the border. They were designed to assist communities in building anti-drug coalitions as catalysts for evidence-based approaches to community problem solving. Training materials used in the workshops included a prevention toolkit developed and provided by the Government of Mexico. (*Action Item 1.4C*)



Principle 2. Prevention Efforts Must Encompass the Range of Settings in Which Young People Grow Up

Multiple factors influence the likelihood a young person will use drugs. Moreover, some factors may be more powerful than others at certain stages of life. For example, although peer pressure during the teenage years can influence attitudes toward drug use, a strong parent-child bond early in life can help reduce this. For this reason, effective community-based prevention requires coverage of a broad range of settings in which young people grow up, including families, schools, clubs, worksites, recreational programs, and faith-based centers. In addition to the numerous examples of programs and campaigns described above that focus on youth and teens, it is also important to focus on college students, who are also susceptible to the pressures to use substances.

Addressing Substance Use among College Students

About 40 percent of college students report binge drinking.³⁸ Other drug use, including marijuana and prescription drug abuse, is also of concern. About 25 percent of college students report academic

consequences of their drinking, including missing class, falling behind, doing poorly on exams or papers, and receiving lower grades.³⁹ In addition, college administrators report believing that alcohol specifically was involved in 21 percent of all cases of student attrition.⁴⁰

Reducing substance use behaviors among college students requires prevention strategies at the college or university as well as in the surrounding off-campus community. In response, Education launched an initiative in 2010 to provide a more integrated and comprehensive response to issues related to alcohol and other drug use on college campuses as well as violence among college students. This includes a new Healthy College Campuses grant program called for in the Administration's FY 2011 and 2012 budgets. It also includes ongoing technical assistance provided via the Higher Education Center for Alcohol, Drug Abuse, and Violence Prevention. (*Action Item 1.3A*) In addition, Education, HHS, and ONDCP are collaborating to identify and partner with university leaders to more effectively address the high rates of substance use and its consequences among college students.

Ensuring a Drug Free Workplace

The consequences of the illicit use of drugs are also seen in America's workforce. Drug use has a serious impact upon job related accidents and injuries, absenteeism, health care costs, and productivity losses. Workers who use illicit drugs are more likely to injure themselves or others in a workplace accident and have higher rates of absenteeism. They also incur higher medical costs than employees who do not use illicit drugs.⁴¹

Workplace programs that provide clear policies about drug use, offer prevention and education opportunities for employees and supervisors, conduct drug testing, and support referral and treatment for those with substance use disorders can play a large role in reducing the demand for drugs throughout our Nation and in helping drug users get into treatment. In addition to deterring illicit drug use, these programs provide employees with the opportunity to self-identify. Often, the programs enable employees to return to the same job, or a similar job in the same industry, thereby creating an incentive to succeed in their recovery to resume a fulfilling career. Ultimately, drug-free workplace programs are good for our labor force, families, and communities.

Principle 3. Develop and Disseminate Information on Youth Drug, Use

Communicating the Health Risks of Youth Drug Use

An important ingredient for preventing drug use is ensuring that communities, youth, parents, and healthcare providers have the most up-to-date scientific information about drug use and its consequences. The Office of the Surgeon General, in collaboration with several HHS agencies and ONDCP, is developing a series of reports on the health risks of youth drug use. The first in this series, focusing on prescription drug abuse, will be released in 2011. The report will build upon NIH-supported research. (*Action Item 1.3B*)

Principle 4. Criminal Justice Agencies and Prevention Agencies Must Collaborate

Law enforcement agencies are critical partners in community-based prevention strategies and can help reduce youth involvement in drug-related criminal activity. Some communities have begun to employ effective collaboration among police, prosecutors, judges, probation officers, corrections officials, and their counterparts in the prevention field. For example, PACT360 (Police and Communities Together) is a community education program funded by DOJ and implemented in collaboration with the Partnership at Drugfree.org. In FY 2010, DOJ awarded two new PACT360 grants for a total of \$1.2 million from the Edward Byrne Memorial Justice Assistance Grant Program. An enforcement-led effort, PACT360 provides education to parents, youth, and community leaders about the risks and consequences of youth drug use. Many government-private partnerships have been formed through PACT360. To date, lead law enforcement agencies have been recruited in more than 30 states. (Action Item 1.4B)

In 2010, ONDCP awarded \$800,000 to 12 HIDTAs to support participation in drug awareness and education activities. Currently, 20 of the 28 HIDTAs participate in prevention initiatives. Using evidence-based prevention practices, HIDTA members partner with community-based coalitions and organizations to better tailor prevention messages to youth, share time and personnel resources with local law enforcement agencies, and use juvenile justice programs to prevent and reduce gang and other criminal activity. (Action Item 1.4A)

Safe & Sound, Milwaukee, WI

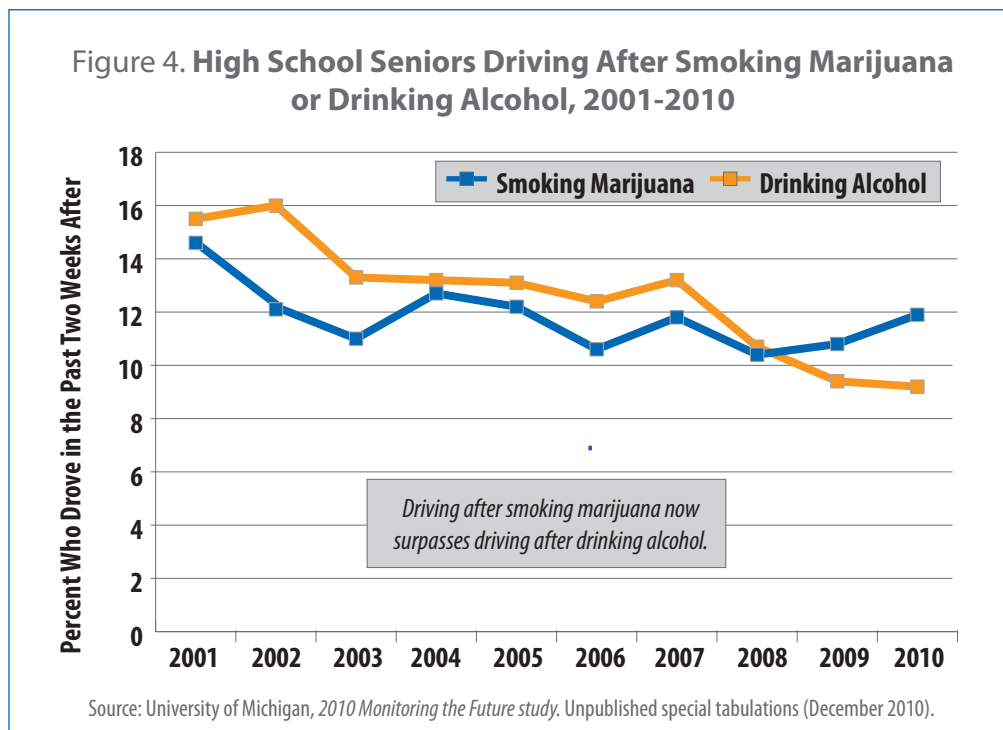
In April 2010, the Milwaukee HIDTA received the Outstanding HIDTA Prevention Effort award for its Safe & Sound program. Safe & Sound is a partnership of law enforcement, prosecutors, youth-serving organizations, elected and civic leaders, businesses, city services, and clergy aimed at reducing drug use and crime and rebuilding neighborhoods. The project organizes residents and youth and connects them with these groups to identify and report criminal activity and prevent youth gang affiliation, crime, and substance abuse. Safe and Sound does so by utilizing interdependent strategies of positive youth development at after-school "Safe Places", neighborhood organizing through its "Safe & Sound Community Partners" program, and tough law enforcement. It is a unique, collaborative approach to fighting crime, violence, illegal drug and alcohol sales, and other neighborhood problems. Safe & Sound's collaborating partners empower youth and adults to work together, creating a better, safer community for all.

After-school Safe Places for youth operate during the hours when youth are most apt to commit, or become victims of, crime. Engaging more than 20,000 young people every year, the Safe Places involve them in youth-led crime reduction and neighborhood improvement projects, drug and alcohol prevention activities, and gang resistance and violence prevention efforts. Programs offered include structured activities to help youth develop personal and social skills through interactive forms of learning. Safe & Sound Community Partners are community organizers, who conduct year-round door-to-door visits in high-crime neighborhoods to listen to and address the individual concerns of residents. These organizers recruit youth to attend Safe Places, and they work with youth leaders to implement community anti-crime initiatives. In conjunction with residents, Community Partners organize block watches, thereby building relationships and communication between residents, law enforcement and city services. Partners develop neighborhood-based initiatives, enhancing safety, reducing crime, positively affecting the community, and improving the overall quality of life for residents.

Principle 5. Preventing Drugged Driving Must Become a National Priority on Par with Preventing Drunk Driving

Each year thousands of drivers, passengers, and pedestrians tragically lose their lives because of impaired and distracted driving. This reckless behavior not only includes drunk driving, but also driving after taking drugs. The use of drugs, including prescription drugs, can impair judgment and motor skills.

The data on the risks of drugged driving are compelling. Among drivers killed in motor vehicle crashes with known drug test results, one in three tested positive for drugs.⁴² In a 2007 roadside survey conducted by the Department of Transportation (DOT), one in eight nighttime weekend drivers tested positive for an illicit drug. This number rose to one in six when pharmaceuticals with the potential to impair driving (i.e., opioid pain relievers, tranquilizers, sedatives, and stimulants) were included.⁴³ Additionally, according to the most recent Monitoring the Future (MTF) Study—the Nation’s largest survey of drug use among young people—one in eight high school seniors reported that in the 2 weeks prior to the survey, they had driven after smoking marijuana, a 14 percent increase over 2008.⁴⁴



The Administration has made combating drugged driving a drug control strategy priority and has set a goal of reducing the prevalence of drugged driving by 10 percent by 2015. To better understand the threat posed by drugged driving and to aid in developing an appropriate response, NIDA and ONDCP convened a multidisciplinary meeting in 2010 to establish a research agenda on the topic and started defining protocols to detect the presence of specific drugs, such as smoked marijuana and MDMA (Ecstasy). (Action Item 1.5E)

In addition to supporting NIDA in this important effort, ONDCP works with other Federal agencies to highlight the problem of drugged driving and reduce its prevalence. For example, ONDCP is working

with national associations and experts to raise awareness of the dangers of drugged driving, provide technical assistance to states considering anti-drugged driving laws, and provide law enforcement with the tools it needs to effectively detect and prosecute drugged drivers. Already, 17 states have *per se* or zero tolerance statutes. (Action Item 1.5A) In these states, it is a criminal offense to drive after taking illegal drugs while the drugs are still detectable in one's system. ONDCP has partnered with youth and community organizations such as the National Organization for Youth Safety, as well as state and local law enforcement, prosecutors, courts, and DMVs to help educate and enhance public awareness of the alarming prevalence of drivers on roadways with drugs in their systems. (Action Item 1.5C)

Domestic law enforcement agencies are also partnering to reduce the prevalence of drugged driving. NHTSA and ONDCP will provide funding to develop an online version of the Advanced Roadside Impaired Driving Enforcement (ARIDE) program. ARIDE will bridge key gaps in the training of law enforcement officers to better identify and assess drivers suspected of driving under the influence of alcohol or drugs. The online ARIDE program will provide this important training in a consolidated, online application that enables trainees to become more familiar with the key points of identifying a drugged driver, effectively providing training more quickly to more officers, and at lower costs. Trained officers can immediately use these new skills to identify and assist in removing drugged drivers from the road. (Action Item 1.5D)

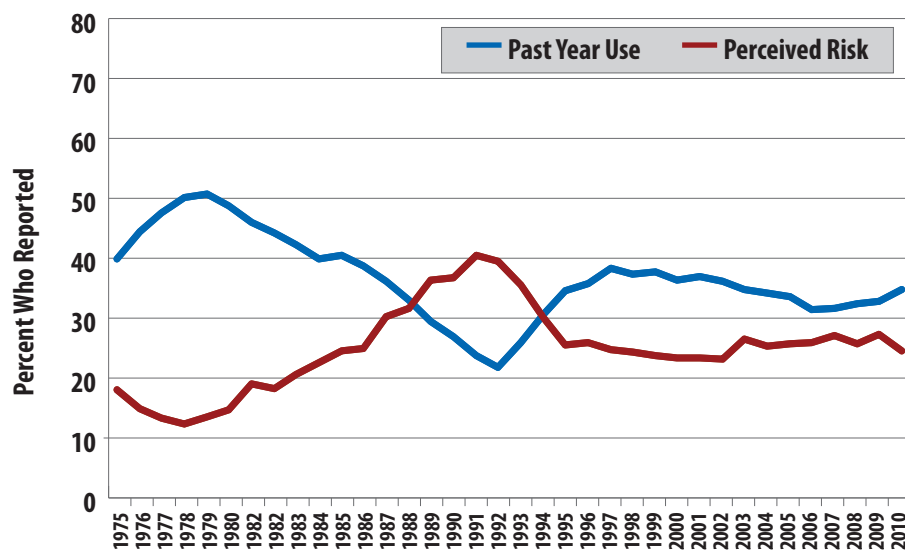
The Facts About Marijuana

Marijuana

Marijuana use is the highest it has been in 8 years. In 2010, daily marijuana use increased significantly among all three grades surveyed (8th, 10th, and 12th graders) in the MTF study. Daily use for high school seniors increased from 5.2 percent to 6.1 percent of the respondents.⁴⁵ One in 11 people who start marijuana use will become addicted—a rate that rises to one in six when use begins during adolescence.^{46,47} In 2009, marijuana was involved in 376,000 emergency department visits nationwide.⁴⁸

Making matters worse, confusing messages being conveyed by the entertainment industry, media, proponents of “medical” marijuana, and political campaigns to legalize all marijuana use perpetuate the false notion that marijuana use is harmless and aim to establish commercial access to the drug. This significantly diminishes efforts to keep our young people drug free and hampers the struggle of those recovering from addiction.

Figure 5. Trends in Past Year Use of Marijuana and Perceived Risk of Occasional Marijuana Use Among 12th Graders, 1975-2010



Source: University of Michigan, 2010 *Monitoring the Future* study (December 2010).

Marijuana and other illicit drugs are addictive and unsafe especially for use by young people. The science, though still evolving in terms of long-term consequences, is clear: marijuana use is harmful. Independent from the so called “gateway effect”—marijuana on its own is associated with addiction, respiratory and mental illness, poor motor performance, and cognitive impairment, among other negative effects.

Despite successful political campaigns to legalize “medical” marijuana in 15 states and the District of Columbia, the cannabis (marijuana) plant itself is not medicine. While there may be medical value in some of the individual components of the cannabis plant, the fact remains that smoking marijuana is an inefficient and harmful method for delivering the constituent elements that have or may have medicinal value. As always, the FDA process remains the only scientific and legally recognized procedure for bringing safe and effective medications to the American public. To date, the FDA has not found smoked marijuana to be either safe or effective medicine for any condition (see more on medical marijuana below).

The Administration steadfastly opposes drug legalization. Legalization runs counter to a public health approach to drug control because it would increase the availability of drugs, reduce their price, undermine prevention activities, hinder recovery support efforts, and pose a significant health and safety risk to all Americans, especially our youth.

Many “quick fixes” for America’s complex drug problem have been presented throughout our country’s history. In the past half-century, these proposals have included calls for allowing the legal sale and use of marijuana. However, the complex policy issues concerning drug use and the disease of addiction do not lend themselves to such simple solutions.

On November 2, 2010, Californians rejected one simplistic solution (Proposition 19) that would have legalized marijuana in their state. Parents, community and business leaders, and other concerned citizens realized marijuana legalization was a gamble they were not willing to take. Our Administration opposed Proposition 19 and was joined by a number of political figures, including candidates for governor and U.S. Senate. In the months leading up to the vote, the RAND Corporation released two independent studies that examined the theory that California would realize a net benefit from legalization and see reductions in the illicit proceeds and violence associated with drug trafficking.

The first RAND study appraised the claim that California would realize financial gains from marijuana legalization. Counter to proponents’ assertions, the study concluded that the pretax retail price of marijuana in California would decline by as much as 80 percent to levels not seen in 30 years due to less legal risk for suppliers, more automation, and economies of scale through farm field and greenhouse production. They concluded that the retail price would have been dependent upon the taxes (sales and excise), the structure of the regulatory scheme, and how taxes and regulations would be enforced. Moreover, the revenue from taxes would be dependent upon the compliance rate: by growing their own marijuana or purchasing it on the gray market, some consumers could avoid the taxes.

In addition, while proponents of Proposition 19 argue the high cost of enforcing existing marijuana laws (an amount they suggest is nearly \$2 billion) renders legalization a compelling course of action, the RAND study estimates these costs to be dramatically lower (\$300 million). Finally, the RAND report raises a powerful counter to the arguments made by proponents of Proposition 19, namely that legalizing marijuana would result in increased consumption of the drug.⁴⁹

Legalization supporters have also claimed that illicit profits to Mexican traffickers and violence in both Mexico and the United States would be reduced if drugs were sold on the open market. A second RAND study examined this argument and found that marijuana accounts for only about 15 to 26 percent of Mexican traffickers’ revenue (or about \$1.5 to \$2.0 billion) and therefore, legalization in California—which accounts for about one-seventh of U.S. marijuana consumption—would likely only reduce drug traf-

ficking organizations' profits by between 2 and 4 percent. The extent of such smuggling would depend upon the actions of Federal and state governments to prevent this illicit commerce.

Ultimately, RAND concluded that any projections with respect to reduced revenues leading to less violence are particularly uncertain. The researchers found that some mechanisms (i.e., disruptions in the illicit workforce due to declining revenues) suggest a large decline in revenues might provoke increased violence in the short-term but reduced violence after several years.⁵⁰

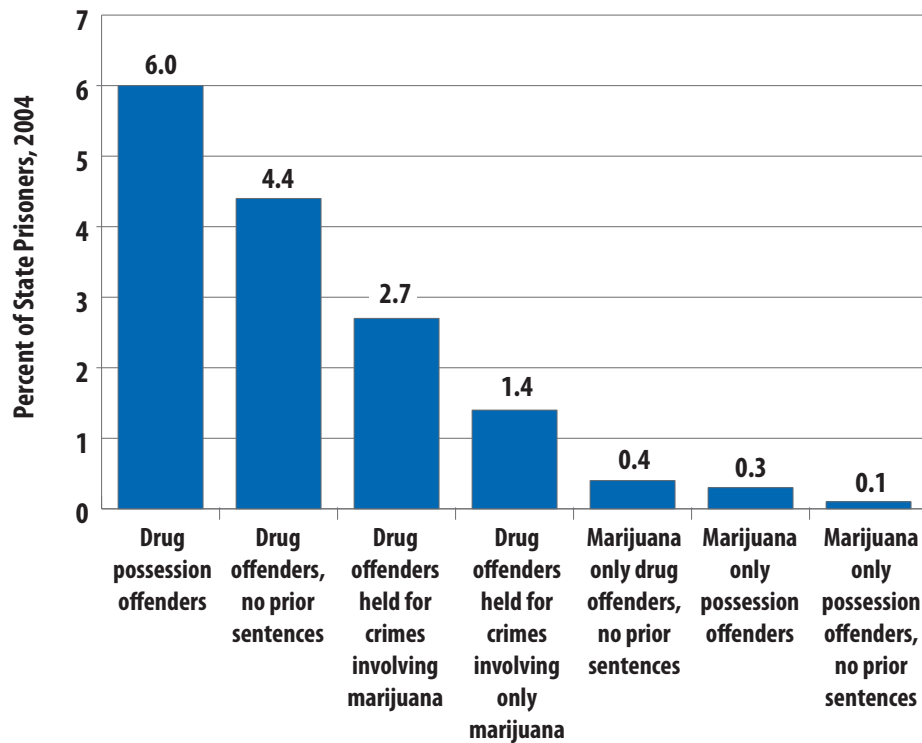
Controls and prohibitions help to keep prices higher, and higher prices help keep use rates relatively low. This is because drug use, especially among young people, is known to be sensitive to price.

Our current legal drugs—alcohol and tobacco—are examples of commercialized products with addiction potential and high usage rates fueled by easy availability. Although these products are taxed, neither produces a net economic benefit to society. The healthcare and criminal justice costs associated with alcohol and tobacco far surpass the tax revenue they generate, and little of the taxes collected on these substances is contributed to the offset of their substantial social and health costs.

Federal excise taxes collected on alcohol in 2007 totaled around \$9 billion,⁵¹ and states collected around \$5.6 billion.⁵² Taken together, this is less than 10 percent of the more than \$185 billion in alcohol-related social costs such as healthcare, lost productivity, and criminal justice system expenses.⁵³ Nor does tobacco carry its economic weight when taxed: each year, tobacco use generates only about \$23 billion in taxes but results in more than \$183 billion per year in direct medical expenses as well as lost productivity.⁵⁴

Further, our current experience with legal, regulated prescription drugs shows that legalizing drugs only widens their availability and potential for abuse, no matter what controls are in place. In 2007, drug-induced deaths climbed to more than 38,000, according to CDC.⁵⁵ This increase was driven primarily by drug overdose deaths from the non-medical use of legal pharmaceutical drugs, particularly narcotic pain relievers.⁵⁶

Advocates of legalization say the costs of prohibition, mainly through the criminal justice system, place a great burden on taxpayers and governments. While there are certainly costs to current prohibitions, legalizing drugs would not cut costs associated with the criminal justice system (see figure). Arrests for alcohol-related crimes, such as violations of liquor laws and driving under the influence, totaled nearly 2.7 million in 2008⁵⁷—far more than arrests for all illegal drug use. These alcohol-related arrests are costly. Legalizing marijuana would further saddle government with the dual burden of regulating a new legal market while continuing to pay for the negative effects associated with an underground market whose providers have little economic incentive to disappear.

Figure 6. **Drug Possession Offenders in State Prisons**

Source: Bureau of Justice Statistics, 2004 Survey of Inmates in State Correctional Facilities.
Unpublished special tabulations (February 2008).

At a time when our efforts should be focused on reversing a troubling increase in drug use, legalization would only make matters worse by lowering the drug's price, increasing its use, and creating billions of dollars in new social costs.

'Medical' Marijuana

Marijuana and other drugs are addictive and unsafe, especially for use by young people. Unfortunately, efforts to "medicalize" marijuana have widened the public acceptance and availability of the drug.

There is no substitute for the scientific approval process employed by the FDA. For a drug to be made available to the public as medicine, the FDA requires rigorous research followed by tests for safety and efficacy. Only then can a substance be classified as medicine and prescribed by qualified health care professionals to patients.

In the wake of state and local laws that permit distribution of “medical” marijuana, dozens of localities have been left to grapple with poorly written laws that bypass the FDA process and allow marijuana to be used as a so-called medicine. John Knight, director of the Center for Adolescent Substance Abuse Research at Children’s Hospital Boston, recently wrote: “Marijuana has gotten a free ride of sorts among the general public, who view it as non-addictive and less impairing than other drugs. However, medical science tells a different story.”

Similarly, Christian Thurstone, a board-certified Child and Adolescent Psychiatrist, an Addiction Psychiatrist, and also an Assistant Professor of Psychiatry at the University of Colorado, said:

“In the absence of credible data, this debate is being dominated by bad science and misinformation from people interested in using medical marijuana as a step to legalization for recreational use. Bypassing the FDA’s well-established approval process has created a mess that especially affects children and adolescents. Young people, who are clearly being targeted with medical marijuana advertising and diversion, are most vulnerable to developing marijuana addiction and suffering from its lasting effects.”

—Dr. Christian Thurstone, MD, Assistant Professor at Denver Health & Hospital Authority

In the United States, the Drug Enforcement Administration (DEA) has approved 109 researchers to perform *bona fide* research with marijuana, marijuana extracts, and marijuana derivatives such as cannabidiol and cannabinol. Studies include evaluation of abuse potential, physical/psychological effects, adverse effects, therapeutic potential, and detection. Fourteen researchers are approved to conduct research with smoked marijuana on human subjects.

As a result of this extensive research, several marijuana-based medications have been found to be safe and effective by the FDA and are available for doctors to prescribe. *Dronabinol*, a synthetic form of tetrahydrocannabinol (THC), the most active ingredient in marijuana, is used to treat nausea and vomiting caused by chemotherapy. It is also used to treat loss of appetite and weight loss in people who have AIDS. *Nabilone*, a synthetic drug that mimics marijuana’s main ingredient, is also prescribed to treat nausea and vomiting caused by cancer chemotherapy. Other medications based on one or more marijuana components are being carefully studied.

Aside from the problems accompanying the commercialization of marijuana, smoking any drug is unhealthy. That is why no major medical association has come out in favor of smoked marijuana for widespread medical use. For example, the American Cancer Society, American Glaucoma Foundation, National Pain Foundation, National Multiple Sclerosis Society, and other medical societies are not in favor of smoked “medical” marijuana. The American Medical Association has called for more research on the subject, with the caveat that this “should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.”

According to the American Academy of Pediatrics:

Evidence suggests that pediatricians should continue their vigilant efforts to prevent the use of this drug by young people. The abuse of marijuana by adolescents is a major health problem with social, academic, developmental, and legal ramifications.⁵⁸ Marijuana is an addictive, mind-altering drug capable of inducing dependency. Pediatricians are obligated to develop a reasoned approach to dealing with its use by children and adolescents so they can provide appropriate care and counsel... Additional reasons for concern and counsel include anxieties and uncertainties about the potential harm that marijuana use may cause to adolescents during a period of rapid change in hormonal secretion, possible teratogenicity, and the known consequences of long-term use.

This Administration joins major medical societies in supporting increased research into marijuana's many components, delivered in a safe (non-smoked) manner, in the hopes that they can be available for physicians to legally prescribe when proven to be safe and effective. Outside the context of Federally approved research, the use and distribution of marijuana is prohibited in the United States.



Chapter 2. Seek Early Intervention Opportunities in Health Care

The devastating impact substance abuse has on individuals, families, and communities is visible to most Americans; however, less visible but still significant is the impact substance abuse has on the healthcare system. Medical professionals spend a great deal of their time and resources treating patients with injuries and illnesses that resulted from substance abuse. Unfortunately, health care providers often do not have the training or resources to identify and treat patients' underlying issues of substance abuse. Health care providers can play a crucial role in reducing drug use and its consequences. Health care providers must have the education and sufficient training to identify substance use problems and get patients the treatment they need.

The Affordable Care Act Includes Substance Use Disorder Services as an Essential Health Benefit

The Affordable Care Act, signed into law by President Obama in March 2010, includes substance use disorders as one of the ten elements of essential health benefits. This is significant because it means that all health insurance sold on Health Insurance Exchanges or provided by Medicaid to certain newly eligible adults starting in 2014 must include services for substance use disorders. By including these benefits in health insurance packages, more providers can offer and be reimbursed for these services, which will result in more individuals being able to access treatment. The specific substance abuse services that will be covered are currently being determined, and will take into account evidence on what services allow individuals to get the treatment they need and put them on a path to recovery.

Principle 1. Catching Substance Use Disorders Early Saves Lives and Money

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

It is critical for medical professionals to be able to identify the early signs of substance abuse in their patients and to intervene early. These early interventions can result in savings to the healthcare system and, most important, saves lives. SBIRT is a tool that enables health care professionals to ask patients about substance use during routine medical visits. SBIRT helps healthcare providers identify individuals with problems related to substance use, provide medical advice to help patients who have been identified as having risky substance use to understand the related health risks and consequences, and refer patients with more severe substance use-related problems to treatment

A number of Federal agencies, including SAMHSA, HRSA, the CDC, and the Indian Health Service (IHS), have incorporated SBIRT into many of the healthcare settings they support. In 2011, the IHS will introduce, in six Indian Health Service Emergency Departments and six Tribal Emergency Departments, an SBIRT model (tailored toward Native populations) to address substance use disorders. HRSA made costs

related to SBIRT a fundable activity that requires annual reporting for Federally Qualified Community Health Centers. It expects as many as 260 of its health centers to participate. (Action Item 2.1A)

Reducing substance use through SBIRT is one way of providing healthcare professionals with the tools necessary to speak to patients about their substance use and help them get the treatment they need. One study on the use of SBIRT in Washington State showed a reduction in total medical costs and inpatient hospital costs (see inset).⁵⁹

Washington State Expands Services and Reduces Healthcare Costs: Treatment Expansion Initiative

In 2005, the State of Washington expanded drug and alcohol treatment for individuals receiving Medicaid or state disability benefits. This expansion covered the integration of substance use disorder treatment into primary healthcare settings. The state Medicaid agency found that providing services for substance use disorders in healthcare settings reduced overall healthcare costs:⁶⁰

- Prior to the initiative, medical costs for disabled Medicaid clients *with* substance use disorders were rising much faster than the medical costs for Medicaid clients *without* substance use disorders (11 percent compared to 8.5 percent annually).
- Since the initiative, medical costs have been growing more slowly for clients *with* substance use problems compared to clients *without* substance use problems (2.8 percent compared to 4.7 percent annually).
- Expansion of treatment services in 2006 through 2009 yielded \$107.4 million in savings. For every dollar the State spent, it is estimated to have saved two dollars in future healthcare costs.

SBIRT in Colleges and Universities

Underage drinking and substance use among college students threaten not only the present well-being of millions of students, but also our Nation's future capacity to maintain its leadership in the fiercely competitive global economy. Studies have shown that drinking and substance use are a significant problem on our Nation's college and university campuses. Nearly 4 million college students age 18 to 22 reported binge-drinking in the past 30 days, and 20 percent reported past-month use of marijuana or other illegal drugs.⁶¹

While the problem is significant, use of SBIRT in campus health centers has shown promising results. Notably, a study funded by SAMHSA and conducted by the University at Albany – State University of New York found that SBIRT programs in campus health centers can help address college drinking. At a 6-week follow-up, students reported decreased alcohol use, more accurate perceptions of other students' drinking, and increased use of strategies to enhance self-esteem and self-worth. Results of the study also indicate that changes in alcohol use were positively correlated with changes in perceptions of drinking among peers.⁶² This year, ONDCP in partnership with Education, will disseminate information on SBIRT to campus health centers and school administrators and provide university officials with screening tools and information on substance use that can be accessed on the schools, websites and in orientation materials by both parents and students.

School-Based SBIRT in New York City Public Schools

Since fall 2010, the New York City Health Department has been working to implement and integrate two SBIRT approaches in public high schools. Last December, 125 trained counselors in New York City's Education Department were stationed in 75 public high schools. These counselors began delivering "Teen Intervene," an evidence-based, multi-session intervention program. Although it is too early for formal evaluation of the program, preliminary reports from the field are positive.

The NYC Health Department is implementing an SBIRT approach in five licensed school-based health centers. In these settings, a universal screening will be administered by clinical staff, and SBIRT services can be billed to health insurance. If the model is successful at these test sites, it will be implemented at all 45 school-based health centers in New York City. In schools where both of these SBIRT approaches are implemented, students with greater severity scores may be referred to the "Teen Intervene" counselor for the intervention component.

Families Referred to the Child Welfare System

Of children ages 3 and younger, 30 percent had drug abuse of parent(s) as one of the reasons identified for removal from home. Of children between the ages of 4 and 8, 25 percent of cases cited drug abuse of parent(s) as a reason for removal.⁶³ Because of the connection between substance abuse and child welfare involvement, ONDCP has begun to collaborate with HHS' Administration for Children, Youth, and Families (ACYF) on finding opportunities to get families the treatment they need without having children enter the foster care system.

ACYF has been working collaboratively with other HHS agencies to address the co-occurrence of substance abuse and child abuse and neglect. Along with SAMHSA, ACYF supports the National Center on Substance Abuse and Child Welfare, which builds knowledge about effective, family-focused practice and provides technical assistance. The Center also provides significant support to 53 recipients of Regional Partnership Grants, administered by ACYF. These grants support and enhance a region's capacity to meet the range of needs for families involved with substance abuse and child welfare.

One area of collaboration between ONDCP and ACYF is exploring the use of assessments by child welfare workers to evaluate families who have been referred to the child welfare system. If substance abuse and other issues families are facing are properly identified and treated, parents will be more equipped to provide the care, love, protection, and support that all children need. Assessors screen families for issues related to substance abuse along with a host of other issues (such as domestic violence and other mental health problems). After the family has been screened, the assessor, in collaboration with a child welfare worker, refers families to interventions and treatment that holistically address the entire family's needs. This approach allows families to stay unified and avoids placement of children into the foster care system, while providing families with the services they need.

Expanding the Addiction Medicine Workforce

Providing tools such as SBIRT is one way of helping current medical professionals properly address issues of substance abuse. However, it is equally important to train future health care professionals on

substance abuse issues and provide current healthcare professionals with additional training about the complex nature of the disease of addiction, especially in light of the parity requirements contained in the Affordable Care Act. Education and training will become even more important in the coming years. It is anticipated that by 2020, approximately 7,000 addiction medicine doctors will be needed to care for an estimated 27 million patients who are dependent on substances.⁶⁴

Addressing the needs of these patients requires an expanded workforce of doctors, physicians' assistants, counselors, nurses, and social workers. Work across the Federal government has begun to address the growing demand for an expanded work force. In particular, HRSA and SAMHSA established a technical assistance and training center to train healthcare providers on behavioral healthcare services, including substance use disorder services. HRSA and SAMHSA are aiming to increase the number of trained healthcare professionals. (Action Item 2.1C)

In addition, the Department of Labor established a grant program in 2011 that allows community colleges to compete for funds to expand and develop programs for substance abuse counselors and address the need for these professionals in this field. NIDA's Centers of Excellence for Physician Information have developed curriculum resources on substance abuse and addiction that can be integrated into existing curricula to enhance medical student/resident physician education. These curriculum resources address pressing issues facing physicians today, in particular recognizing risk factors for, as well as identifying prescription drug abuse in their patients.

Along with increasing the specialization of providers in behavioral health, all doctors should have a baseline understanding of the disease of addiction. In 2010, ONDCP collaborated with the National Board of Medical Examiners to identify areas for improved substance use disorder content in the United States Medical Licensing Examination (USMLE). As a result, the USMLE will include a broader range of questions on substance use disorders and their relationship with other health conditions. Inclusion of these questions signals the importance of this knowledge to the practice of medicine, suggests that students need to master this material, and underscores the need for schools to include it in their curricula. (Action Item 2.1C)

Enhancing the psychological and behavioral health of military families was the first identified priority in the Presidential report, *Strengthening our Military Families*, which is designed to provide a comprehensive strategy to improve and expand substance abuse prevention, treatment, and recovery services available for active duty Armed Forces, the National Guard, and the Reserves.

New Action Item: Identify and Make Available Additional Training in Evidence-based Practices for Substance Use Disorder Assessment and Care to Healthcare Professionals Providing Care to Military Health System Beneficiaries. [DOD]

DOD will identify and make available additional training in evidence-based practices for substance use disorder assessment and care to healthcare professionals providing care to Military Health System beneficiaries. Additional training integrated into existing professional training and available online will make it more likely that providers can identify substance use disorders when present and can institute or refer for further care based on evidence-based principles.

Electronic Health Records

In 2009, the Health Information Technology (HIT) for Economic and Clinical Health Act (HITECH, Title XIII of the American Recovery and Reinvestment Act) funded several programs allowing doctors to accurately document patients' complete medical histories, including the development of electronic health records (EHRs). EHRs will allow for the integration of substance use disorder treatment records into a patient's medical records, thereby permitting the exchange of substance use information among medical professionals when appropriate, and with a patient's consent.

Unfortunately, many health professionals who serve those with substance use disorders do not routinely use electronic health records. This presents a significant hurdle to integration of substance use disorder care into the primary care system. Without electronic health records, providers and their patients are not connected to statewide health information technology systems, and reimbursement for health services. To address this issue, the Office of the Assistant Secretary for Planning and Evaluation at HHS developed a web-based guide on providing services to certain vulnerable populations.⁶⁵ The guide provides an explanation to providers on how to be included in state health information exchange activities.

While electronic health records can help improve care and reduce costs, there are concerns about privacy and security. In 2010, the Office of the National Coordinator for Health Information Technology at HHS established an advisory committee to develop health information technology and electronic health records that protect patients' privacy and can be linked to the larger health information technology system.

Protecting patient privacy is especially important for individuals with substance use disorders because of the stigma often attached to these disorders. A person's substance abuse treatment records remain confidential unless they sign a release, or unless a court order and a warrant are issued. If a patient is referred to treatment by the criminal justice system and signs a consent for disclosure, the patient cannot revoke the consent until he or she is no longer under the jurisdiction of the justice system.

ONDCP will work throughout 2011 with Federal partners to disseminate updates, announcements, and developments surrounding the national infrastructure for Health Information Technology to prevention, treatment, and recovery service providers.

Massachusetts Screening, Brief Intervention, and Referral to Treatment (MASBIRT) Program Impacts Clinic Practice and Patients' Lives

Health Promotion Advocates in three urban hospitals and five community health centers in the greater Boston area used MASBIRT to screen more than 130,000 patients for unhealthy substance use and conducted more than 22,500 brief interventions within healthcare settings between 2007 and 2010.

Medical providers realize substance use can have a significant impact on health, but they are often overwhelmed by competing clinical demands. Dr. John Knight at Children's Hospital in Boston cited lack of time, lack of training, triaging competing concerns, lack of treatment resources, and unfamiliarity with screening tools as challenges he and other providers face when addressing substance use. MASBIRT is an approach that has made it possible for medical professionals in Massachusetts to do screening for unhealthy substance use in real time.

"As a primary care pediatrician, I witnessed MASBIRT becoming a natural part of our clinical practice. Using MASBIRT, we have been able to get valuable information from patients about the extent of their substance use and what triggers their use. For example, during conversations with patients about substance use, it is often discovered that patients have mood disorders or exposure to violence, often in their relationships. As the medical provider, I am able to address the root causes of substance use. Using MASBIRT, in my opinion, is a satisfying approach for both the patient and the physician."

—Susan Gray, MD, a Primary Care Provider

Principle 2. Curb Pharmaceutical Abuse While Preserving Medical Benefits of Pharmaceuticals

Prescription drug abuse is the Nation's fastest-growing drug problem. While there has been a marked decrease in the use of some illegal drugs, such as cocaine, data from the National Survey on Drug Use and Health (NSDUH) show that nearly one-third of people aged 12 or over who used illicit drugs for the first time in 2009 began with non-medical use of a prescription drug.⁶⁶ Additionally, the latest MTF study—the Nation's largest survey of drug use among young people—showed that prescription drugs are the second-most abused category of drugs after marijuana.⁶⁷

The epidemic warrants a significant public health response. Accordingly, in April the Administration released the Prescription Drug Abuse Prevention Plan titled, *Epidemic: Responding to America's Prescription Drug Abuse Crisis*. The complete plan can be found here:

<http://www.whitehousedrugpolicy.gov/prescriptiondrugs/>

Preventing the misuse and diversion of prescription drugs while ensuring the availability of these important medications for those who have a medical need for them, requires a multi-pronged approach that includes prescriber and patient education, monitoring systems, disposal, and enforcement strategies.

HHS's Behavioral Health Coordinating Committee (BHCC) has a subcommittee specifically dedicated to preventing prescription drug misuse.

Prescription Drug Monitoring Programs

The easy availability of prescription pain medications and the misconception they are safer than illicit drugs, even if taken improperly, have led to dramatic increases in prescription drug abuse, overdose, and addiction. Nationally, an estimated seven million people aged 12 or older reported having used prescription drugs non-medically in the past month in 2009.⁶⁸ Between 1998 and 2008, there was a four-fold increase in treatment admissions for individuals age 12 or over reporting abuse of prescription pain medication.⁶⁹ In addition, CDC reports that the number of drug-induced deaths involving opioid pain medications more than tripled between 1999 and 2006, exceeding those from heroin and cocaine combined.⁷⁰

Prescription Drug Monitoring Programs (PDMPs) are a way to combat the misuse of prescription drugs and the harmful consequences associated with them. PDMPs are statewide electronic databases of dispensed controlled substance prescriptions that help healthcare providers identify prescription drug misuse. These medications are monitored because, in addition to their beneficial medical uses, they have abuse potential. Currently, 48 states have authorization to establish and operate a PDMP: 34 are operational. The structure, location within state government agencies, and the kinds of information PDMPs collect vary from state to state.

Legislatures in Georgia, Maryland, and Arkansas have recently passed legislation to institute PDMPs. However, there are states that remain without this helpful tool to help reverse prescription drug abuse trends. Without PDMPs, a state can become a haven for illegal drug diversion and drug-seeking behavior.

PDMPs can help in the delivery of comprehensive health care in many ways. For example, a PDMP can help pharmacists and prescribers support access to legitimate medical use of controlled substances. PDMPs can also help identify, deter, and prevent prescription drug abuse. They also have the capability to identify those with a substance abuse problem and facilitate an intervention and treatment. PDMPs can also assist regulatory and law enforcement authorities in identifying sources of diversion of abused pharmaceutical drugs. The usefulness of PDMPs has been supported by a Government Accountability Office (GAO) report. This report indicated that the PDMPs in Kentucky, Nevada, and Utah reduced unwarranted prescribing.

While the success of PDMPs has been documented, many states unfortunately still do not have programs in place. Of the 10 states with the highest number of prescriptions for OxyContin at the time of the GAO study, only two had PDMPs.⁷¹ Further, a recent study found that when Ohio's PDMP data were used in an emergency department, providers changed the clinical management in 41 percent of cases. In cases of altered management, the majority (61%) resulted in fewer or no opioid medications prescribed than originally planned, whereas 39 percent resulted in more opioid medication than previously planned, indicating the database's usefulness as a clinical tool to the doctor.⁷²

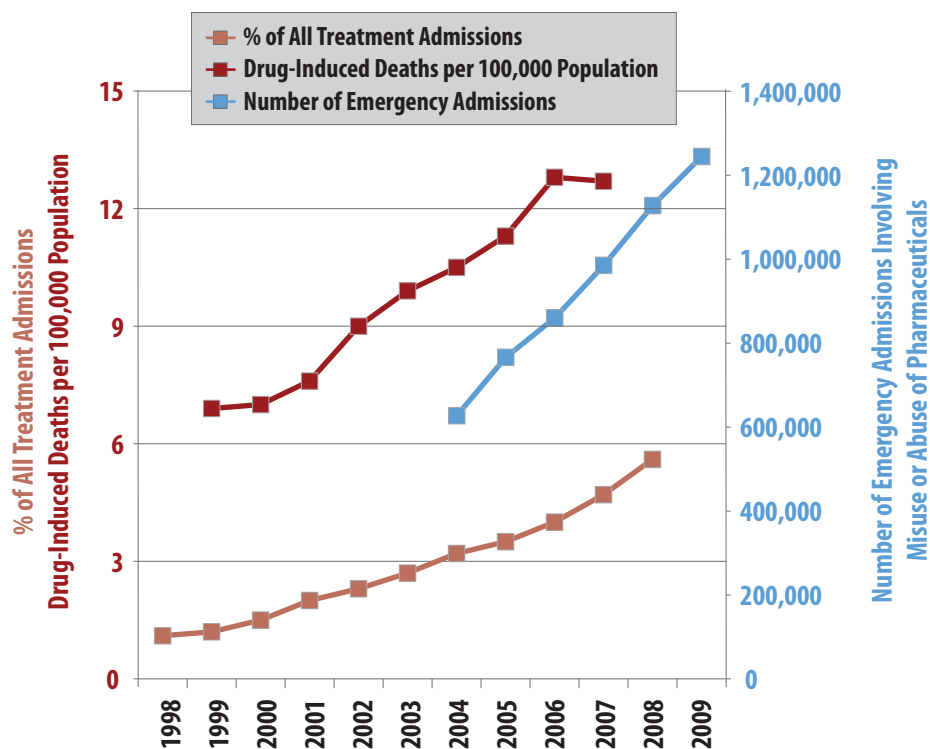
Because of the significant potential PDMPs can have in curbing abuse and helping link those in need of treatment, the Federal government is providing funds to support PDMPs. In 2010, the Bureau of Justice Assistance (BJA) administered the Harold Rogers Prescription Drug Monitoring Program (HRPDMP), which made grant funding available to states to plan for, implement, and enhance prescription drug monitoring programs. In future budget proposals, funding for these activities are included in other DOJ budget components. BJA also continued its work with the nonprofit IJIS Institute to develop standards

for state PDMPs in sharing prescription drug data across state borders, to prevent doctor-shopping and drug diversion. Ohio and Kentucky PDMPs will be initiating real-time data exchange in 2011. (Action Item 2.2B)

In 2010, additional support for PDMPs came from SAMHSA, which oversaw the National All Schedules Prescription Electronic Reporting (NASPER) program. Under NASPER, states can apply for grants to support the establishment and improvement of their PDMPs. NASPER is a formula-based grant program that requires states to have a plan for interoperability and meet specific requirements for electronic standards and data reporting. To qualify for funding, states must also have a plan for information security and access. (Action Item 2.2B)

On October 12, 2010, President Obama signed the Secure and Responsible Drug Disposal Act into law. This law directs the Attorney General to develop rules making such disposal of controlled substances safe, easy, and affordable. As a result, fewer drugs will be available for diversion.

Figure 7. **Consequences of Non-Medical Use of Pharmaceutical Drugs, 1998-2009**



Sources: SAMHSA, *Treatment Episode Data Set, 1998-2008* (April 2010); National Center for Health Statistics/CDC, *Deaths: Final Data for 2007* (May 2010); and SAMHSA, *Drug Abuse Warning Network, 2004-2009* (December 2010).

In 2010, DEA held the first National Take-Back Day, resulting in the safe and proper disposal of 121 tons of unwanted or expired medications nationwide. A subsequent event in April of 2011 netted 188 tons for safe and proper disposal at the 5,361 take-back sites that were available in all 50 states. This is 55 percent more than the 121 tons the public brought in during the September 2010 event. Because youth report that the prescription drugs they abuse come primarily from friends and family, activities that help adults remove expired or unneeded medications from their home are critical to abuse and diversion prevention efforts. These events also help educate adults about the importance of properly securing medications in their homes. (Action Item 2.2C)

Getting rid of unused or expired medication is one step to combating prescription drug abuse, but it must be coupled with education of medical professionals about proper prescribing. SAMHSA is helping train physicians about the importance of proper prescribing practices for opioids, which are routinely prescribed to relieve pain. Topics include doctor-shopping (the practice among some patients of seeking prescriptions from multiple providers to support intentional misuse) and dangerous interactions that can occur when mixing prescription and alcohol or illegal drugs. As part of this initiative, SAMHSA will educate at least 1,500 physicians in FY 2011 and provide training in at least eight states. (Action Item 2.2A)

Oxycodone Pills Purchased by Medical Practitioners January to June 2010 (Figure 8)

South Florida has gained notoriety as the epicenter of the Nation's prescription drug abuse epidemic due to a tremendous growth in operations inappropriately advertised as pain management clinics but better known as "pill mills." Unlike legitimate pain clinics run by doctors specially trained in pain management, these operations indiscriminately peddle opioid painkillers and sedatives, and in fact, are the primary suppliers for the Nation's growing appetite for prescription drugs.

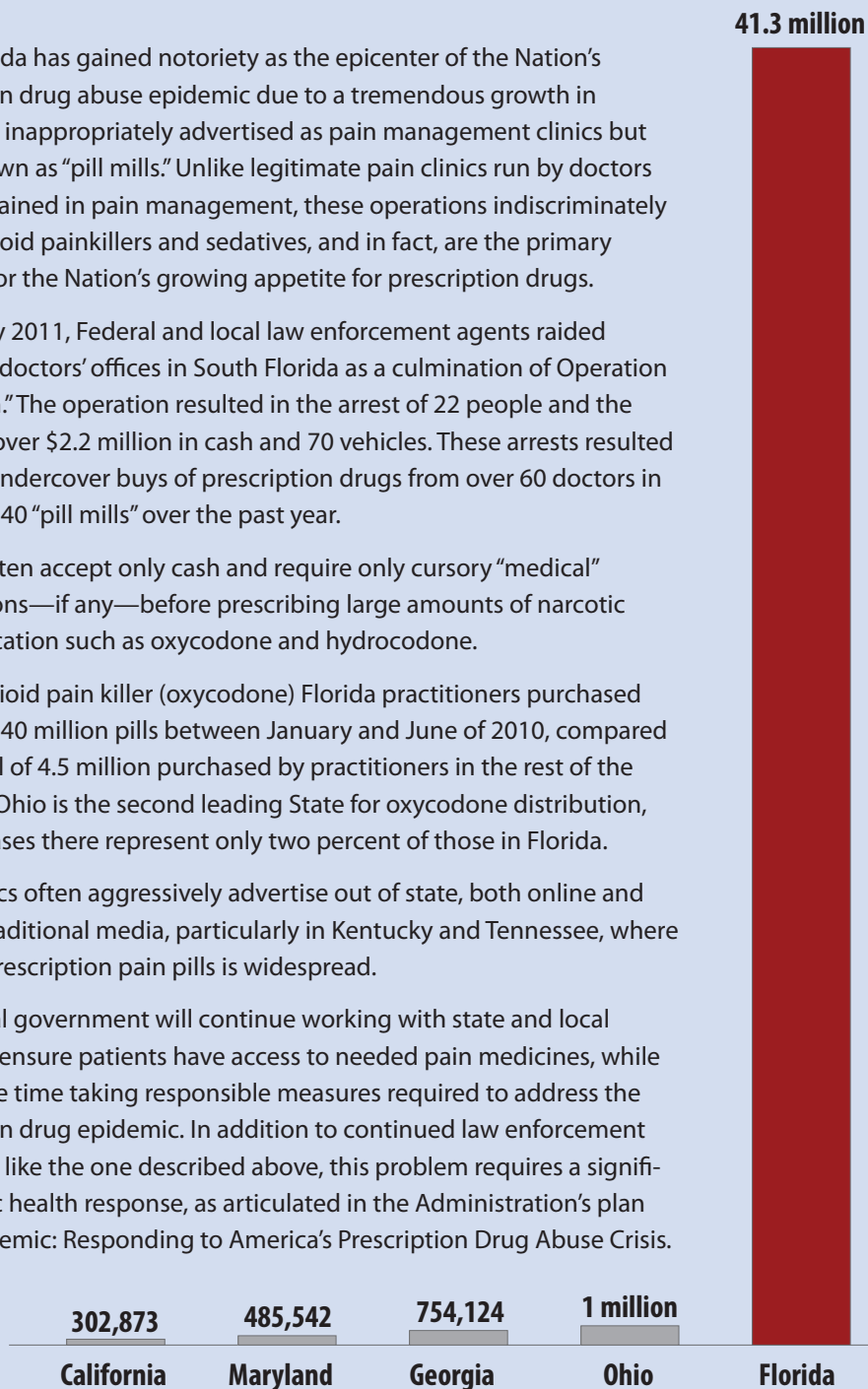
In February 2011, Federal and local law enforcement agents raided numerous doctors' offices in South Florida as a culmination of Operation "Pill Nation." The operation resulted in the arrest of 22 people and the seizure of over \$2.2 million in cash and 70 vehicles. These arrests resulted from 340 undercover buys of prescription drugs from over 60 doctors in more than 40 "pill mills" over the past year.

Pill mills often accept only cash and require only cursory "medical" examinations—if any—before prescribing large amounts of narcotic pain medication such as oxycodone and hydrocodone.

For one opioid pain killer (oxycodone) Florida practitioners purchased more than 40 million pills between January and June of 2010, compared with a total of 4.5 million purchased by practitioners in the rest of the country.⁷³ Ohio is the second leading State for oxycodone distribution, but purchases there represent only two percent of those in Florida.

These clinics often aggressively advertise out of state, both online and through traditional media, particularly in Kentucky and Tennessee, where abuse of prescription pain pills is widespread.

The Federal government will continue working with state and local officials to ensure patients have access to needed pain medicines, while at the same time taking responsible measures required to address the prescription drug epidemic. In addition to continued law enforcement operations like the one described above, this problem requires a significant public health response, as articulated in the Administration's plan titled, *Epidemic: Responding to America's Prescription Drug Abuse Crisis*.



Source: Drug Enforcement Administration, unpublished data from ARCOS [Automation of Reports and Consolidated Orders System] (February 2011).



Chapter 3. Integrate Treatment for Substance Use Disorders into Mainstream Health Care and Expand Support for Recovery

The Administration calls for broader integration of substance use disorder services within primary care, mental health, criminal justice, child welfare, housing and homeless services, and other systems. In 2009, an estimated 23 million Americans had active substance use disorders and yet, only about 10 percent of this population received specialty treatment.⁷⁴

Recovery, like addiction, is multi-dimensional and progressive in nature. It involves not merely abstinence from substances, but rather a process through which individuals actively pursue and achieve health, wellness, and accountability to self and others. Recovering individuals are responsible parents, neighbors, and citizens. They serve their communities and share the gift of recovery with others in need. The Obama Administration is committed to spreading the promise of recovery across the Nation.

Principle 1. Addiction Treatment Must Be an Integrated, Accessible Part of Mainstream Health Care

Increase Information to Healthcare Workers

In 2011, HRSA and SAMHSA's joint technical assistance and training centers will educate healthcare providers on effective approaches for identifying, diagnosing, and treating substance use disorders. (Action Item 2.1C)

Additionally, in 2011 ONDCP will work in partnership with CDC to disseminate materials and conduct training for first responders. The goal is to help them recognize and effectively manage overdoses to reduce deaths and disabilities. (Action Item 3.2D)

HHS will develop public health strategies that include issuing guidelines and providing technical assistance related to the use of Federal funds to support syringe exchange programs as part of a comprehensive strategy to get people into treatment and into the mainstream public health system. (Action Item 3.1E)

Increasing Addiction Treatment Services within the Indian Health Service

American Indian and Alaskan Native communities are particularly in need of expanded addiction treatment services. Drug use rates are significantly higher among these communities (18.3%) than among other ethnicities (e.g., 9.6% for African Americans and 8.8% for Caucasians). To address this need, the Indian Health Service (IHS) implemented a specially tailored version of SBIRT in emergency rooms in these communities. To further improve access and quality for American Indians and Alaskan Natives who have served in the Armed Forces, IHS and the Veterans Health Administration (VHA) in 2010 entered into a formal collaborative agreement under which American Indian and Alaska Native Veterans and active duty military have access to substance use disorder treatment services that can be integrated with posttraumatic stress disorder and traumatic brain injury protocols as needed. (Action Item 3.1B)

Expand Addiction Specialty Services in Community Health Centers

Community Health Centers (CHCs), which provide care for more than 19 million low-income Americans, have not traditionally offered extensive specialized services for substance use disorders, despite the fact they are prevalent in the populations served by CHCs. The Health Resources Services Administration (HRSA) is working to improve CHC substance use disorder services. In 2010, HRSA added SBIRT to the list of fundable services for CHCs and established a Training and Technical Assistance Center in collaboration with SAMHSA. The center will help integrate behavioral health services in primary care settings and provide information and consultation to CHCs interested in offering behavioral health services. (Action Item 3.1A)

Promulgate the National Quality Forum Standards for Addiction Treatment

As mentioned in Chapter 2, work will continue over the next 4 years with Federal partners (HRSA, SAMHSA, the Indian Health Service, the Centers for Medicare and Medicaid Services, the Office of the National Coordinator for Health Information Technology, and HHS' Office of the Assistant Secretary for Planning and Evaluation) to ensure services for substance use disorders meet the National Quality Forum Standards to treat substance use conditions and are integrated in essential benefits packages by 2014. National Quality Forum Standards are a set of agreed-upon and endorsed national voluntary consensus standards on evidence-based practices to treat substance use disorders.⁷⁵ (Action Item 3.2C)

Principle 2. Addicted Patients and Their Families Must Receive High-Quality Care

Support the Development of New Medications for Addiction

The effectiveness of addiction treatment has been hampered by the limited range of available FDA-approved medications relative to other chronic medical disorders. Fortunately, advances in neuroscience research are identifying promising directions for medication development, including medications that help in the management of acute withdrawal symptoms and others that reduce cravings and counter relapse triggers. The Administration has actively supported research to develop new medications. For example, NIDA research is supporting the development of vaccines for cocaine, opiates, and nicotine.

These vaccines act by preventing the drug from reaching the brain. The cocaine and nicotine vaccines have had promising results in human trials, effectively reducing drug use in those who achieve high antibody levels. (Action Item 3.2A)

Additionally, NIDA has continued its work to combat HIV infection, which is more prevalent among drug users than in the general population and is especially common among injecting drug users. In September 2010, NIDA funded 12 “Seek, Test, and Treat” research applications in the criminal justice system. These studies will develop and test strategies to expand access to HIV testing for individuals in the criminal justice system, increase availability of antiretroviral therapy for criminal justice-involved HIV-positive individuals, and ensure continued access to services following community reentry. (Action Item 3.2E)

Family Treatment Programs

In September 2010, ONDCP co-sponsored a Family Treatment Forum. Experts from HHS, Education, and DOJ participated in panel discussions and answered questions from family treatment providers.

The forum resulted in a new partnership between the HRSA’s Federally Qualified Health Centers (FQHCs) and family treatment providers. Through FQHCs, which offer basic medical services to underserved populations, family treatment providers will now be able to create partnerships and refer their clients to medical services. Often people who are being treated for substance use disorders require additional medical treatment. In 2011, ONDCP continues to facilitate this new connection to ensure access to medical care for women and children taking part in family treatment programs.

Principle 3. Celebrate and Support Recovery from Addiction

Because treatment is not the only path to recovery, development of integrated treatment and recovery support services (RSS) networks and Recovery Oriented Systems of Care (ROSC) is critical. RSS are non-clinical services that are often provided by community organizations, faith groups, and other grassroots entities. They include coaching, peer mentoring, housing, employment readiness, spiritual support, and transportation. ROSCs are networks of formal and informal services developed and mobilized to sustain long-term recovery for individuals and families impacted by severe substance use disorders.⁷⁶

ONDCP’s Recovery Branch

In 2010, ONDCP established a Recovery Branch within its Office of Demand Reduction. The new branch has engaged Federal partners, state and local governments, membership and advocacy organizations, service providers, and other stakeholders in the design and development of policies, systems, services, communication campaigns, and other activities that support long-term recovery.

During its initial year of operation, the Recovery Branch convened and co-sponsored a series of events to inform policy development. These events included an expert roundtable that explored strategies for integrating peer recovery support services and peer-led organizations into substance use disorder treatment and general health systems under healthcare reform; two national summits focusing on developing policies, systems, and services to support recovery, one focusing on adults and the other on adolescents and young adults in both secondary and postsecondary education settings; the first-ever

Young Peoples Networking Dialogue on Recovery, through which youth were able to inform policy-makers about their needs, goals, and aspirations; and the 2010 Joint Meeting on Adolescent Treatment Effectiveness (JMATE), which brought together researchers, program developers, public officials, and youth in recovery.

In 2011, ONDCP will focus its recovery efforts on developing a national plan for promoting and supporting the adoption of ROSC approaches by states, tribes, and local governments; identifying and eliminating regulatory, policy, and practice barriers to recovery; and celebrating and supporting recovery through messaging, outreach, and information strategies as well as through participation in and/or sponsorship of recovery-focused events. Additionally, ONDCP in collaboration with Education will continue its ongoing efforts to foster the development of recovery high schools, campus recovery programs, and treatment recovery support services within mainstream high school and higher education settings. This work will build on Federal investments in the Texas Tech Center for the Study of Addiction and Recovery to develop and disseminate information on a model collegiate recovery community curriculum. (Action Item 3.3C)

Supporting Recovery

As part of its eight Strategic Initiatives, SAMHSA has developed a Recovery Support Initiative. Through this effort, SAMHSA is supporting the new technical assistance program, Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). The purpose of BRSS TACS is to provide policy and practice analyses, as well as training and technical assistance to states, providers, and systems to increase the adoption and implementation of integrated, peer-driven recovery supports for people with mental and substance use disorders. Through BRSS TACS, SAMHSA will work with a broad array of stakeholders including, but not limited to, people in recovery.

Several SAMHSA grants will provide funds to propagate promising practices for building and expanding ROSCs at the state and community levels and to support the development of peer recovery support services. ROSC frameworks support the delivery and coordination of services across systems and organizations through information technology and the use of individualized service/recovery plans that are designed and implemented in partnership with clients with the goal of long-term recovery in the community.

SAMHSA's recovery-focused grant programs have seeded the infrastructure necessary for ROSC in communities across the Nation. Lessons learned from these programs will help policymakers understand the challenges and opportunities encountered by states and tribes as they seek to develop recovery-focused systems, policies, and programs.

In 2010, SAMHSA issued 30 new Access to Recovery (ATR) grants to 23 states, 6 tribes, and the District of Columbia. Funded at \$98.9 million annually over 4 years, this program expands treatment and recovery support services that are critical to sustaining recovery by establishing voucher programs. (Action Item 3.3A)

The Targeted Capacity Expansion (TCE) Local ROSC grant program has increased the Administration's understanding of how to implement ROSC in local communities, which can be especially challenging if infrastructure to accommodate them is not established through statewide systems, such as publicly funded treatment services and the child welfare and criminal justice systems. (Action Item 3.3C)

Through these programs, more people will succeed in their long-term recovery, thus reducing the number of chronic drug users in the United States and expanding the number of resilient and healthy families and communities.

Preventing Homelessness for People with Substance Use Disorders

Approximately 30 percent of the chronically homeless population has a serious mental illness and around two-thirds have a primary substance use disorder or other chronic health condition that create major difficulties in accessing and maintaining stable, affordable, and appropriate housing.

Through the Grants for the Benefit of Homeless Individuals program (GBHI), SAMHSA is helping to provide supportive permanent housing and reduce the barriers that homeless persons experience during recovery from substance use and/or mental disorders. GBHI supports the expansion of treatment and services for homeless individuals with substance use and/or mental health disorders, and supports the integration of these services into primary care. SAMHSA will fund programs that demonstrate effectiveness in treating persons who are homeless, including runaways, street youth, and Veterans, and transitioning them into permanent housing with supportive services as needed. Services include outreach, screening and assessment, referral, direct treatment, and wrap-around supportive services, all directed to permanent and stable housing.

El Paso Alliance, Inc., El Paso, Texas

Through grants awarded by SAMHSA, the El Paso Alliance, National Alliance of Methadone Advocates (NAMA), and numerous other peer-led organizations have created successful peer recovery support programs. NAMA, in collaboration with the Albert Einstein College of Medicine, established Medication Assisted Recovery Services (MARS), the first medication-assisted recovery community organization in the 10-year history of the program.

In 2006, the El Paso Alliance developed *The Recovery Alliance*, a peer-led recovery community organization that provides peer-designed and peer-delivered recovery support services for persons in recovery from addiction. These include recovery coaching, education, vocational skill development, and informational support. *The Recovery Alliance* acts as a bridge between treatment providers, drug courts or probation officers, and other service providers in the local community, providing long-term peer recovery support services. Outcomes for the 449 persons served to date by *The Recovery Alliance* include substantial increases in employment rates and substantial decreases in homelessness.

In 2008, The El Paso Alliance developed *Project Sendero al Bienestar (Pathway to Wellbeing)*. This project uses a peer recovery model and motivational enhancement strategies to serve indigent populations who are seeking recovery from substance use disorders and co-occurring mental health problems. It was funded by a grant under SAMHSA's Treatment Capacity in Targeted Areas of Need, Local Recovery-Oriented Systems of Care Grant (TCE-ROSC) Program. The project provides detoxification, peer-operated residential services, and peer recovery services to a culturally diverse and largely Hispanic population. Outcomes for the 290 individuals served to date include marked improvements in rates of employment, abstinence, and homelessness.

Reaching the Military, Veterans, and their Families with Recovery Support

New Action Item: Deliver Quality Recovery Support Services to Veterans and Military Families [ONDCP, VA, DOD, SAMHSA]

Consistent with the Presidential Study Directive—*Strengthening Our Military Families*, ONDCP will lead an interagency effort to identify recovery support services for alcohol and drug addiction that are appropriate for active duty military, Veterans, and their families and to ensure that those services are made available to our military families to the greatest extent possible.

Legal Barriers to Recovery

Several agencies are partnering to help persons in recovery from substance use disorders become successful and productive members of American society. Often, there are legal barriers that impede one's ability to fully integrate back into the workforce and society due to barriers triggered by a person's past use of illegal drugs or those triggered by a former drug user's interaction with the criminal justice system.

The societal implications of these barriers to persons working to recover from substance use disorders are significant. In the last 30 years there has been substantial growth in the number of prisoners released from prison each year in the United States: 150,000 in 1972 to 630,000 in 2002.⁷⁷

Offenders returning to the community face numerous obstacles to resuming a normal life. Research shows that state prison inmates with substance abuse problems are more likely to have a past criminal record, have a history of homelessness and exposure to physical or mental abuse, and have family who have been incarcerated or abuse alcohol or drugs.⁷⁸ Many individuals leaving the criminal justice system are unable to obtain access to housing and as many as 45 percent return to homelessness.⁷⁹

In 2011, ONDCP will partner with the Department of Housing and Urban Development (HUD) and DOJ to implement Project Reunite. Project Reunite, a recently launched pilot program, is a promising model for improving access to housing for ex-felons or homeless individuals whose families live in public housing. Local Housing Authorities, who have broad discretion in allotting housing to applicants, often deny public housing to individuals with a criminal record. Project Reunite will encourage policy changes at the local level that allow participating Housing Authorities to establish leases with eligible former offenders, allowing them to reside with their families and also link them to a variety of support services. For example, these individuals will not only have access to housing, but also access to case management, employment training, mental health and substance abuse treatment, as well as parenting classes.

This model has the potential to substantially reduce recidivism rates and greatly improve relationships between former offenders, their families, and their surrounding communities. An effort will be made to encourage other local housing authorities across the country to adopt this model. (Action Item 3.3B)



Chapter 4. Break the Cycle of Drug Use, Crime, Delinquency, and Incarceration

Decades of research and experience have shown that drugs and crime are inextricably linked. In 2009, more than 7 million individuals were under supervision by the criminal justice system: 2,284,900 offenders incarcerated, more than 1.5 million in state and Federal prisons, and more than 5 million offenders supervised in the community, of which 819,308 were on parole. Survey data from 2004 indicate that over half of state and Federal inmates used drugs during the month preceding the offense corresponding to their sentence, and nearly one-third of state prisoners and a quarter of Federal prisoners used drugs at the time of the offense.

This *Strategy* calls for a stop to the revolving door of the criminal and juvenile justice systems by addressing not only the offenders' criminal activities, but, equally important, their underlying substance abuse problems. The *Strategy* outlines a spectrum of approaches and initiatives, from pre-trial diversion and alternatives to incarceration, to reentry efforts that can be implemented at the local and state levels in order to change how drug-related crime and substance-abusing offenders are addressed. The 2011 *Strategy* seeks to broaden these efforts, continuing to promote innovative and evidence-based practices, as well as supporting the need to tailor these initiatives to specific populations.

Principle 1. Provide Communities with the Capacity to Prevent Drug-Related Crimes

Drug Market Interventions (DMI)

This Administration strongly supports community-based strategies, such as Drug Market Intervention programs, which have shown promise in disrupting violence and other drug-related problems. Overt drug markets, such as public street-corner dealing or drug houses, are among the most toxic of public safety problems. They are responsible for a host of social problems: the initiation into drug use and addiction; drawing local youth into the drug trade; the acquisition and use of firearms; and the loss of control of public space.

A number of communities, discouraged by the cycle of drug dealing and violence, followed this new multi-pronged operational plan. DMI directly engages drug dealers, their families, and communities to address these problems by creating clear and predictable sanctions, offering a range of community services, improving community-police relations, and establishing community standards for acceptable behavior.

Communities implementing DMI have seen positive results, and rigorous evaluations have shown significant crime reductions. A recent analysis of DMI implementation in High Point, North Carolina, the first site, indicated that the target area experienced a substantial decline in violent (30.6%) and drug-related crime (32.2%).⁸⁰ In Rockford, Illinois, property crime declined by 24 percent and in Nashville, Tennessee, drug crime declined by 39.5 percent. In all three communities, interviews with local residents revealed a perceived decline in crime and disorder, reported improvement in the quality of neighborhood life, and appreciation for the police.^{81, 82}

Providence, Rhode Island, Drug Market Intervention

In 2006, the Providence Police Department implemented a Drug Market Intervention (DMI) in the Lockwood section of Providence. A year after its implementation, calls for police service went down 58 percent, reported drug crime 70 percent, and drug calls to police 81 percent.⁸⁴

Due to its success in Lockwood, the DMI model was implemented in another part of the city, the Chad Brown Public Housing Projects. That site had long been the scene of overt drug dealing and gang warfare and, in June of 2009, after careful crime mapping, the Providence Police Department began their drug investigation, targeting the cocaine-trafficking hierarchy from the major players to the street dealers.

After identifying 16 dealers at Chad Brown, the detectives prepared arrest warrants but did not execute them immediately. A team of law enforcement officers and a prosecutor then reviewed each pending warrant, and 13 of the dealers were excluded from participation because of past criminal history. The remaining three low-level offenders were selected for the intervention (or “call-in”), in which family members, representatives from the faith-based community, social workers, and a number of other community organizations pleaded with them to end their disruptive actions. Ultimately, the offenders were presented with the option to continue dealing and face prosecution, or agree to change. Two of the three agreed to change.

While this intervention was similar to the DMI in Lockwood, its scope was broadened to include follow-up services for offenders and the community. Lt. Daniel Gannon, who was in command of the area, noted that the police recognized the neighborhood needed positive alternatives to discourage its next generation from repeating the actions of the arrested drug dealers.

Additional measures were taken to engage local youth and to maintain the DMI’s momentum. One such measure was “Night Vision”, which, for the first time, opened a local recreation center at night and organized positive activities for the youth. Within a short time, police officers were seen where the drug dealers used to gather, and park benches, a new playground, and a water park were installed.

The Providence Police Department also wanted to address the historical tension that existed between police and residents of Chad Brown. “It took a full 6 months before any of them would even talk to me,” Lt. Gannon recalls, “there was that much distrust.”⁸⁵ However, Gannon persisted, visiting the complex on a daily basis and gradually building the trust and relationships to openly discuss their differences.

Statistics kept by the police department show that reports of crime have plummeted in Chad Brown. One year following the DMI, violent crime was down 76 percent, property crime down 23 percent, and all other crime, including drug-related crime, down 23 percent.^{86, 87}

In 2011, BJA will provide training and technical assistance for DMI implementation to seven new sites throughout the United States.⁸³ In FY 2010, the National Institute of Justice (NIJ) initiated an evaluation of the BJA DMI Training and Technical Assistance Initiative. The evaluation includes rigorous process, outcome, and impact assessments of the DMI training, technical assistance, and implementation at 12 sites selected by BJA. The study will also assess the impact of DMI on various types of crime, and survey communities to examine if DMI increases community cohesion, law enforcement legitimacy, and perceptions of community safety. This evaluation will provide a comprehensive assessment of

the effects of DMI training, technical assistance, and implementation at these sites. By funding these initiatives, BJA and NIJ are enabling DMIs to spread to other jurisdictions, lowering crime and recidivism rates and improving public safety. Based on the evaluation, BJA will create a best practices model for implementing DMI. (Action Item 4.1A)

Principle 2. Develop Infrastructure to Promote Alternatives to Incarceration When Appropriate

Fair Sentencing Act

The Administration is committed to the fair and equal application of the Nation's laws. Laws and policies that treat all Americans equally should be promoted, which will increase public confidence in the criminal justice system. In recognition of these principles, the President signed the Fair Sentencing Act in 2010. Prior to the Fair Sentencing Act, the disparity in sentencing between offenses for crack cocaine and powder cocaine was 100-to-1. The Fair Sentencing Act dramatically reduces the disparity and marks the first time in 40 years that Congress has reduced a mandatory minimum sentence. (Action Item 4.2D)

Institutional Change

Providing a variety of interventions within the criminal justice system is critical to decreasing recidivism. Educating key leaders within the system on the science of addiction and models for system change can lead to a more systemic approach incorporating these varied interventions. Accordingly, several Federal partners have developed the National Judicial Leadership Program - Systems Change Initiative. This program will be offered to presiding judges in 2011 by the Center for Substance Abuse Treatment, NIDA, and BJA in partnership with the National Judicial College and the Center for Health and Justice at Treatment Alternatives for Safe Communities (TASC).

In addition, TASC will conduct trainings and provide technical assistance to leader judges on its intensive case management model for drug offenders. The model is based on in-depth assessments for developing individualized service plans that connect these individuals to the proper intervention and treatment. Institutional change within the criminal justice system requires collaboration with entities outside that system. For example, an offender in the criminal justice system can be involved simultaneously in the child welfare, mental health, and workforce development systems. A multi-system approach strengthens the response to the offender's needs and lessens the chance of recidivism. Therefore, BJA and SAMHSA are collaborating to address public health in the criminal justice system. SAMHSA is expanding screening for co-occurring substance use and mental health disorders in offender populations, an important step in providing the proper treatment to offenders. BJA is expanding reentry support nationwide through its Second Chance Act grants, training state, local, and tribal governments to provide ex-offenders with key skills and support to enable their successful reintegration into society. (Action Items 4.3D and 4.4A)

Court-Based Strategies and Programs

Drug courts are a proven method for addressing substance-abusing offenders. Currently, there are over 2,500 drug courts in the United States.⁸⁸ Drug courts promote treatment approaches rather than traditional incarceration for non-violent offenders drawn into the criminal justice system because of substance abuse-related problems. They reduce recidivism and save money at all levels of government.

In FY 2010, BJA, the Office of Juvenile Justice and Delinquency Prevention (OJJDP), and SAMHSA awarded nearly \$76 million in grants to enhance the court services, coordination, and substance abuse treatment capacity of adult and juvenile drug treatment courts. This funding will enable further improvement to existing courts and support the implementation of new courts. (Action Item 4.2B) In 2009, BJA and NIJ jointly funded the Adult Drug Court Research-to-Practice (R2P) Initiative to promote the timely dissemination of relevant information from this growing body of research to practitioners and policymakers.⁸⁹ Forthcoming is a webinar on target populations based on NIJ's Multi-site Adult Drug Court Evaluation and other current research.⁹⁰

The Obama Administration also supports community courts—neighborhood-based courts that address livability problems, targeting non-violent quality-of-life crimes, while providing immediate defendant accountability to the community. These community courts involve stakeholders both within and outside of the justice system, including community residents, businesses, schools, and religious leaders. The courts proactively address local public safety concerns with community-based and community-designed solutions to the problems while providing necessary services to the offenders. In an effort to spread best practices to jurisdictions throughout the country, the Center for Court Innovation and BJA hosted the first International Conference of Community Courts in 2010 and are currently working with three community courts in Dallas, Hartford (Connecticut), and Seattle to serve as regional mentors for other jurisdictions on community court issues.

Following the success of the drug court model, Judge Robert Russell created the first Veterans Treatment Court in Buffalo, New York. Currently, the Buffalo Veterans Treatment Court is collaborating with Erie Community College to provide educational and vocational training for Veterans associated with the drug court. One innovative program at the college trains veterans to become substance abuse counselors, many of whom return to the drug court as mentors. In addition, the Veterans Drug Court is working with the VA to connect eligible Veterans with home loans, medical benefits, and other services intended to help their reentry to the community. Because of Judge Russell's vision, veterans treatment courts are now being promoted to serve our Nation's Veterans. Through a coordinated response involving the Department of Veterans Affairs, state Veterans Affairs Agencies, volunteer Veteran mentors, and support organizations for Veterans and their families, 65 Veterans courts are now operational nationwide. Veterans treatment courts are successfully promoting sobriety, recovery, and stability for our Nation's Veterans.

To further spur the growth of this promising initiative, BJA funded the development, pilot, and expansion of the Veterans Treatment Court Planning Initiative. VA, the National Drug Court Institute, and numerous Veterans treatment court professionals collaborated to develop curriculum for this new initiative. This is the first Veterans treatment court training program in the Nation. Eleven Veterans court teams were trained at the inaugural event at Judge Russell's Buffalo court in September 2010, and an additional ten teams were trained in Santa Ana County, California, in February 2011.

Women and Girls

Between 2000 and 2009, the number of men in prison grew by 16 percent, while the number of incarcerated women grew by 22 percent.⁹¹ Incarcerated women in treatment are significantly more likely than incarcerated men to have severe substance abuse histories, as well as co-occurring physical health

and psychological problems.⁹² Women are also more likely to be victims of physical or sexual abuse, which contribute to drug and alcohol abuse, depression, and criminal activity. Because of this, there is a growing recognition of the need for gender-specific risk assessments and gender-responsive and trauma-informed substance use treatment services for women. Correctional facilities and community corrections systems are starting to implement these programs; however, they should be implemented and made available to more women offenders.

Also, women offenders are often primary caregivers for their children. An estimated 62 percent of female inmates in state prisons and 56 percent in Federal prisons are parents of minor children.⁹³ In addition, national survey data for 2002 through 2008 estimate that more than one quarter of the 5.3 million adults on probation or parole (approximately 1.5 million) live with at least one child aged 17 or younger, demonstrating a significant need for specialized services and support upon release and reentry into the community.⁹⁴ Women offenders with children would benefit from sentencing alternatives to incarceration, expansion of family-based treatment, improved conditions of maternal incarceration, and increased support for programming focused on parent-child relationships during a mother's sentence.

New Action Item: Improve Intervention and Treatment Services for Female Offenders in the Juvenile and Criminal Justice Systems [ONDCP, DOJ/National Institute of Corrections (NIC)]

ONDCP will work with the Women and Trauma Federal Partners' Committee⁹⁵ to support interventions (including sentencing alternatives to incarceration, expansion of family-based treatment, improved conditions of maternal incarceration, and increased support for programming focused on parent-child relationships during a mother's sentence) and work to incorporate these issues into Federal programs and funding requests.

Military Personnel, Veterans, and their Families

While the use of illicit drugs remains rare in the military, the misuse of prescription drugs has increased dramatically in the past 5 years.⁹⁶ A 2008 Department of Defense (DOD) survey revealed that 11.9 percent of active duty military personnel reported current illicit drug use, including non-medical use of prescription drugs. Largely due to regular testing, the use of illicit drugs such as marijuana, cocaine, heroin, and methamphetamine is rare among active duty military. The percentage reporting prescription drug misuse (11.5%) is more than double that of the civilian population in the age group 18-64 (4.4%)⁹⁷ Furthermore, upon retirement or discharge from the military, the injuries or trauma experienced during their service can lead to drug use and other negative behaviors.

In recognizing the profound importance of ensuring the health and well being of our servicemen, servicewomen, and their families, the President directed his Cabinet and the Executive Office of the President (EOP) to develop a government-wide approach to supporting military families. Enhancing the psychological and behavioral health of military families was the first identified priority and, to that end, the Administration has generated a comprehensive strategy to improve and expand support services available for active-duty Armed Forces, the National Guard, and the Reserves.

New Action Item: Examine Interventions and Treatment Services for Veterans within the Criminal Justice System [ONDCP, DOD, VA, HHS/SAMHSA, DOJ]

ONDCP, in partnership with DOD, VA, HHS/SAMHSA, DOJ, and other stakeholders, is taking steps to address Veterans within the criminal justice system. The role of traumatic brain injury and post trau-

matic stress disorder (PTSD) in substance abuse and mental health will be more fully examined in the Veterans treatment court initiative. This is just one of many initiatives designed to reduce the burdens that multiple deployments, combat injuries and trauma, the challenges of reintegration, and substance abuse can have on military families.

New Action Item: Connect Incarcerated Veterans with Critical Substance Abuse and Reentry Services [VA, ONDCP, DOJ/Bureau of Prisons (BOP)]

Every year, approximately 40,000 Veterans are released from incarceration.⁹⁸ Many of these Veterans have significant substance abuse or mental health issues which, if left untreated, contribute to homelessness, further criminal behavior, and drastically reduce the likelihood for successful reentry into their community.

The VA estimates that there are currently approximately 150,000 Veterans imprisoned and 40,000 released each year. Through the Healthcare for Reentry Veterans Program, VA conducts pre-release assessments with Veterans six months prior to their release from prison so that upon release they are connected to critical services, including substance abuse treatment. They are conducting this work in 72 percent of U.S. prisons. In the past three years, they have assisted nearly 25,000 Veterans. Approximately 45 percent of them access VA outpatient services in their first year out of prison.

Accessing this population for assessment and release planning at an earlier stage of their incarceration would increase successful reentry. For this reason, in 2011, ONDCP and VA will explore opportunities to identify incarcerated Veterans with substance use disorders and conduct reentry planning at an earlier phase of their incarceration to give them the necessary treatment and other services immediately upon their release, thus increasing the possibility for successful reentry.

American Indians/Alaskan Natives (AI/AN) living in the United States face a host of challenges surrounding drug use and criminal justice. In addition to significantly higher current illicit drug use rates, AI/AN populations demonstrate higher rates for substance dependence or abuse (15.5%) than any other demographic group.⁹⁹ AI/AN communities also experience violent crime (101 violent crimes per 1,000 AI/AN) at far higher rates than other Americans (41 per 1,000 persons) - more than twice the rate for the U.S.¹⁰⁰ Furthermore, AI/AN victims are more likely than all victims to report an offender who was under the influence of alcohol or drug use at the time of the crime (70%).¹⁰¹ Overall, about 62 percent of American Indian victims experienced violence by an offender using alcohol, compared to 42 percent for the national average.¹⁰²

New Action Item: Address the Issue of Drug Use and Drug-Related Crime for American Indian/Alaska Natives. [ONDCP, DOJ/OJP]

The significant problems of drug use and drug-related crime in tribal regions throughout the Nation pose a critical challenge for Federal, state, local, and tribal leadership. In 2011, ONDCP and OJP will consult with tribal leaders, including the National Congress of American Indians and United South and Eastern Tribes (USET), to develop a plan to tackle some key issues regarding drug use and crime and to discuss their role in the involvement of Native American and Alaskan Natives in the criminal and juvenile justice systems.

Principle 3. Use Community Corrections Programs to Monitor and Support Drug-Involved Offenders

Testing and Sanctions

In 2009, the rate of current illicit drug use among persons aged 12 to 49 on probation was more than double that of the population not on probation.¹⁰³ Large caseloads for probation officers and judges, combined with the low priority given to service of warrants for probation violations, have made compliance with probation an ongoing challenge, resulting in compliance failure rates of approximately 40 percent.¹⁰⁴

Over the past year, several jurisdictions in Alaska, Arizona, Florida, Oregon, and Virginia have begun implementing models similar to Project HOPE (Hawaii's Opportunity Probation with Enforcement). Probationers in HOPE receive swift, predictable, and immediate sanctions for each detected violation, such as detected drug use or missed appointments with a probation officer. The California Department of Corrections and Rehabilitation is piloting the HOPE approach and will be assessing whether the same benefits and successes found in Hawaii are realized in California.

Treatment in Prison

Though many of the criminal justice innovations for offenders with substance abuse problems are focused on diversion, drug courts, and alternatives to incarceration, incarceration may, in some cases, be the appropriate response to an offender's criminal activity. However, it is important that treatment and other services are provided during incarceration. One way the Federal government is addressing this issue is through BJA's Residential Substance Abuse Treatment (RSAT) program for state prisoners. The RSAT program helps states, tribes, and local governments provide residential substance abuse treatment to inmates and prepare offenders for their reintegration into the community. The program incorporates reentry planning activities into treatment programs, and encourages the use of community-based treatment and other broad-based aftercare services upon release.

New Action Item: Improve and Advance Substance Abuse Treatment in Prisons [DOJ/BOP, ONDCP, DOJ/OJP/BJA, HHS/SAMHSA and DOJ/NIC]

In 2011, BOP will work with BJA and NIC to ensure evidence-based treatment services are provided to Federal prisoners. BJA and SAMHSA will also provide training and technical assistance to state RSAT programs with the intent of maximizing the use of evidence-based substance abuse treatment and aftercare for inmates in need of such treatment. New training curricula, incorporating the latest evidence-based practices and aftercare research, will be available through a website. This will advance the field of residential substance abuse treatment for current grantees, as well as for directors, key correctional personnel, and treatment providers implementing or planning to implement residential treatment.

Principle 4. Create Supportive Communities to Sustain Recovery for the Reentry Population

Preventing Recidivism by Supporting Reentry and Recovery

The Administration is committed to expanding reentry services for offenders returning to their communities. In order to reduce their chances of committing new crimes, ex-offenders must be provided with an assortment of support services, ranging from education to accessible housing. Providing these individuals with an array of critical support services prepares them for reentry into society and helps them restore their lives.

A recently established Federal Interagency Reentry Council coordinates Federal efforts and resources and seeks to eliminate the barriers to recovery and stability that many offenders face when they are released. For 2011, HUD proposes a 2-year demonstration pilot, Project Reunite, involving 6 to 10 Public Housing Authorities. This project will support the successful reunification of formerly incarcerated or chronically homeless men and women with their families, and will offer the wrap-around support needed to help them avoid reoffending while becoming both social and economic assets to their family and community. (Action Item 4.4C)

In addition, in 2011, the Department of Labor will fund its fourth round of the Reintegration of Ex-Offenders - Adult Program grants designed to strengthen urban communities through an employment-centered program that incorporates mentoring, job training, and other comprehensive transitional services. This program seeks to reduce recidivism by helping former inmates find work when they return to their communities. (Action Item 4.4D)

In October 2010, under the Second Chance Act, the Department of Justice awarded \$100 million to 187 grantees. The grants have gone to government agencies and nonprofit organizations to provide employment assistance, substance abuse treatment, housing, family programming, mentoring, and other services that improve reentry to society and reduce recidivism. (Action Item 4.4A)

In 2011, in collaboration with BJA and the National Reentry Resource Center, ONDCP will facilitate family-based treatment training and technical assistance to the BJA's Second Chance Act Family-Based Prisoner Substance Abuse Treatment Program grantees.

SAMHSA's Center for Substance Abuse Treatment (CSAT), through its Offender Reentry Program, awarded 18 grants in FY 2010 to organizations that seek to enhance substance abuse treatment and reentry services to juvenile and adult offenders returning to the community from incarceration. These grants require grantees to plan, develop, and provide a transition from incarceration to community-based substance abuse treatment and related reentry services for the reentering population. This funding provides for existing reentry programs to be expanded and evaluated.

The Next Door Chattanooga



The Next Door Residential Transition Center (RTC) opened in June of 2010, serves women who are ending their incarceration through services, including transitional housing, recovery support services, individual and group counseling, workforce development, and case management services. The RTC has the capacity to serve up to 16 women at a time. The structured curriculum of the RTC provides job preparation, readiness, communication skills, and conflict management to support retention and career planning.

The Chattanooga location builds on the success of The Next Door Nashville, a faith-based, residential reentry program that has helped more than 800 women exiting the criminal justice system to rebuild their lives. Leigh Ann, a recent graduate says, “The Next Door gave me structure and taught me how to live, not just survive. I was given all the tools I needed

to start my new life, and people who wanted to see me succeed helped me use those tools.” The dramatic difference in re-arrest rates tells the story: women completing the program have a 14 percent re-arrest rate, compared to a nationwide estimate of 67 percent.¹⁰⁵

In addition to the RTC, The Next Door Chattanooga has also opened Tennessee’s first ever Release Center, which provides transitional housing and services for up to 30 currently incarcerated female offenders. Eligible offenders who are within 90 to 120 days of release receive residential, on-site case management services and release-readiness programming that addresses the specific needs of the offender, including employment readiness, life skills, cognitive behavioral therapy, substance abuse support, and family reunification services.

Seed money for The Next Door Chattanooga (as well as a program in Knoxville) was provided through a grant to the Tennessee Office of Criminal Justice Programming, which was made possible by the American Recovery and Reinvestment Act. The funds are used to pay for three staff members—the Program Manager, the Case Manager, and the Counselor—in each city.

Annual Recidivism Studies

While there have been individual studies on particular criminal justice programs to determine rates of recidivism, given the number of state and local criminal justice systems, it is difficult to accurately assess recidivism rates on a national scale. To develop effective strategies for reducing recidivism among drug offenders, we must first determine the extent to which released offenders reenter the system. This requires better data from state and Federal corrections institutions. The Bureau of Justice Statistics (BJS) currently funds the Criminal History Record Information Sharing Project, which provides BJS with a secure system to automate and standardize the collection of criminal history records from the Federal Bureau of Investigation (FBI) and state criminal history repositories. Over the past year, it has made some impressive improvements to advance the collection of data. In 2011, BJS will take another significant step by converting state-specific criminal history data on prisoners released in 2005 from approximately 30 states into a single research database that supports national-level recidivism analysis. The results of this study are expected to be available in 2012. This new data collection process will ensure a more comprehensive analysis of recidivism and advance the development of a national recidivism study. (Action Item 4.4E)

Safer Foundation

For over three decades, the Safer Foundation has used innovative and proven methods to support formerly incarcerated individuals and help them find gainful employment. Headquartered in Chicago with 20 facilities throughout Illinois and eastern Iowa, the Safer Foundation offers a wide range of services to ex-offenders and incarcerated persons, including juvenile and adult probationers and parolees, community corrections residents, and persons in the county jail.

One of their programs, Safer Return, is a community-based reentry initiative that seeks to engage the entire community in positively affecting prisoner reentry and reducing recidivism. The initiative is a collaborative effort of community members, law enforcement, service providers, businesses, and participants. As part of the program, community members and parole officers visit offenders while they are still in prison to begin reentry planning. Reentry coaches work with clients on a range of important issues, such as physical health, substance abuse treatment, housing, and employment. The Illinois Department of Corrections provides specially trained, community-based parole officers who partner with Safer Return coaches.

The Safer Foundation conducted a 3-year study and found that clients who attain employment have a recidivism rate of 18 percent, which is a marked contrast from the State of Illinois average of 52 percent.¹⁰⁶

Principle 5. Improve Treatment for Youth Involved with the Juvenile Justice System

Juvenile Justice

To prevent young people from cycling through the juvenile justice system or entering the adult criminal justice system, early intervention and evidence-based approaches are critical. Youth should be screened and treated not only for substance use problems, but also for unmet emotional, behavioral, and academic needs.

Juvenile drug courts are one response; however, the model has not proven as effective for juveniles as for adults. Over the past several years, OJJDP, and CSAT, through a public/private partnership, worked with a number of existing juvenile drug courts to improve the model by implementing best practices for adolescent treatment. In addition, CSAT and OJJDP partnered to support juvenile courts and juvenile drug courts in enhancing their capacity through the Screening, Brief Intervention, and Referrals to Treatment (SBIRT) program. This program enables the courts to use a short, non-intensive intervention, which helps identify the most appropriate referrals and admissions criteria for youth involved in the juvenile justice system.

In 2011, OJJDP will continue providing training and technical assistance to further expand the use of best practices for adolescent treatment and SBIRT for both juvenile court systems and juvenile drug courts. (Action Item 4.5A)



Chapter 5. Disrupt Domestic Drug Trafficking and Production

Drug trafficking organizations, associated criminal organizations, and the activity that fuels them—the transport and distribution of illicit drugs throughout the Nation—pose a persistent and dangerous threat to the United States. These organizations, often operating in multiple countries, are present in every region of the Nation, from the Southwest to the Northern border. Their criminal enterprises involve producing illicit drugs on public and private lands, trafficking narcotics, smuggling bulk cash beyond our borders, acquiring and shipping weapons via our highways and postal facilities, diverting precursor chemicals for illicit drug manufacture and unlawfully distributing both illegal and diverted legal drugs in our communities. The negative effects of the drug trade pose tremendous challenges, and threaten the well-being of citizens and the fabric of institutions at every level.

The Administration's response recognizes the importance of partnering with other nations that are invested in disrupting major transnational drug networks and criminal organizations. At the same time, domestic law enforcement at the Federal, state, local, and tribal levels must continue to share information and align resources to identify and disrupt drug trafficking operations in the United States, including the diversion of prescription drugs and the diversion of precursor chemicals used to manufacture illicit controlled substances. This effort requires a wide array of intelligence gathering, investigation, enforcement operations, and prosecutions, involving a diverse and sophisticated law enforcement infrastructure.

ONDCP is working closely with interagency partners to implement the forthcoming Strategy on Transnational Organized Crime, which will address the growing convergence between drug trafficking and other organized criminal activities, as well as other relevant strategies focused on domestic and international trafficking. These strategies complement the initiatives highlighted in this *Strategy*.

Principle 1. Federal Enforcement Initiatives Must be Coordinated with State, Local, and Tribal Partners

Federal policymakers have taken a number of steps to appropriately align Federal drug enforcement with the efforts of state, local, and tribal partners. (Action Item 5.1A)

Federal, State, and Local Interagency Task Forces

The HIDTA program is at the forefront of efforts to target and disrupt drug trafficking networks. Last year, there were 670 HIDTA-funded task forces and strategic initiatives staffed by more than 8,700 Federal agents and analysts and nearly 17,000 state, local, and tribal law enforcement officers, analysts, and other representatives. In 2010, the HIDTA program assisted with the disruption or dismantlement of more than 1,900 drug trafficking organizations, trained more than 25,000 law enforcement and analytical personnel to further improve investigative and enforcement practices, provided analytical support for more than 36,000 cases, and seized drugs valued at nearly \$12 billion. HIDTAs provide a mechanism for every level of law enforcement to share resources, information, and strategies.

A New Approach to Drug Threat Assessment

Patterns of illegal drug production, distribution, and consumption change over time and vary widely across and within different regions of the United States. Each year, HIDTAs are required to conduct an assessment of emerging drug threats in their areas and develop strategies to address those specific threats. The New York/New Jersey (NY/NJ) HIDTA has identified a need to better evaluate and respond to trends in illegal drug use in its 23 counties. A more detailed understanding of the number of chronic drug users, their geographic distribution, demographic characteristics, and patterns of use is needed, as is timely reporting and analysis of drug-related deaths, injuries, and admissions to drug treatment at the state and municipal levels.

To this end, the NY/NJ HIDTA has partnered with state and municipal public health and law enforcement agencies to collect and monitor data on a comprehensive set of drug-use indicators. This effort has two major objectives:

- Develop an in-depth assessment of trends in illegal drug use for each HIDTA county to better inform local drug control policy and improve resource allocation for state and local public health and law enforcement agencies.
- Identify new and emerging patterns in drug consumption.

A key component of this effort has been the forging of new and productive partnerships with the New York City Department of Health and Mental Hygiene's Bureau of Alcohol and Drug Use Prevention, Care and Treatment and the New York State Office of Alcoholism and Substance Abuse Services. Beginning in 2009, the NY/NJ HIDTA hosted a series of meetings with officials from both agencies, as well as with law enforcement representatives, to explore sharing information on illegal drug use, drug-related crime and drug treatment in the 16 New York HIDTA counties.

In addition, HIDTA-funded analysts and drug intelligence officers in several New York counties, particularly Westchester and Nassau, have independently developed strong working relationships with county medical examiners, hospital administrators, substance abuse treatment providers, and others in the public health and education communities. The NY/NJ HIDTA has also fostered and drawn upon partnerships between key public health agencies and law enforcement in New Jersey.

Through these efforts, new opportunities for collaboration on assessing trends in drug use have emerged. In August 2009, the NY/NJ HIDTA called upon the expertise and analyses of this expanding network of partners to fulfill an ONDCP request for a county-by-county analysis of trends in heroin trafficking and use. In sum, these partnerships are enabling the NY/NJ HIDTA to more accurately identify emerging drug threats and more effectively target the specific problems in the region.

In 2011, in addition to the New York/New Jersey (NY/NJ) HIDTA, the Washington/Baltimore, Atlanta, and Chicago HIDTAs will all develop similar threat assessments.

Intelligence Exchange and Information Sharing

The sharing of intelligence and information is required to continuously pinpoint the most acute aspects of the drug threat and ensure the proper focus of a law enforcement strategy. Ongoing partnerships among ONDCP, the DOJ, the Department of Homeland Security (DHS), and state and local law enforce-

ment are expanding intelligence gathering resources and capabilities, while The Interdiction Committee (TIC) continues to lead the interagency effort to develop national law enforcement coordination and deconfliction¹⁰⁷ capability. (Action Item 5.1B)

The Organized Crime Drug Enforcement Task Force (OCDETF) Fusion Center provides investigative and operational intelligence support to OCDETF investigations through the development of organizational target profiles and the development of specific investigative leads. These leads and intelligence products are disseminated to the appropriate field elements of the OCDETF agencies through the DEA-led multi-agency Special Operations Division (SOD). The primary mission of SOD is to establish seamless law enforcement strategies and operations aimed at dismantling national and international trafficking organizations by attacking their command and control communications. SOD is able to facilitate coordination and communication among law enforcement entities with overlapping investigations and ensure tactical and operational intelligence is shared and that enforcement operations and investigations are fully coordinated among and between law enforcement agencies. SOD is also utilized as a deconfliction center for all drug-related and money laundering investigations. (Action Item 5.1B)

In 2010, DHS and HIDTA expanded from three to nine co-located DHS Fusion Centers and HIDTA Intelligence and Investigative Support Centers (IISC) to improve intelligence sharing. The DHS Fusion Centers collect, analyze, and disseminate crime and national security threat information to Federal, state, local, tribal, and private stakeholders. Fusion centers help avoid duplication of effort, leverage intelligence resources, connect crime databases, and support efforts to combat organized crime. (Action Item 5.1C)

In addition, there are currently 21 operational DHS-led Border Enforcement Security Task Force (BEST) offices, including one in Mexico City, which leverage more than 350 Federal, state, local, and foreign law enforcement agents and officers representing more than 80 law enforcement agencies. BESTs provide a co-located platform to conduct intelligence-driven investigations aimed at transnational criminal organizations operating on the Southwest and Northern borders in the air, land, and sea. In 2010, Immigration and Customs Enforcement (ICE) doubled the number of special agents and personnel assigned to BESTs. This expansion strengthened the Nation's ability to dismantle the leadership and infrastructure of criminal organizations seeking to exploit our borders.

El Paso Intelligence Center (EPIC)

The DEA-led El Paso Intelligence Center (EPIC) supports U.S. law enforcement and interdiction components through the timely analysis and dissemination of intelligence on illicit drug and alien movements and criminal organizations that are responsible for these illegal activities. EPIC, originally established as a regional intelligence center focused on the Southwest border, is now a national tactical intelligence center that focuses its efforts on supporting law enforcement efforts in the Western Hemisphere. EPIC is jointly staffed by a number of personnel from DOJ (DEA, FBI, and the Bureau of Alcohol, Tobacco, Firearms and Explosives [ATF]), DHS (Customs and Border Protection [CBP], ICE, and the U.S. Coast Guard), DOD, and state and local agencies; it gathers and shares important drug trafficking, interdiction, and other national security-related intelligence.

Through its 24-hour Watch function, EPIC provides immediate access to participating agencies' databases to law enforcement agents, investigators, and analysts. This function is critical in the dissemination of relevant information in support of tactical and investigative activities, deconfliction, and officer safety. EPIC also provides significant, direct tactical intelligence support to state and local law enforcement agencies, especially in the areas of clandestine laboratory investigations and highway interdiction. In 2010, EPIC contributed to a number of key arrests on both sides of the U.S.-Mexico border, sharing important intelligence with U.S. and Mexican law enforcement agencies to disrupt key drug trafficking operations in the region.

In 2011, law enforcement will expand participation in targeted drug enforcement teams to include; HIDTA task forces, OCDETF Strike Forces, BESTs, Integrated Border Enforcement Teams (IBET), and Safe Streets and Safe Trails Task Forces. In addition to enforcement task forces, Federal, state, local, and tribal partners will also increase their integration and involvement in intelligence and information sharing centers and databases, to include DHS Fusion Centers, EPIC, HIDTA IISCs, the ICE Bulk Cash Smuggling Center, OCDETF Fusion Center, the National Seizure System, deconfliction databases, and other analytical systems.

Indian Country

Drug trafficking, distribution, and consumption, pose significant and ongoing challenges for tribal areas throughout the United States. In addition, tribal communities are encountering significant trafficking operations within their regions, particularly along U.S. borders. Despite increased Federal, state, and tribal enforcement efforts, Mexican drug trafficking organizations (DTOs) continue to use routes through tribal lands along the Southwest border. One particularly affected tribe is the Tohono O'odham Nation, whose lands include more than 2.7 million acres in south central Arizona and northern Mexico. Federal partners are working with state and tribal law enforcement to expand enforcement in this region to reduce the burden of drug trafficking on the members of the Tohono O'odham tribe.

The ICE Shadow Wolves program directly engages state and tribal law enforcement officers on the Tohono O'odham Nation to disrupt drug trafficking and related crime on the reservation. Established by Congressional mandate in 1974 in response to the rampant smuggling occurring through the Tohono O'odham Indian Nation, the Shadow Wolves are Native American ICE Tactical Officers who, together with tribal police and Border Patrol, use technology and traditional tracking techniques to interdict

and investigate narcotics smugglers operating on the reservation. In addition, the Shadow Wolves work to raise awareness of smuggling activity within the region and solicit information the community may have pertaining to smuggling activities. The Shadow Wolves have advised other tribes seeking to establish similar partnerships. They are working in the Blackfeet Indian Reservation in Montana and the Bay Mills Chippewa Indian Reservation to more effectively connect Federal, state, and tribal law enforcement leaders.

The Northern border is also a target, with DTOs frequently using tribal territories in the region as trafficking routes and distribution points for illicit drugs entering the U.S. In response, ONDCP is working with tribal leadership and law enforcement to improve information and resource sharing in these important regions of the country. Additionally, six HIDTA grantees are currently conducting enforcement operations and trainings with tribal nations located in Arizona, New Mexico, Oregon, Texas, Oklahoma, and Washington.

In 2010, the Warm Springs Indian Reservation was designated as a HIDTA and is now a partner in the Oregon HIDTA. Warm Springs is the first Indian reservation to be designated as a HIDTA. Many HIDTA-designated counties include portions of tribal lands, but Warm Springs is the first in the history of the HIDTA Program to be designated regardless of county lines.

Also in 2010, Navajo County, Arizona, home to the Hopi, Navajo, and White Mountain Apache tribes was designated as a HIDTA county. These designations are in response to growing threats within Indian country and serve to enhance Federal drug investigation and enforcement support in tribal communities.

In addition, the FBI maintains an Indian Country Special Crimes Unit (ICSCU), which is charged with developing and implementing strategies targeted to the specific crime threats on tribal lands. In partnership with the Bureau of Indian Affairs, the ICSCU provides critical funding and training for Indian country law enforcement officers, including courses on drug and gang investigations. This program trains more than 1,000 Indian country officers, support personnel, and community leaders every year, and represents an important tool in addressing drug-related crime on tribal lands.

In September 2010, DOJ awarded \$127 million to several hundred American Indian and Alaskan Native communities to enhance law enforcement, strengthen justice systems, prevent youth substance abuse, provide support services to elderly victims of crime and victims of sexual assault, and support other efforts to combat crime. These grants are the first under the Coordinated Tribal Assistance Solicitation, a new effort combining 10 different DOJ grant programs into a single solicitation. These funds were awarded in response to the input of tribal leaders from across the United States, who expressed their need for expanded investigation and enforcement infrastructures. All of these initiatives will further enable tribal law enforcement to reduce drug-related and other crimes within their communities.

Principle 2. United States Borders Must be Secured

Border regions are important transit zones for drug trafficking organizations. Targeted enforcement along the borders is a critical mechanism to prevent and disrupt the flow of drugs.

Southwest Border

A major transit zone for drugs, weapons, and money, this region requires a unique focus to effectively disrupt large scale drug operations. In recognition of the Southwest border's significance in domestic drug trafficking, the Administration drafted the 2009 National Southwest Border Counternarcotics Strategy. This targeted strategy seeks to substantially reduce the flow of illicit drugs, drug proceeds, and associated instruments of violence across the Southwest border by enhancing intelligence capabilities; interdicting drugs, proceeds, and weapons; conducting investigations of and prosecuting significant drug traffickers; and enhancing U.S.-Mexico cooperation in joint counterdrug efforts. In the coming year, the Administration will implement the 2011 National Southwest Border Counternarcotics Strategy. This Strategy sets specific operational priorities to more effectively respond to the threats posed by drugs and drug trafficking in the southwestern United States. (Action Item 5.2A)

Implementation of the National Southwest Border Counternarcotics Strategy will also be significantly advanced by the latest step in the Administration's comprehensive approach to securing the Southwest border: the Emergency Supplemental for Border Security (Public Law 111-230) signed by President Obama in August of 2010. It includes \$600 million in supplemental funding for enhanced border protection and law enforcement activities. The law also includes \$244 million to hire new and fund existing Border Patrol agents and CBP Officers; \$196 million for DOJ to increase the number of Federal law enforcement officers, enhance its prosecutorial efforts along the border, and increase its training of and assistance to its Mexican law enforcement counterparts; and \$80 million for new ICE agents and supporting investments in the region, along with significant funding for new detection, communications, and training systems. Additional funds are also provided for detention and incarceration of criminal aliens in coordination with DHS enforcement activities.

Also in 2010, the President authorized the temporary deployment of up to 1,200 additional National Guard troops to the border to contribute additional capabilities and capacity to assist law enforcement agencies as a bridge to longer-term enhancements in the efforts to target illicit networks' trafficking in people, drugs, illegal weapons, money, and the violence associated with these illegal activities. These National Guard troops provide Entry Identification Teams and criminal investigation analysts in support of these efforts. Their support has allowed CBP to bridge the gap and hire additional agents to support the Southwest border, as well as field additional technology and communications capabilities that Congress provided. These deployments have provided significant results. The California National Guard provided important support to ICE agents in finding two tunnels under the border in November 2010. The discovery of the first tunnel resulted in the discovery of 30 tons of marijuana, the single largest drug seizure associated with a border tunnel. Another 20 tons of marijuana were seized upon the discovery of a second tunnel. (See box below.)

ATF is coordinating with DHS to continually improve intelligence sharing and identify opportunities for joint operations. On October 5, 2010, ATF signed an agreement with the Government of Mexico to trace

all recovered weapons through ATF's eTrace, an important step in connecting domestic intelligence and enforcement capabilities with efforts to secure the border. ATF will continue to train Mexican government personnel on the identification of firearms and usage of the eTrace system. This groundbreaking agreement will improve tracking and help disrupt the transnational flow of illegal guns used by drug trafficking and other criminal organizations.

ATF developed Project Gunrunner, a national initiative which seeks to detect, disrupt, and dismantle illicit firearms trafficking schemes and networks operating within the United States on behalf of Mexican transnational criminal organizations. Project Gunrunner uses a three-pronged approach that includes targeted criminal investigations, outreach and partnership with the firearms industry and licensed firearms dealers, and training of state, local, tribal, and Mexican law enforcement partners in state-of-the-art firearms-trafficking techniques, firearms tracing, explosive post-blast and Improvised Explosive Device (IED) investigation. In the coming year, ATF will establish two new operational ATF Gunrunner Impact Teams to target Southwest border firearms trafficking activities, co-located when possible with existing OCDETF Strike Forces and BESTs. (Action Item 5.2C)

San Diego Tunnel Task Force



On Thanksgiving Day 2010, a multi-agency San Diego Tunnel Task Force, a unit of the San Diego BEST, discovered a major drug tunnel in a dense industrial area of Otay Mesa just north of the border. The tunnel was about 2,200 feet long, about the length of seven football fields. On the U.S. side of the border it connected to two warehouses about 800 feet apart, both east of the Otay Mesa border crossing. On the Mexican side, in Tijuana, it connected to a two-story home.

Eight people—two U.S. citizens and six Mexicans—were arrested in connection with the tunnel. More than 20 tons of marijuana were seized, most of it in a tractor-trailer stopped at a Border Patrol highway check-point in Temecula, a few tons in the tunnel, and the rest at a ranch in Mexico. The wholesale value of the marijuana was \$17 to \$20 million.

Drug smugglers likely spent \$2 to \$3 million to build the tunnel, which had flooring, lighting, ventilation systems, an expertly laid rail system, and a sizable room for storing the drugs. Authorities also said it was the first time they had seen a tunnel with two fully constructed exit points in the United States. Earlier in the same month, the Tunnel Task Force had uncovered an 1,800-foot tunnel ending at another Otay Mesa warehouse just a few blocks from the Thanksgiving Day find. That discovery also resulted in a massive seizure of marijuana—an estimated 30 tons.

Northern Border

Following passage of the Northern Border Counternarcotics Strategy Act of 2010 (P.L. 111-356), Federal, state, and local enforcement agencies took steps to improve border management and reduce drug trafficking threats along the U.S.-Canada border. DHS is developing a departmental Northern Border Strategy that identifies the need for increased intelligence, information sharing, and coordination at, along, and away from the U.S.-Canada border. Similar to the BESTs, which integrate intelligence, interdiction, and investigations among participating Federal, state, local, and Canadian law enforcement agencies at the major ports of entry along the Northern Border, IBETs, composed of U.S. and Canadian Federal, state, provincial, and local law enforcement personnel, conduct intelligence-driven operations along the U.S.-Canada border between the ports of entry. The 15 IBETs in 24 locations actively share information and participate in bi-national enforcement operations. To build on these efforts, ONDCP will lead an interagency process to develop the inaugural Northern Border Counternarcotics Strategy, which will be released in 2011. (Action item 5.2D)

Securing the Borders

Additionally, DHS/ICE will expand the BEST program by adding teams in Honolulu, San Francisco, Norfolk (Virginia), San Juan, and Massena (New York). These teams will build upon the 21 existing BESTs currently in operation to better leverage the Federal, state, local, and foreign law enforcement capabilities in crucial drug trafficking regions along the borders.

Principle 3. Focus National Efforts on Specific Drug Problems

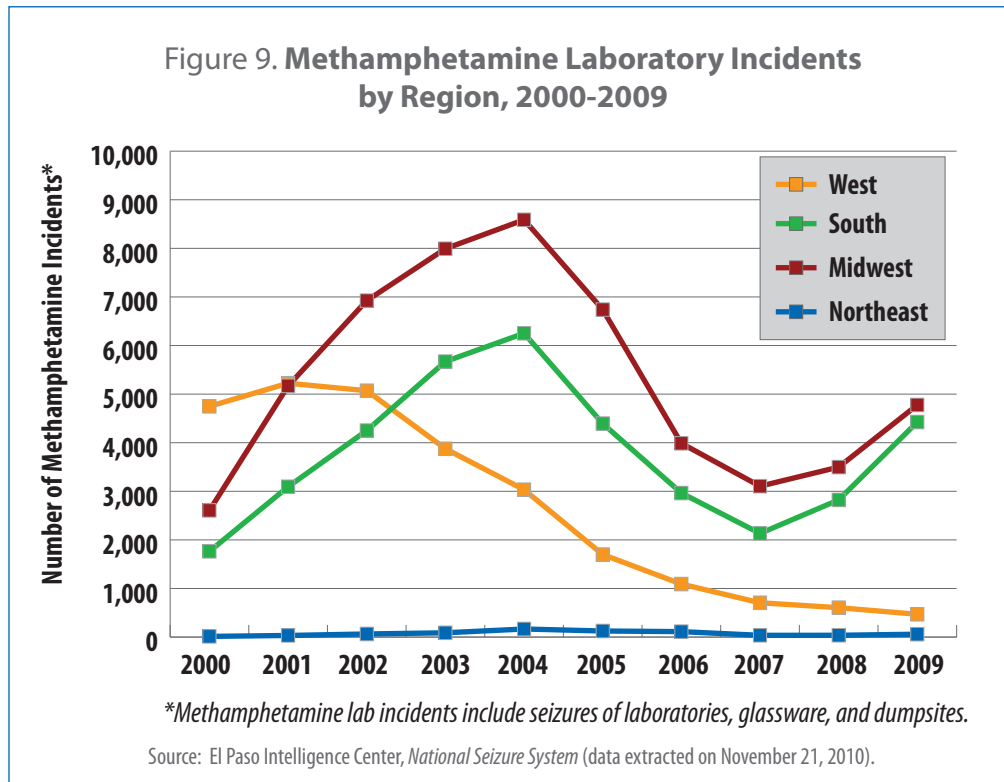
The Administration recognizes the Nation faces more than just one drug problem. Each part of the country has distinctive drug-related challenges that require unique, community-based responses. Therefore, the *Strategy's* domestic enforcement objective focuses national efforts on specific drug problems.

Methamphetamine Production

One example of a regionalized threat is the domestic production of methamphetamine, which is an increasing problem in the southern and Midwestern regions of the United States. According to EPIC, during 2009 there were 10,221 laboratory seizure incidents (incidents represent seizures of dumpsites, labs, and equipment/glassware). Preliminary 2010 data indicate the number of methamphetamine lab incidents is likely to have increased, continuing an upward trend that started in 2008. While we have made gains in reducing the number of large “superlabs” operating in the United States, the overall upward trend in smaller labs is a serious concern.

The Administration continues to seek refinements to current laws and regulations to prevent and disrupt methamphetamine production. On October 12, 2010, President Obama signed the Combat Methamphetamine Enhancement Act of 2010 (Public Law 111-268), which became effective 180 days later in April 2011. This law extends to mail-order retailers the training and “self-certification” requirements previously applicable only to other retailer sellers of over-the-counter drug products containing the precursor chemicals pseudoephedrine, ephedrine, or phenylpropanolamine. It also creates two new offenses, primarily punishable by civil penalties, one for negligently failing to self-certify as required and another to distribute these over-the-counter drugs to sellers who are not self-certified: the law requires

DEA to maintain a list of self-certified persons for this purpose. This law builds upon the 2006 Combat Methamphetamine Enhancement Act to ensure retailers effectively control methamphetamine precursors and handle and distribute these chemicals in a safe, responsible manner. These types of policy and regulatory solutions will enable domestic enforcement to more effectively reduce methamphetamine manufacturing in the United States. (Action Item 5.3A)



State precursor controls and the Combat Methamphetamine Enhancement Act, which limited the amount of pseudoephedrine that could be purchased, were initially successful. However, state-by-state lab incident data indicate the effectiveness of these laws has eroded. Domestic production is rising again. Drug traffickers now evade retail sales controls by using teams of pseudoephedrine purchasers, known as “smurfers”, to go store-to-store and buy small, lawful amounts of products containing pseudoephedrine, which are then sold at substantial profit to those who manufacture methamphetamine. This smurfing is feeding large-scale superlabs run by drug-trafficking organizations.

The National Methamphetamine and Pharmaceutical Initiative (NMPI)

The National Methamphetamine and Pharmaceutical Initiative (NMPI), an initiative of ONDCP's HIDTA program, is working with state and local leaders to explore policy, regulatory, and enforcement options to reduce the availability of methamphetamine throughout the United States, as well as precursors and other chemicals to illicit methamphetamine manufacturers through a unified law enforcement and prosecutorial effort. The NMPI currently provides assistance to states and local governments in implementing the current CMEA regulations, which placed restrictions on the sale of pseudoephedrine/ephedrine, the precursor chemicals used to manufacture methamphetamine. NMPI and other stakeholders have identified another promising practice, which involves changing the scheduling of over-the-counter medicines that contain these precursor chemicals and reinstituting prescription requirements that were dropped in the 1970s. NMPI further provides training to law enforcement professionals, fosters exchange of intelligence and investigatory information, and promotes coordination of nationwide and increasingly international efforts to address methamphetamine production. For example, NMPI has held 16 national strategy and training conferences since its inception in late 1999, with nearly 8,600 personnel trained in 2009 alone.

Electronic tracking (e-tracking) is another response to the problem. However, purchasers use false forms of identification to get around e-tracking systems. A prescription requirement for pseudoephedrine may be a promising tool in a comprehensive plan to address methamphetamine production. Any additional measures to reduce diversion by restricting the sale of pseudoephedrine, however, should be balanced with the need to maintain access for legitimate and safe use. In Oregon, where pseudoephedrine is obtained by prescription only, the number of labs declined from more than 100 to just 10 labs seized this past year. In Mississippi, where pseudoephedrine was made available only by prescription in July 2010, the Mississippi Bureau of Narcotics reported the number of labs seized declined by 65 percent from July to December 2010. For states with no or relatively few clandestine labs detected within their borders, a prescription requirement can still be an important tool to prevent smurfers from neighboring states crossing their borders to take advantage of pseudoephedrine availability. A prescription requirement may also help prevent the pattern of smurfing and small-scale lab operations from starting or increasing.

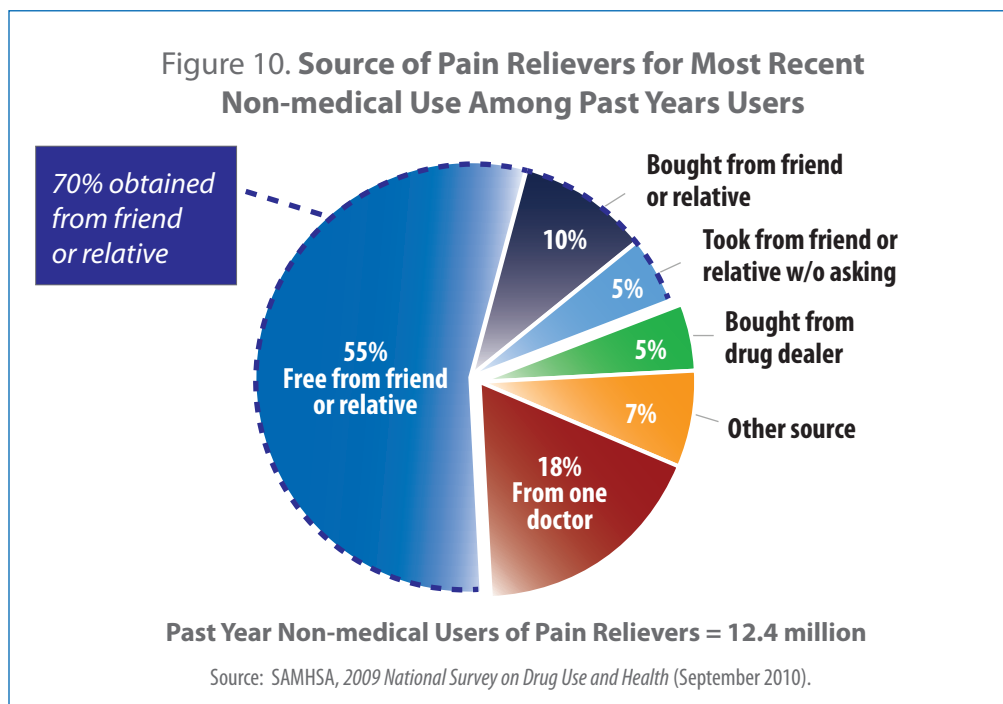
Border Transit

In an effort to secure the Nation's highway infrastructure and disrupt drug trafficking and distribution into the country, ONDCP initiated the Domestic Highway Enforcement (DHE) initiative to assist its HIDTA grantees with market disruption through a coordinated, nationwide highway enforcement strategy. The 48 contiguous states share plans and intelligence and coordinate joint enforcement operations. In 2010, the DHE initiative resulted in almost \$1 billion in cash, property, and products seized, including nearly \$52 million in cash assets alone. This initiative will continue in 2011, with the goal of further disrupting drug traffickers' attempts to transport illicit drugs and money around the country. (Action Item 5.3B)

Prescription Drug Diversion

As discussed in Chapter 2, domestic law enforcement agencies and policymakers have taken steps to facilitate the return of unused, unwanted prescription drugs that can easily fall into the wrong hands. ONDCP and DEA worked with Members of Congress and provided practical expertise to facilitate passage of the Secure and Responsible Drug Disposal Act, signed into law by President Obama on October 12, 2010. This important law directs the Attorney General, who will work through DEA, to develop rules to govern the safe disposal of unused or unwanted prescription drugs by allowing citizens to return them in a convenient and affordable manner.

Also in an important effort to raise awareness of prescription drug abuse and collect unwanted prescriptions, in September 2010 and April 2011, DEA held two separate national prescription drug take-back days. These programs resulted in the collection of over 300 tons of unused medicine for safe and proper disposal. This is especially noteworthy, given that youth report the number one source for medications they abuse is friends and family. (Action Item 2.2C)



While safe disposal of prescription drugs is an important tool in preventing prescription drug abuse, there is also a critical need to stop prescribers who improperly and dangerously prescribe vast quantities of controlled substances. In June 2010, as part of "Operation Compound Fracture," DEA, the Internal Revenue Service (IRS), and local police identified and obtained the conviction of the doctor behind a "pain clinic" that had used Internet sites to distribute 7 million tablets of prescription drugs without proper prescriptions from 2001 through 2007. The "pain clinic" owner, who faces up to 20 years in prison upon sentencing, was convicted of conspiracy to manufacture, distribute, and dispense a controlled substance not for a legitimate medical purpose; money laundering; and the spending of illicit proceeds. In March 2010, DEA and Federal, state, and local law enforcement agencies, served immediate suspen-

sion orders on six doctors, who were among the top 20 doctors dispensing the most oxycodone in the United States in 2009. (Action Item 2.2D)

Federal law enforcement agencies continue to improve efforts to crack down on 'rogue' pain clinics. DEA is exploring and applying best practices to better identify these clinics. This effort will enhance existing databases to improve the investigative tools and information available to field offices, and thereby better support enforcement activities and prosecutions. Also, under its Distributor Initiative, DEA continues to apprise wholesale distributors about current methods of diversion and to remind them of their responsibilities to identify and report suspicious activity. (Action Item 2.2F)

As part of its ongoing effort to drive illegal pharmacies out of business, DEA's SOD has also met with Internet industry representatives including Internet Corporation for Assigned Names and Numbers (ICANN), Regional Internet Registries, Registrars, Webhost Providers, and the three largest Internet search engine companies to jointly determine best practices for blocking rogue Internet pharmaceutical sales. (Action Item 2.2E)

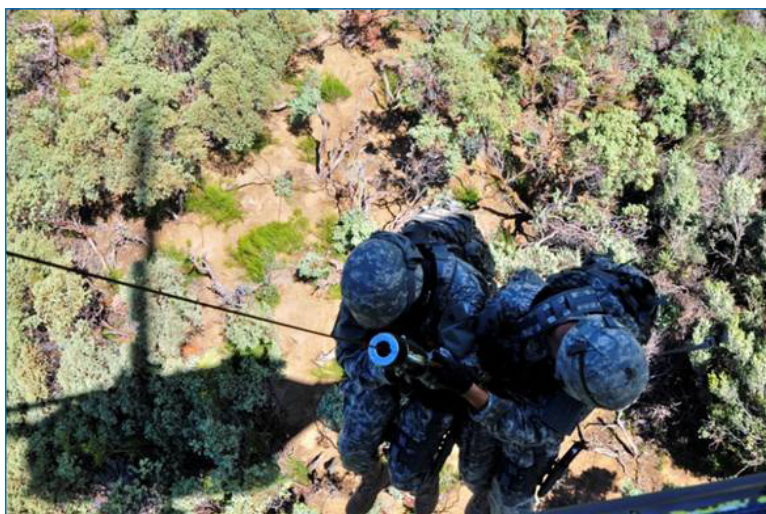
Marijuana on Public Lands



Marijuana cultivation on public lands is particularly damaging to both the environment and the public safety of the surrounding areas. Marijuana growing operations commonly degrade local ecosystems, clearing native brush, diverting water resources, and using banned pesticides. Further, the potential for harm to visitors and management staff is a major safety concern. Members of the drug trafficking organizations involved in these marijuana growing operations are often armed and dangerous. They protect their illegal marijuana operations through the use of force and intimidation. Such incidents have increased on public lands in recent years. There were nine shootings on public lands in California in 2010, compared to only one such shooting in both 2008 and 2009.

In an effort to address marijuana cultivation on public lands, the Public Lands Drug Coordination Committee, co-chaired by ONDCP and the Department of the Interior, brings together Federal agencies to develop policies and comprehensive strategies to substantially reduce the illegal production, cultivation, processing, and trafficking of marijuana on public lands. (Action item 5.3C)

As of November 2010, Operation “Trident,” an ongoing, multi-agency, marijuana enforcement effort in Madera, Fresno, and Tulare Counties, California, resulted in the eradication of approximately 664,000 marijuana plants, primarily from public lands, seizure of nearly 6,900 pounds of processed marijuana, arrest of 126 individuals and the Federal prosecution of 79 defendants. The success of this massive effort relied upon a coalition of agencies and programs, including members from Federal, state, and local law enforcement; public land agencies; California National Guard; California Drug Free Youth; High Sierra Volunteer Group; the U.S. Attorney’s Office; and the District Attorneys’ Offices. Based upon these successes, similar operations targeting marijuana growing operations will continue in 2011, with the goal of eliminating these illegal and dangerous operations on public lands.



Combating Drug Gangs

In 2010, the FBI partnered with other Federal, state, and local officers to support 160 Violent Gang Safe Street Task Forces in targeted areas across the country. These task forces conduct investigations to disrupt violent gangs and prosecute gang members responsible for drug trafficking and distribution in their communities. Approximately 800 FBI Special Agents are working with 1,500 state and local officers and Special Agents from other Federal agencies to prevent violent gang-related crime. In addition, the FBI trained approximately 240 state and local Safe Streets Task Force Officers to further enhance investigative and enforcement capabilities. The Task Forces provide state and local law enforcement partners access to Federal investigative resources, the Federal judicial process and Federal prosecution for significant gang targets. These combined efforts are using the expertise and enforcement capabilities available to disrupt domestic drug trafficking and related crime. (Action Item 5.3E)

Operation “Community Shield” (OCS) is the ICE-led National Gang Unit that connects ICE’s criminal and administrative enforcement authorities with state, local, and tribal law enforcement agencies to combat the growth and proliferation of transnational street gangs in communities throughout the United States. More than 350 ICE agents are involved in this effort, working with other law enforcement stakeholders to locate, investigate, prosecute and, if appropriate, remove gang members from the United States. Since the inception of OCS, ICE annual criminal arrests of gang members has grown from 306 in 2005 to more than 2,600 in 2010. The OCS program has been responsible for the arrest of more than 20,000

gang members or their associates. In addition, OCS agents have been responsible for seizing more than 1,700 firearms from the hands of gang members and their associates.

In 2010, ICE conducted Project “Southern Tempest”, an anti-gang initiative that included enforcement actions in 168 U.S. cities and involved the efforts of 173 other Federal, State, and local law enforcement agency partners. The operation resulted in the arrest of 678 gang members and associates and the seizure of 86 firearms. Nearly half of those arrested during this operation were members or associates of gangs affiliated with Mexican DTOs, and 322 had previous violent criminal histories.

In 2010, the Department of Justice established a partnership between the National Gang Targeting, Enforcement, and Coordination Center (GangTECC) and SOD. Under the terms of that partnership, which became effective with the signing of a charter and memorandum of understanding in July 2010, GangTECC became a unit under the operational lead of SOD. The GangTECC unit is positioned to expand coordination efforts, link and deconflict gang cases, and share investigative intelligence

Financial Investigations

In 2010, Federal, state, local, and tribal law enforcement partnered to deny drug traffickers almost \$3 billion in currency, property, and drugs. OCDETF component agencies conducted operations to disrupt drug traffickers’ smuggling of bulk cash. Efforts in the OCDETF Great Lakes, Mid-Atlantic, New England, New York/New Jersey, Southwest, and West Central regions opened 44 new investigations, secured 67 new indictments against 247 defendants, and obtained convictions of 194 defendants previously charged. (Action Item 5.3F)

On June 2, 2010, DHS released the Bi-National Criminal Proceeds Study (BNCPS) at a U.S.-Mexico Money Laundering Conference in Mexico City. The purpose of the study was to provide a strategic-level analysis of the processes and methods used by transnational criminals, particularly drug trafficking organizations, to repatriate illicit money from the United States into Mexico and other countries. Information collected from the study is being used by both the U.S. and Mexican Governments to deny criminals the ability to move money, and to ultimately dismantle their operations.

Operationally, ICE coordinated a summer financial investigative surge in furtherance of their enhanced investigative efforts targeting Mexican Criminal Enterprises (CEs) entitled Operation Overload. ICE special agents, CBP officers, and our Mexican counterparts collaborated to initiate joint enforcement initiatives targeting the movement of illicit proceeds into out of and through the United States and Mexico via physical (i.e., air, sea, and land ports of entry) as well as electronic (i.e., banks, money service businesses, etc.) modes of transmission. These surge efforts resulted in the initiation of 56 financial investigations, 104 arrests in both the United States and Mexico, and the seizure of over \$23.5 million in illicit proceeds.

In 2011, the Administration will publish the National Bulk Cash Threat Assessment, identifying major bulk currency collection hubs, transit routes, and stash locations throughout the United States. This important tool for all levels of domestic law enforcement and the Nation’s intelligence community will improve allocation of investigative and enforcement resources and better target the highest priority drug trafficking threats. (Action Item 5.3F)

The Department of Treasury’s Financial Crimes Enforcement Network (FinCEN) has built upon its relationships with authorities in all 50 States to support local law enforcement efforts to disrupt drug traffickers’

financial operations. FinCEN continues to use this network of contacts to more systematically obtain information from law enforcement agencies about criminal organizations and their financial activities. FinCEN is also working jointly with the government of Mexico to more accurately and efficiently report cross-border money flow trends and has increased its level of direct strategic coordination and information sharing. These accomplishments are a testament to the capabilities of targeted, collaborative enforcement efforts in disrupting domestic drug trafficking.

DEA has established a broad-based approach for investigating and disrupting illicit financial networks located throughout the United States and globally. By targeting the flow of revenue back to the narcotics sources of supply, DEA is able to hinder the financing of subsequent cycles of illicit drugs destined for the United States. Domestically, DEA conducts complex investigations aimed at identifying, documenting, and prosecuting major drug-money laundering and threat finance organizations. Financial Investigation Teams (FITs) have been established in all 21 DEA Domestic Field Divisions throughout the United States to assist in carrying out DEA's *Global Financial Attack Strategy*. Additionally, DEA builds capacity amongst other Federal, state, and local law enforcement agencies and interacts with the financial services industry regarding money laundering and threat finance matters.

One of the core goals of ICE is to target cross-border smuggling organizations and the organizations' illicit proceeds used to fund their criminal activities. ICE employs its expansive investigative authority and the largest force of investigators within DHS to protect the United States against transnational criminal networks and terrorist organizations that seek to exploit our borders and America's legitimate trade, travel, and financial systems.

National Parcel Post Initiative

In addition to targeting individual drug threats, domestic enforcement agencies are employing innovative tools to disrupt trafficking networks. One forthcoming domestic enforcement tool is the development of the National Parcel Post Initiative. (Action Item 5.3G) This initiative will help state and local law enforcement identify suspicious packages, analyze emerging trends in parcel post trafficking and interdiction, and learn about the appropriate procedures and guidelines for these types of investigations. The U.S. Postal Service (USPS), ONDCP, DHS, and private mail delivery services are developing a nationwide training effort for law enforcement officers so they can effectively counter the emerging trend of using mail couriers to traffic and distribute drugs. In addition, CBP, USPS, and Royal Mail (UK) have joined to implement a pilot program in 2011 to develop an inbound mail manifest system to identify and target suspicious international packages in airports.

Drug Endangered Children

Substance abuse has a devastating impact on families. Parental substance abuse is the primary reason for removal in 33.8 percent of cases involving children under one, and a quarter of cases involving children ages 2 to 8. Separating a child from his or her parents should be a last resort. Multi-system approaches should be employed to assess the needs of the family. When indicated, parents should receive treatment and other services to strengthen the family unit. Effective comprehensive treatment that supports families will need to target the multiple needs of infants, young children, and their families. This will mitigate the need for separation of parents and their children. The building of collaborative relationships among family-serving agencies, the assurance of timely access to comprehensive substance abuse

treatment services, the improvement of the ability to engage and retain clients in care and to support ongoing recovery, the enhancement of children's services and the filling of information gaps are all identified as important actions that must occur in order to improve outcomes for vulnerable children and families affected by substance use. For example, family drug courts and family-based treatment programs benefit children, families, and communities by diverting involvement in the criminal justice or child welfare systems and addressing needs in a holistic, family-centered way.

The 2010 *Strategy* called for a Federal interagency task force for Drug Endangered Children (DEC) to address drug use and its impact on children in a broader context. The term "drug endangered children" emerged during the dramatic increase in methamphetamine use and production in the 1990s, when children were found in homes where methamphetamine production caused toxic environments and caused abuse and neglect. The Task Force, established in May 2010, immediately expanded the definition of drug endangered children to include any person under age 18 affected by the production, distribution, and use of any drugs. This includes children who live in or are exposed to an environment where drugs are present, along with the associated physical, sexual, or emotional abuse, neglect, or other possible harms to their health and well-being.

In 2011, the task force plans to promote practices to prevent, intervene, and correct the profound harm that can result from drug use and its associated crime and violence. The task force is developing information on promising practices, as well as resource cards, reporting forms, and medical checklists for law enforcement, educational workers, and child protective services practitioners. These materials will be made available online and the cards, forms and checklists will be downloadable for mobile use. This will enable first responders, and adults who are responsible for children in other contexts, to conduct better assessments of children at risk and determine the appropriate actions to be taken. The DHS Federal Law Enforcement Training Center will provide training for first responders and multidisciplinary teams from states, localities, and tribal areas. (Action Item 5.3H)

All of these efforts will help reduce the profound devastation drug use and related crimes have on children.



Chapter 6. Strengthen International Partnerships

In countries where drug trafficking organizations threaten public safety and prevention efforts, our international drug control programs facilitate sharing of law enforcement and intelligence information and reduce illicit drug trafficking. They strengthen economic development, the rule of law, government institutions, and local communities seeking to reduce their own internal drug consumption.

When we help our partner nations defeat drug trafficking organizations and curb consumption, we also defend against one of the primary drivers of the growing global security threat posed by transnational organized crime. This challenge was described in the President's inaugural *National Security Strategy* in 2010:

“Transnational criminal threats and illicit trafficking networks continue to expand dramatically in size, scope, and influence—posing significant national security challenges for the United States and our partner countries. These threats cross borders and continents and undermine the stability of nations, subverting government institutions through corruption and harming citizens worldwide. Transnational criminal organizations have accumulated unprecedented wealth and power through trafficking and other illicit activities, penetrating legitimate financial systems and destabilizing commercial markets. They extend their reach by forming alliances with government officials and some state security services.”

—2010 National Security Strategy

Principle 1. Collaborate with International Partners to Disrupt the Drug Trade

The global reach and sophistication of major DTOs necessitates international collaboration and flexibility to effectively break these illegal networks. In Monrovia, Liberia, the DEA, in coordination with Liberian officials, conducted an unprecedented undercover operation in which seven defendants were arrested on U.S. charges. Drug trafficking organizations based in South America have used countries along the West African coast as trans-shipment hubs for importing cocaine to be distributed in Europe and Africa. Through a combination of privately owned aircraft and maritime vessels, these organizations, predominantly based in Colombia and Venezuela, have transported hundreds of tons of cocaine, worth billions of dollars, to places such as Guinea Bissau, Guinea Conakry, Sierra Leone, Togo, Mali, Ghana, Nigeria, and Liberia. In so doing, representatives of these drug trafficking organizations have often sought to bribe high-level public officials with large cash payments and narcotics in order to ensure the safe passage, storage, and distribution of their cocaine shipments. Efforts to disrupt drug trafficking organizations not only work to reduce cocaine trafficking in Africa, but reduce the amount of illicit proceeds returning to South American-based drug trafficking organizations.

In Karachi, Pakistan, DEA and Pakistan Customs officials coordinated seizure of 15.8 metric tons of acetic anhydride, a precursor chemical used in the manufacture of heroin. In Australia, DEA and the Australian Federal Police (AFP) seized 460 kilograms of cocaine and two vessels off the coast of Australia. This was the third largest cocaine seizure by the AFP. In Bulgaria, DEA and Bulgarian National Police seized 8.25 metric tons of acetic anhydride. (Action Item 6.1A)

Federal agencies also increased their focus on international demand reduction to help partner nations address their own drug consumption problems. Working bilaterally and through the Organization of American States (OAS) Inter-American Drug Abuse Control Commission (CICAD) and the United Nations Office on Drugs and Crime (UNODC), ONDCP promoted the exchange of best practices information and the latest research on what works to reduce drug use. For example, the United States Government took the lead in promoting community-based prevention and prescription drug abuse prevention at the United Nations 51st Commission on Narcotic Drugs in April 2010. Through ONDCP's leadership, two resolutions on these issues received broad support and helped to advance dialogue on the importance of international demand- and supply-reduction efforts.

In our hemisphere, the United States served last year as Chair of CICAD, during which the Commission approved the Hemispheric Drug Strategy, which sets out a comprehensive approach for counterdrug cooperation in the hemisphere. CICAD also started the process of developing a Plan of Action to carry out the strategy. In addition, the United States served as Vice Chair under Mexico's Chairmanship of the CICAD Demand Reduction Experts Group, which developed the Basic Principles of the Treatment and Rehabilitation of Drug-Abusing and Drug Dependent Persons in the Hemisphere. This document provides guidelines to inform policies and practices related to the provision of drug treatment services in OAS member states. In December 2010, the U.S. was elected to succeed Mexico as the Chair and will focus the group's work on evidence-based approaches to community prevention. (Action items 6.1B and 6.1E)

United States/European Union (E.U.) Bilateral Drug Exchange

Another important mechanism for building international partnerships is the twice-yearly U.S./E.U. bilateral drug exchange. During these meetings, the United States provides an update on implementation of our *Strategy*, learns about the drug-related priorities of the European Union, and discusses how to improve coordination on key international issues, such as drug trafficking in West Africa. Over the next year, this forum will be employed to improve the coordination of international aid and development assistance, law enforcement training, and demand reduction programs we jointly provide to developing nations grappling with drug-related challenges. (Action Item 6.1C)

Multilateral Engagement

In March of this year, the United States organized a widely attended discussion of the drugged driving threat, one of ONDCP's signature initiatives, during the annual Commission on Narcotics Drugs (CND) meeting in Vienna. This meeting, the largest annual gathering of government officials on the subject of drugs, is organized each year by the UNODC. This year, the CND passed a U.S. proposed resolution on drugged driving, a subject that has emerged as a major problem around the world, in part due to the growing use of prescription drugs. The resolution, co-sponsored by 17 countries and the European Union, will foster information exchange among countries on different approaches to this problem,

encourage joint research, and accelerate efforts by governments and the UNODC to develop comprehensive responses to the threat posed by drugged driving. Later in the year, the United States will participate in a global research conference in Montreal on the subject of drugged driving. (Action Item 6.1E)

The United States participates in a range of vital regional counternarcotics initiatives and facilitates cooperation through observer positions manned by DEA personnel. The Southeast European Cooperative Initiative for Combating Trans-Border Crime (SECI), located in Bucharest, Romania, supports common trans-border crime fighting efforts of participating countries and enables law enforcement agencies to collaborate on joint investigations that target trans-border criminals, including drug traffickers.

The Central Asian Regional Information and Coordination Centre (CARICC) combats the illicit trafficking of narcotic drugs, psychotropic substances, and their precursors throughout Central Asia. The CARICC coordinates multilateral international investigations, including controlled deliveries, and provides training to member states that enhance their investigation and drug prevention efforts.

Russia

New Action Item: Enhance the Relationship Developed with Russia Under the U.S.-Russia Bilateral Presidential Commission to Encourage Counternarcotics Cooperation [ONDCP, State, DOJ/DEA, DHS/ICE, Treasury, HHS, DOD]

This Administration established a Counternarcotics Working Group under the Bilateral Presidential Commission co-chaired by ONDCP Director Gil Kerlikowske and Russian Federal Drug Control Service (FSKN) Director Viktor Ivanov. The Working Group addresses a range of drug control issues between the United States and the Russian Federation, including reducing narcotics originating in Afghanistan; disrupting financial operations of major DTOs in Central Asia; and exchanging information and best practices on demand reduction programs.

In October 2010, in conjunction with the most recent meeting of the Counternarcotics Working Group, Russian officials visited drug treatment sites in Baltimore, as well as sites at NIDA and SAMHSA, to learn more about U.S. demand reduction programs. In 2011, ONDCP will continue to seek to enhance Russian/U.S. counternarcotics cooperation in close collaboration with agencies such as DEA, Education, and SAMHSA, the Treasury Department's Terrorist and Financial Crimes division, and the Departments of State and Justice, among others. Success in this bilateral relationship can lead to future cooperation among countries throughout the Central Asian region in reducing the output of the world's major opium and heroin-producing organizations.

To support the interdiction initiatives, the Northern Route Working Group (NRWG) was established in 2010 to share drug trafficking trends and coordinate investigations in northern Afghanistan. Member agencies include the FSKN, Tajikistan Drug Control Service, Kyrgyzstan Drug Control Service, and DEA Country Offices in Dushanbe, Kabul, and Moscow.

Health Interventions for Injection Drug Users

The Administration is dedicated to stopping the nexus between HIV and drug use. The President's Emergency Plan for AIDS Relief (PEPFAR) continues to work with governments worldwide on synchronizing drug control and HIV prevention and treatment. In combating the problem, special attention has been paid to comprehensive HIV prevention services for injection drug users (IDUs) that include

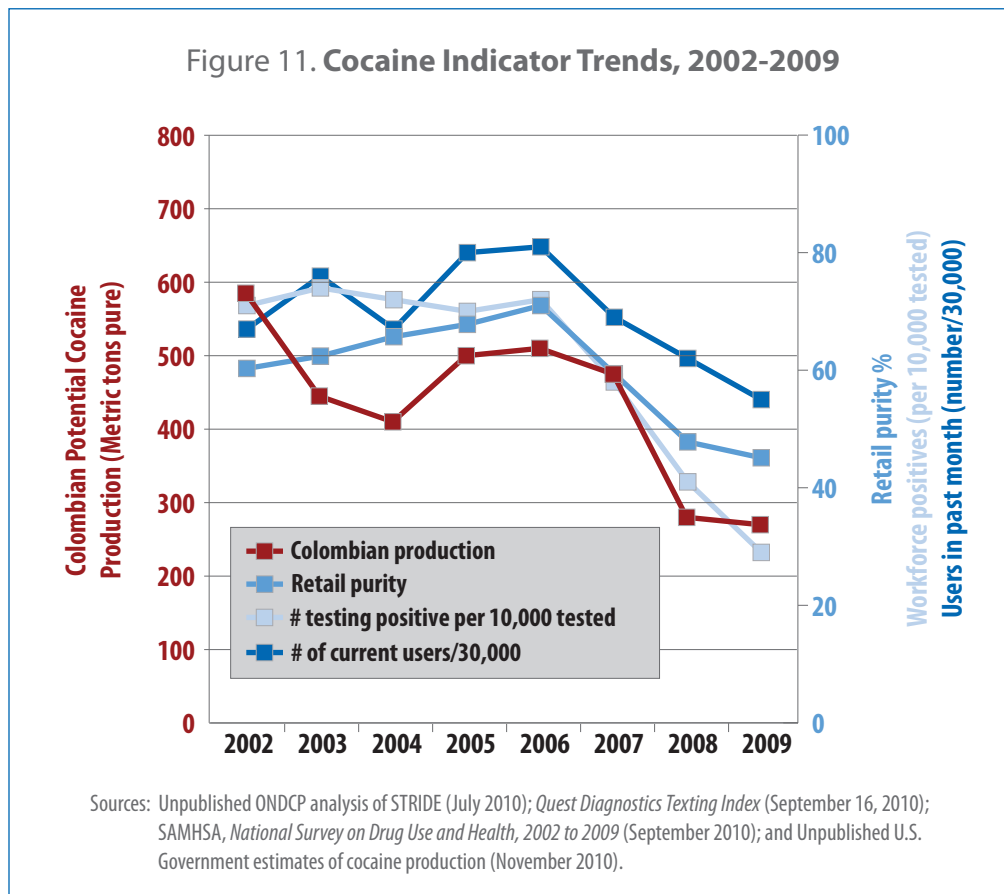
providing HIV prevention education. The recommended core package of comprehensive HIV prevention services for IDUs includes needle and syringe programs; drug treatment (including medication-assisted treatment for opioid dependence); HIV testing and counseling; antiretroviral therapy for HIV-positive IDUs; prevention and treatment of sexually transmitted infections; condom programs for IDUs and their sexual partners; targeted information, education, and communication for IDUs and their sexual partners; vaccination, diagnosis, and treatment of viral hepatitis; and diagnosis and treatment of tuberculosis. (Action Item 6.1F)

Principle 2. Support the Drug Control Efforts of Major Drug Source and Transit Countries

Western Hemisphere

Efforts by the United States and partner nations have achieved major and sustained progress against cocaine use and distribution throughout the Western Hemisphere. Multiple data sets reflecting both demand and supply dimensions of the cocaine threat indicate significant progress in disrupting the international market for cocaine. First, potential cocaine production, particularly in Colombia, has decreased dramatically, due to sustained aerial spraying and manual coca crop reduction over several years. In other areas, mandatory coca elimination and alternative development programs have contributed to a thriving agricultural economy. There was a 72 percent decline in illicit coca over a three-year period in the San Martin area of Peru's Upper Huallaga valley, a historic epicenter for global cocaine drug trafficking. (Action Item 6.2H)

Declining border seizures, increased street price, and falling cocaine retail purity all attest to reduced availability of the drug in U.S. markets. Further, domestic consumption of cocaine has declined sharply during this same time period, as shown by prevalence surveys, arrestee and workplace drug testing results, and changes in the types of drugs for which individuals are seeking treatment. Taken together, the data show a major and persisting impact on the cocaine threat.



The United States will continue to strengthen partnerships around the globe to address all aspects of the drug problem. We will look to re-shape and invigorate our collaboration with the countries in the Western Hemisphere, beginning with the development of a Western Hemisphere Counternarcotics Strategy, to be published in the summer of 2011. (Action Item 6.2G)

Merida Initiative

The Government of Mexico has responded with tremendous resolve and commitment to directly counter drug trafficking organizations. The United States, as the primary market for drugs coming from and through Mexico, is cooperating with Mexico under the Merida Initiative. The Merida Initiative is a \$1.4 billion dollar program providing equipment and training to Mexico. The assistance falls within four areas: disrupting drug trafficking organizations, strengthening the institutions of law enforcement, creating a more secure border, and building stronger communities.

The United States provided equipment and training, including three Black Hawk UH-60M helicopters delivered to Mexico's Federal police in November 2010. The United States has also provided non-intrusive inspection equipment for mobile checkpoints, delivered eight Bell 412 transport helicopters for the Mexican Secretariat of National Defense (SEDENA), and accelerated the anticipated delivery of three UH-60M Blackhawks for the Mexican Secretariat of the Navy (SEMAR) by 2 years to September of

this year. The U.S. will continue our strategic engagement with Mexico, but the focus will change from providing equipment to assisting with training and coordination.

For example, the U.S. Navy, working with the Coast Guard and other partners, has increased cooperation with SEDENA and SEMAR on aerial, maritime, littoral, and amphibious counternarcotics operations. The frequency of planned U.S.-Mexico maritime counternarcotics cooperative operations increased from 4 in 2008 to 10 in 2009 to 24 in 2010. In addition, SEDENA posted a liaison officer at U.S. Northern Command headquarters in 2009, and SEMAR has liaison officers posted at Joint Inter-Agency Task Force (JIATF)-South and Fleet Forces Command, in addition to U.S. Northern Command.

Such assistance will help Mexico confront the violent drug trafficking organizations more effectively, reform their institutions and enhance support for the rule of law, build a secure border, and build resilient communities that work together with Federal, state, and local officials to prevent criminal activity and mitigate the negative consequences of the drug trade. (Action Item 6.2A)

An increasingly important enhancement of the initiative is support for Mexico's strategy to create conditions in communities that will make drug prevention permanent and sustainable. In December 2010, ONDCP worked with partners in both the U.S. Government and the Government of Mexico to organize Bi-National Cross Border treatment and prevention training conferences in El Paso and San Diego. This pilot program focused on strengthening prevention and treatment approaches at the community, school, and individual levels, coalition building, and introducing the Government of Mexico's "Treatment and Prevention Toolkit," which will be used as a training program for U.S. and Mexican students in border regions.

The Initiative has also led to unprecedented bilateral anti-crime information sharing and collaboration, including the placement of vetted Mexican law enforcement professionals within EPIC and the Air and Marine Operations Center. Increased information exchange, expedited operational communications, and the resulting increase in operational capacity between the United States and Mexico have enabled more complex and effective investigations, thereby enhancing interdiction and producing more king-pin arrests. In addition, data from 2007 to 2010 show that CBP and ICE have increased their seizure of southbound illegal currency and enhanced efforts to disrupt the flow of weapons into Mexico.

In response to the violence in Mexico, Central America, and the Caribbean, the Administration continues to expand our cooperation with the Government of Mexico, as well as with governments in Central America and the Caribbean through the Central America Regional Security Initiative (CARSI) and the Caribbean Basin Security Initiative (CBSI), by supporting their courageous efforts to disrupt the drug trade and neutralize its corrosive effects on government institutions and society.

Through CARSI, the U.S. Government provides equipment, training, and technical assistance to support immediate law enforcement and interdiction operations, as well as strengthen the capacities of Central American governmental institutions to address security challenges and the underlying economic and social conditions that contribute to them. The work with these Central American communities helps increase both citizen safety and their resilience against criminal threats.

Through the CBSI, the United States and its Caribbean partners developed a political framework focused on improving citizen safety by substantially reducing illicit trafficking, increasing public safety and security, and promoting social justice. The United States and Caribbean nations also agreed on four technical working groups aimed at implementing the CBSI Joint Plan of Action. (Action Items 6.2C, 6.2D, and 6.2F)

The four technical working groups address maritime security, information sharing, law enforcement strengthening, and crime prevention. They coordinate the implementation of ongoing regional efforts, discuss current unmet needs and deficiencies in the region, and explore potential cooperative efforts at filling those needs.

Afghanistan

Efforts to promote interdiction and develop law enforcement in the global arena, as exemplified by U.S.-led programs in Afghanistan, continue to make progress. In March 2010, the U.S. Government published a revised counternarcotics strategy for Afghanistan that focused on counternarcotics efforts as a means to help provide greater security for the Afghan populace. The counternarcotics strategy has become a supporting document to our overall Afghan stabilization strategy, which promotes sustainable licit economic opportunities as well as increasingly self-reliant and effective law enforcement and judicial entities.

Bilateral law enforcement programs, led on the U.S. side by the DEA, contribute to successful prosecutions of trafficking organizations and help ensure drug kingpins around the world do not operate with impunity. In March 2010, for example, Criminal Justice Task Force judges convicted and sentenced a Counternarcotics Police-Afghanistan Operational Commander to a 15-year prison term for violation of drug trafficking laws. The arrest and prosecution stemmed from an undercover operation initiated by the DEA Sensitive Investigative Unit. (Action Item 6.2B)

The Administration is focused on redevelopment of the agricultural economy in Afghanistan to facilitate job growth and raise incomes for rural families. To re-connect the Afghan people to the licit economy, the United States Agency for International Development (USAID) provides agricultural assistance to rural families through the Afghanistan Vouchers for Increased Production in Agriculture (AVIPA plus) program. In 2010, USAID distributed agriculture voucher packages to more than 466,000 farmers throughout 20 provinces in Afghanistan. In 2011, USAID is implementing a complementary program to AVIPA with the goal of amplifying current successes and sustaining gains made in security and stability.

Guiding the Recovery of Women (GROW)



treatment and family therapy. The basic GROW course has been piloted in a women's residential facility in Guyana, in incarceration and therapeutic community settings in Brazil, and with Kenyan, Nigerian, Afghan, and Brazilian treatment professionals through study tours in the United States. Additional GROW training is scheduled for treatment professionals in South Africa, Afghanistan, and Ecuador in 2011.

Although potential opium production has declined in Afghanistan for 3 consecutive years, limited access to treatment and ready access to illicit opium has resulted in alarming addiction rates among Afghans, with approximately 120,000 women and 60,000 children addicted. To help Afghanistan address their addiction problem, the State Department has partnered with the Afghan Ministry of Counter Narcotics (MCN), the Colombo Plan Drug Advisory Program (CPDAP), and the UNODC to open 26 new treatment facilities since 2007, including six residential treatment facilities for women, six for children, and two for adolescent males. In 2011, three new centers will open, including an adolescent female center in Kabul. With these facilities, enhanced treatment methods, training through the GROW program, and other U.S.-funded Colombo Plan initiatives, the U.S. Government is working closely with the MCN to continue to improve access to gender-responsive treatment in Afghanistan.

Central America and the Andes

In Central America this past year, through the CARSI program, the International Law Enforcement Training Academy in El Salvador trained approximately 450 law enforcement officers from the seven CARSI countries. In just 3 months of 2010, the Transnational Anti-Gang Unit in El Salvador handled 141 investigative leads and disseminated information to domestic and international law enforcement agencies. CBP, working with CARSI national border forces, conducted assessments of more than 30 land, sea, and air entry points throughout the region and has provided training using non-intrusive inspection equipment provided by the State Department. USAID continued its work in crime and violence prevention, working with local and national governments, civil society, and community leaders to build comprehensive prevention approaches and provide opportunities for youth at risk of becoming involved in the narcotics trade and substance abuse. (Action Item 6.2F)

In the coca-producing Andean region, U.S. assistance supports Colombia's Strategic Development Initiative. The program expands government presence, control, and development opportunities in zones subject to influence by drug traffickers and illegal armed groups. U.S. support helps retain and make permanent the government control of territory once dominated by illegal actors, and strengthens democratic institutions. It promotes good governance, respect for human rights, and social and economic development. USAID alternative development activities in Colombia coordinate with these efforts by providing opportunities for alternative livelihoods that provide licit jobs and income. In Peru, U.S. development assistance supports coca eradication, interdiction, and alternative development programs that strengthen economic and social stability in coca growing areas. The best example of the success of these programs is in the transformation of the San Martin region of Peru from a coca growing area to a viable producer of legitimate crops.

In Bolivia, USAID continues to work with Bolivian Government counterparts, non-governmental organizations, and the private sector to reduce poverty and food insecurity, provide alternative, licit opportunities for employment and income, improve health services and education, protect the environment, and combat narcotics trafficking. In Ecuador, considered a significant narcotics transit country, USAID alternative development programs worked with the Government to provide opportunities for increased jobs and income through licit agricultural and forest management activities.

The United States will continue to work closely with Colombia, a strategic partner in efforts for our hemisphere. Our efforts under the Colombia Strategic Development Initiative will consolidate and build upon the accomplishments made during the past 10 years against both cocaine and heroin production through focused eradication and alternative development programs. The transition of U.S.-supported counternarcotics programs to the Colombian government will continue in 2011. (Action Item 6.2H)

Principle 3. Attack Key Vulnerabilities of Drug Trafficking Organizations

Transit Zone (Action Item 6.3B)

The national cocaine interdiction goal, first established in 2007, calls for removing 40 percent of documented cocaine moving through the transit zone by 2015.¹⁰⁸ Annual interim targets, increasing by two percentage points per year, were established to incrementally bridge the gap between the historical 24 percent average removal rate and the 40 percent goal. The interim 30 percent cocaine removal target for FY 2010 was achieved. U.S. law enforcement, working in conjunction with Joint Interagency Task Force South (JIATF-South) and partner nation forces, will continue to pursue the goal of 40 percent removal by 2015; the target for 2011 is 32 percent.

Interdiction in the Transit Zone



The U. S. law enforcement community, working in conjunction with JIATF-South and allied and partner nation forces, met the 2010 cocaine removal rate target of 30 percent of total documented movement through the Western Hemisphere Transit Zone. U.S. interdiction forces, working together with allied and partner nation support through bilateral agreements and USCG Law Enforcement Detachment (LEDET) deployments, removed 244 metric tons of the 804 metric tons of total documented cocaine movement

in FY 2010. In pursuit of a 40 percent removal goal by 2015, the interim goal percentages will increase incrementally each year.

Interdiction challenges continue to grow and include reduced visibility of the threat in 2010, in concert with constantly evolving and ever-more clandestine means, methods, and modes of conveyance used by traffickers. In July 2010, the first fully submersible trafficker submarine, in its last phase of construction, was seized in the Ecuadoran jungle, and in February 2011 another was captured just prior to its departure from the mangroves of southwestern Colombia. These challenges will increase our emphasis on international partnerships and investigations, and will make evolution of interdiction tactics, techniques and procedures, and continued force provider support to JIATF-South even more critical to success in the future. To this end, the USCG sponsors a semi-annual Counter Narcotics Multilateral Summit to address gaps and shortcomings in combined littoral operations and emerging legal issues among the countries in the primary threat vector from the source countries in South America through Central America and Mexico. (Action Item 6.3.B)

Along with the successes, there remain many challenges. While the decline in cocaine availability in the United States has been welcome news, there is still a widespread global market for the drug. In addition, routes through West Africa reach expanding cocaine markets in Europe. Accordingly, although we will continue to work with our international partners to increase seizures of illicit drug shipments as close to their source as possible, where the return on investment in interdiction efforts is greatest, we will also support countries affected by shifting transit routes. We will also continue to work with our partners around the globe to implement both supply and demand reduction strategies that are tailored to each country's unique situation.

Finally, in response to the increasing convergence of transnational criminal threats—including expanded linkages between organized crime and drug trafficking groups—the U.S. Government will issue a new comprehensive national strategy in 2011 to address transnational crime and the threat it poses to governance around the world.



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

Over time, the application of science to drug problems has improved, relying on better research methods for data planning, collection, and analysis. Yet gaps in research make it difficult for policy makers to respond to emerging drug threats. For instance, national data that are available regarding our fastest growing drug threat—prescription drug abuse—are sometimes several years old, discounting their usefulness. Many other data gaps remain in the areas of prevention, recidivism, and drugged driving, to name a few. Also, with the evolution of drug policy, there are often innovations in one system that save money in another, such as family-based treatment. These impacts are valid and must be captured.

The consequences of drug use to society are important to measure to better understand both the scope of the problem and the scale of response required. In today's difficult fiscal environment it is especially important to accurately understand the full impact of drug use. Drug problems intersect with, and contribute to, many other social ills, including child abuse and neglect, school failure, poverty, mental illness, criminal activity, and a wide array of health problems in addition to addiction. Drug use also has tremendous implications for health care in America. With healthcare reform comes both a great opportunity to provide coverage for needed treatment services but also greater scrutiny of the effectiveness of treatment for substance abuse and dependence and increased demands for improving quality and assuring measurable results.

As the volume of prescriptions for medicines has increased dramatically in recent years, so too has abuse of pain relievers and other medications. Abuse of prescription drugs brings forth new data and research challenges regarding prescribing policies, consequences of abuse and misuse, and the relative effectiveness of prevention, treatment, and law enforcement approaches. The scale and complexity of the prescription drug problem demonstrate the need to secure quality data in a timely manner to fully understand the threat and ensure an appropriate national policy response to address it.

Principle 1. Existing Federal Data Systems Need to Be Sustained and Enhanced

Enhancing the Drug Abuse Warning Network System

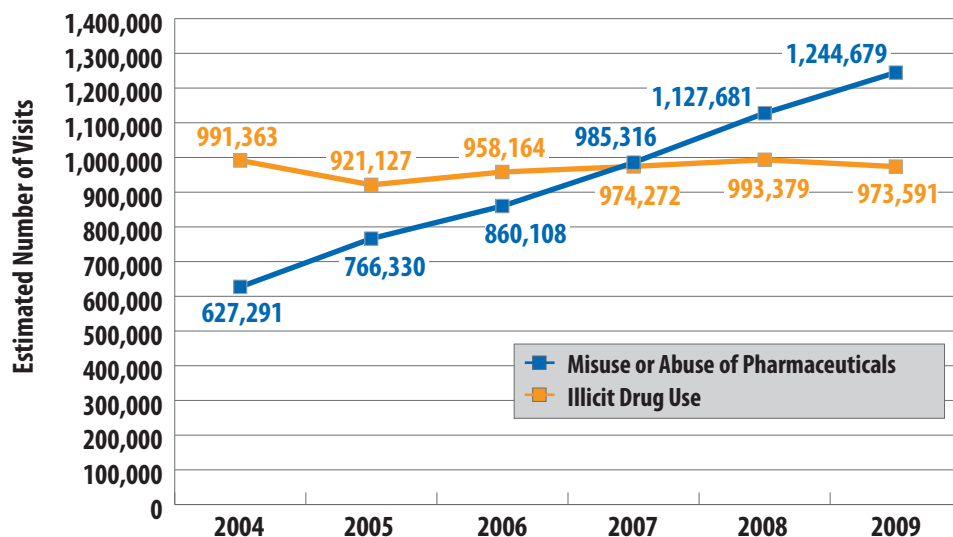
The Drug Abuse Warning Network (DAWN) system provides national and local-area estimates of drug-related emergency department visits and drug-related mortality. Unfortunately, there have been several challenges to enrolling emergency departments into the DAWN sample, including reluctance on the part of the emergency departments to open their patient files to review and the cost associated with this review. These challenges have resulted in low response rates (i.e., less than 50 percent of the selected emergency departments have agreed to participate in the sample) and, consequently, concerns about the accuracy of the resulting estimates). To address these challenges, SAMHSA has

initiated discussions with the CDC and FDA to develop a collaborative survey design built upon the existing National Ambulatory Care Survey (NACS) that will enable the DAWN system to continue to be capable of providing critical and accurate data on the health consequences of illicit drug use, including the misuse of medications. The NACS is an existing survey of nearly 500 emergency departments. Under the proposed plan, the NACS will incorporate drug-related variables currently collected by DAWN. By utilizing the NACS' larger and more stable sample, the problem of DAWN's low response rates will be resolved. (Action Item 7.1A)

Drug Abuse Warning Network

According to DAWN, which provides national estimates on individuals who experience drug-related medical emergencies that are severe enough to require treatment in an emergency department, there were approximately 1.2 million visits by individuals to hospital emergency rooms involving pharmaceutical drugs in 2009. This is nearly a doubling in such visits over the past 5 years—from 627,000 visits in 2004. In contrast, in 2009, there were 974,000 visits involving illicit drugs; these visits have been relatively stable since 2004. Visits to emergency departments involving pharmaceutical drugs do not include adverse reactions to such drugs taken as prescribed or indicated.

Figure 12. **Emergency Department Visits Involving Illicit Drugs or Non-medical Use of Pharmaceuticals, 2004-2009**



Source: SAMHSA, *Highlights of the 2009 Drug Abuse Warning Network (DAWN) Findings on Drug-Related Emergency Department Visits* (December 2010).

Improving the National Survey on Drug Use and Health

SAMHSA's NSDUH is the Federal government's primary survey on substance use among the U.S. population. Over time, much has been done to improve NSDUH, including expanding the sample size to permit state-level estimates; introducing computer-assisted self-interviews to improve confidentiality and response rates; and including questions to better estimate treatment need, methamphetamine prevalence, and drug market characteristics. Opportunities to improve the NSDUH remain, however, so SAMHSA has begun a review to identify areas and means by which it can be enhanced or redesigned. (Action Item 7.1B)

Trends in the Price and Purity of Illegal Drugs

DEA maintains the System To Retrieve Information on Drug Evidence (STRIDE) as an inventory of drug specimens obtained through seizures or undercover purchases. DEA uses the STRIDE data for support of investigations and court cases; however, they are also useful to analysts for tracking trends in the price and purity of specific drugs, yielding important strategic data on drug markets. DEA is working directly with ONDCP to enhance the functionality of STRIDE. (Action Item 7.1D)

Arrestee Drug Abuse Monitoring Program

In 2007, ONDCP revived the Arrestee Drug Abuse Monitoring (ADAM) program to survey recently booked arrestees in 10 U.S. counties. The survey includes collection of a urine specimen for drug testing. This criminal justice population is under-studied. The ADAM II data provide critical information on the nexus between drug use and crime. In 2010, NIJ and BJS sought to identify ways to improve cost-efficiency through survey techniques that enhance data quality and information utility.¹⁰⁹ However, ONDCP continues to have principal responsibility for funding and managing ADAM II data collection and dissemination of data and reports. (Action Item 7.1E)

Developing Measures of Drug-related Crime

This study, to be conducted via a contract currently under solicitation, will develop a methodology to estimate drug-involvement and test the methodology using data from Uniform Crime Reports, the National Incident Based Reporting System, and other relevant data sources.

Principle 2. New Data Systems and Analytical Methods to Address Gaps Should Be Developed and Implemented

Drugged Driving Data

ONDCP is highlighting the issue of drugged driving and educating the public about the inherent dangers of driving after using drugs. We have partnered with DOT and NHTSA to raise the level of awareness about this problem which was highlighted by the findings in NHTSA's 2007 Roadside Survey.¹¹⁰ This survey found that 1 in 8 weekend night time drivers tested positive for illicit drugs. In addition to the Roadside Survey, data are needed to better inform Federal and state policy makers about the extent of the problem and how best to respond to this often underestimated problem. For example, the Fatality Analysis Reporting System documents the circumstances of fatal traffic crashes, including whether alcohol or drugs were involved. Unfortunately, however, many states do not routinely test drivers involved

in these crashes for the presence of drugs. A recent study by NHTSA found that one-third of the drivers killed in traffic crashes, and who were tested for drugs and whose results were known, tested positive for drugs.¹¹¹ A promising approach to countering the drugged driving problem is administrative per se laws, which provide for drug testing to detect the presence of illicit drugs (or in some states, medications that can impair driving) in drivers' bodies. Such detected presence is sufficient proof for violation of the law; it is not required that a level of impairment be established, as with alcohol, since the substance being tested for is illegal (or, in the case of medications, should not be taken prior to driving a motor vehicle). (Action Item 1.5B)

NHTSA is accelerating the schedule for the next National Roadside Survey to provide more timely data on the prevalence of drugged driving. In addition, ONDCP is supporting SAMHSA in assessing whether laboratory toxicology standards for detecting the presence of drugs or drug metabolites in oral fluids can be established. This project will assist prosecutors to successfully bring drugged driving cases to court. ONDCP is also supporting NIDA in conducting a driving simulator study to determine the behavioral impact on driving after consuming marijuana. Results from the research will assist law enforcement in determining whether drivers using marijuana are impaired.

ONDCP's Federal partners also are leading projects that have advanced the goals of the 2010 *Strategy*, such as the transitioning of drug seizure tracking to the National Seizure System (NSS). DEA, EPIC, and ONDCP are committed to ensuring all existing seizures in the Federal Drug Seizure System (FDSS) are included in the NSS. Further, all new seizures and related information will go directly to the NSS, which will allow for the retirement of the FDSS. This effort will evaluate the inclusion of additional drug information to the NSS and will result in more robust statistical and analytical products for NSS customers. By engaging in this effort, DEA can assist in streamlining intelligence dissemination and provide its Federal, state and local partners with information that is crucial for their success. (Action Item 7.2B)

Constructing a Composite Index of Drug Use Consequences

Several of the *Strategy* goals focus on reducing the consequences of drug use, including drug-induced deaths, drug-related mortality, and drugged driving. ONDCP is currently funding a project with the University of South Carolina to assess data on these consequences and others (e.g., crime, economics, quality of life) to develop national and state-level composite indexes of drug consequences that can be used by policymakers, analysts, and consumers.

Studies Designed to Improve the Field of Available Data on Drug Matters

- **Increasing our knowledge about the effectiveness of Hawaii's HOPE probation.** To learn about the long-term outcomes of HOPE probationers, NIJ is conducting a follow-up of the 2004 through 2006 cohort of HOPE probationers. The study will examine long-term outcomes including successful completion of probation, absconding, rearrest, revocation, and incarceration outcomes.¹¹² NIJ is also exploring the possibility of conducting a rigorous multi-site replication of HOPE to test the effectiveness of the program in other jurisdictions.
- **Evaluating Delaware's Decide Your Time Program for Drug-Using Offenders Under Community Supervision.** In consultation with the NIDA, and with funding from ONDCP, the NIJ is supporting a test of deterrence while under community supervision. The Decide Your

Time program employs the principles of certain apprehension and swift response using graduated sanctions and incentives to reduce relapse, violations, and recidivism among drug-using offenders.¹¹³

- **Content analysis of drug and alcohol depiction on social media sites.** More and more, teens are spending their free time on the Internet where they may be potentially exposed to a wide variety of messages that present drug use as normal. ONDCP is currently soliciting for a study to assess how drugs and drug use are depicted on social networking web-based sites.
- **Drug indicator data purchases.** ONDCP is currently planning a project to acquire either data and/or analyses of prescriptions for controlled substances from a commercial vendor's tracking system to assist in the assessment of the diversion of these substances into illicit markets. These data will afford insight into the quantities of prescription that are diverted and, subsequently, abused.
- **Enhancing data regarding global illicit drug markets.** Working with interagency counterparts including DHS, DEA and DOD, ONDCP continues to improve the analyses of various data sets such as the Consolidated Counterdrug Database (CCDB) for a better understanding of the magnitude and trends in illicit drug supply and demand, and the Interagency Assessment of Cocaine Movement (IACM), which estimates cocaine flow from South America toward the United States and other markets. Improvements include the following: providing subject matter expertise in drafting a charter for the CCDB, a key information source for the IACM; updating CCDB's business rules to improve efficiency; expanding the scope of the database and implementing methodological improvements; and expanding interagency participation in the IACM analytical process. Another example of data improvements is enhanced forensic analyses of illicit drug specimens to provide a better understanding of the time between cocaine production and its arrival in U.S. retail markets. ONDCP will also be updating two past reports that estimate illicit drug availability in the United States: one using a demand-based approach by estimating consumption, and the other using a supply-based approach of calculating the net drug supply after subtracting drug removals from production estimates. To further advance the world-wide effort to reduce illicit drug demand and supply, data and analyses from these efforts are shared with the world community through the completion of UNODC's Annual Report Questionnaire. (Action Item 7.2C)

Principle 3. Measures of Drug Use and Related Problems Must Be Useful at the Community Level

While many policymakers look at the drug problem nationally, communities understand their problems locally, based on whatever evidence is available. National indicators may bear only slight resemblance to drug problems in any particular community. Yet all too often, quality data are limited or missing altogether, leaving communities with little empirical basis for determining their focus, and even greater challenges in evaluating the worth of policies and programs they employ. Solutions to the drug problem must be focused locally, involving local approaches, but supported by a national strategy that is based on the best-available science.

The mix of law enforcement, prevention and treatment strategies require a careful balance, and the basis for such decisions should be based not only on epidemiological data but also on evidence of effectiveness, which is still all-too-scarce. The *National Drug Control Strategy* places a priority on improving the system for data collection and analysis, both to spot emerging drug threats and to allow communities to identify their drug problems and design approaches that will work.



Conclusion

The 2010 *National Drug Control Strategy* provided a roadmap for how to achieve ambitious 5-year goals of reducing drug use and its consequences. Since the publication of the *Strategy*, National Drug Control agencies have worked diligently to accomplish these goals, their progress has been tracked through a multi-agency reporting mechanism, and many of their accomplishments are detailed in this document.

Successful counterdrug efforts rely not just on the efforts of Federal drug control agencies, but on cooperation between the state, tribal, and local entities that work every day to reduce drug use and its consequences. This *Strategy* highlights some of the non-Federal programs that demonstrated outstanding success or a unique approach to the problems facing their communities. To truly accomplish our goals, state, local, and tribal governments must also implement smart policies.

Healthy and drug-free communities strengthen the country by creating a workforce ready to respond to the needs of a changing global economy, assuring the safety of our schools and streets, and creating healthy families and communities. This is how we win the future. In the coming year, the Administration will continue to work with partners, both Federal and non-Federal, to accomplish our goals. An update to this document will be published next year at this time.



Director's Closing Remarks

In this document, I have put forward programs and policies that make good use of Federal resources in order to save lives while saving states, communities, and businesses money. Prevention must occur in every setting and be embedded into the fabric of our communities. Treatment and recovery are real and effective. The disease of addiction is unfortunately often obscured by denial. Unlike most diseases, the afflicted often do not seek assistance for their illness. Therefore, treatment must sometimes be coupled with encouragement and sometimes with consequences—thus in non-traditional settings, such as the criminal justice system.

Since the start of this Administration everywhere I've traveled and in every meeting I've attended, I've received helpful feedback from people who work daily in drug control, whether in prevention, treatment, law enforcement, or diplomacy. My staff and I will continue tirelessly to identify the strengths and weaknesses of our current efforts and study novel approaches for wider implementation.



Appendix One

National Drug Control Strategy Goals to be Attained by 2015

Goal 1: Curtail illicit drug consumption in America

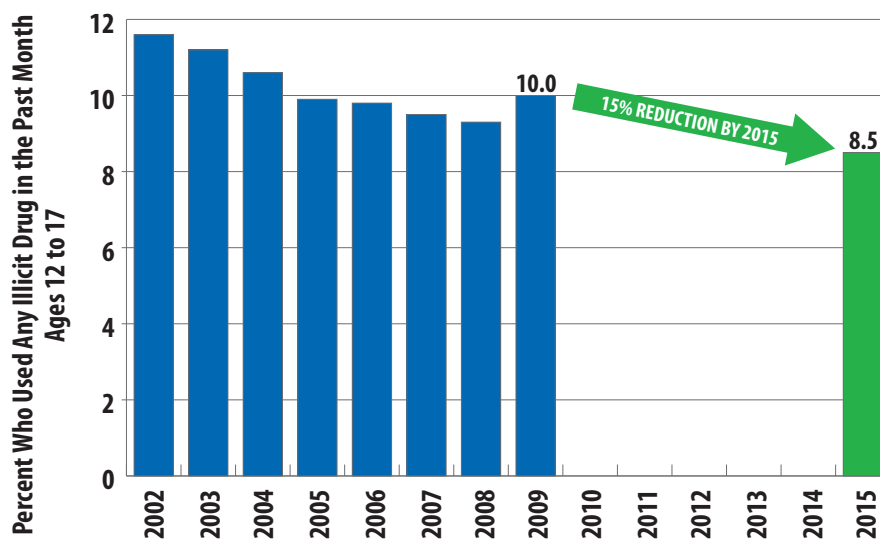
- 1a. Decrease the 30-day prevalence of drug use among 12- to 17- year- olds by 15%
- 1b. Decrease the lifetime prevalence of 8th graders who have used drugs, alcohol, or tobacco by 15%
- 1c. Decrease the 30-day prevalence of drug use among young adults aged 18–25 by 10%
- 1d. Reduce the number of chronic drug users by 15%

Goal 2: Improve the public health and public safety of the American people by reducing the consequences of drug abuse

- 2a. Reduce drug-induced deaths by 15%
- 2b. Reduce drug-related morbidity by 15%
- 2c. Reduce the prevalence of drugged driving by 10%

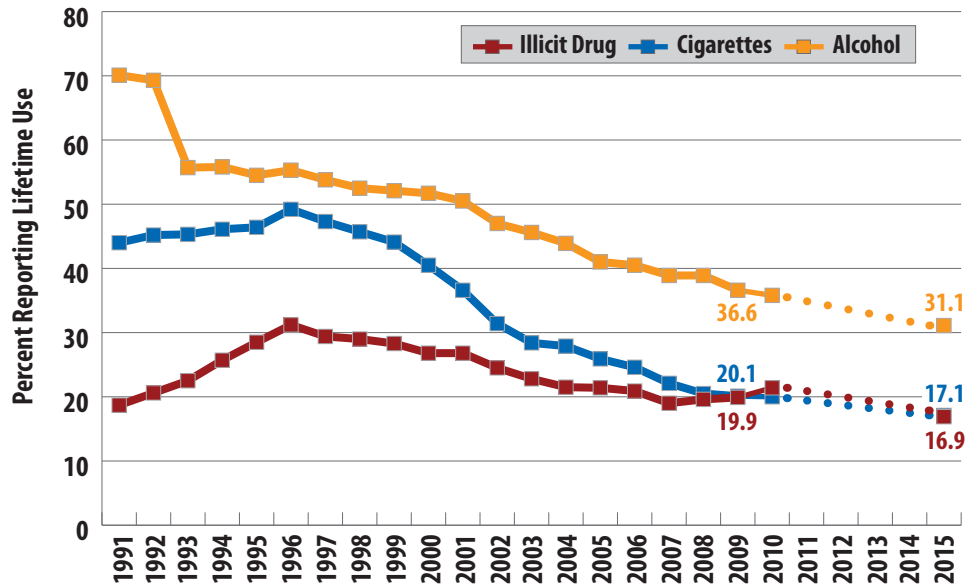
Data Sources: SAMHSA's National Survey on Drug Use and Health (1a, 1c); Monitoring the Future (1b); What Americans Spend on Illegal Drugs (1d); and Prevention (CDC) National Vital Statistics System (2a); SAMHSA's Drug Abuse Warning Network drug-related emergency room visits, and CDC data on HIV infections attributable to drug use (2b); National Survey on Drug Use and Health and National Highway Traffic Safety Administration (NHTSA) roadside survey (2c)

Figure A1. **Goal 1A—Decrease the 30-Day Prevalence of Drug Use Among Youth by 15%**



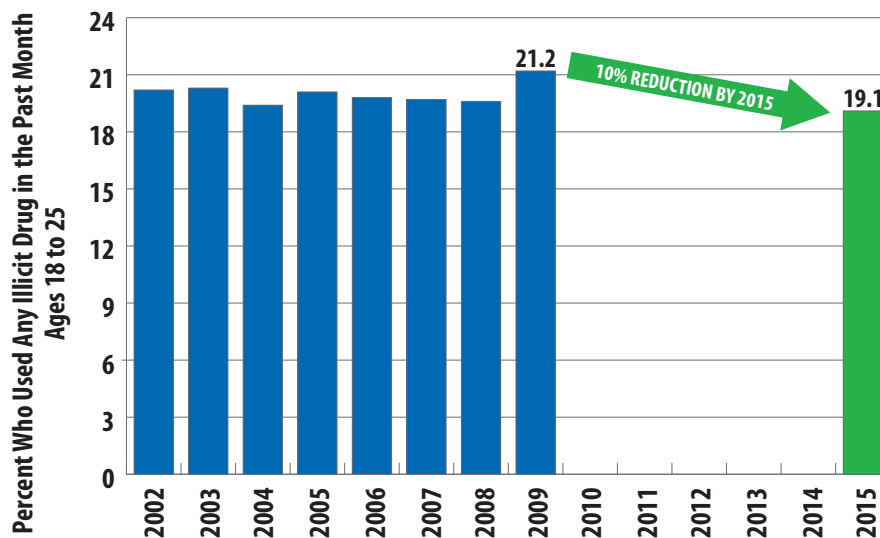
Source: SAMHSA, 2009 National Survey on Drug Use and Health (September 2010).

Figure A2. **Goal 1B—Decrease the Lifetime Prevalence of 8th Graders Who Have Used Drugs, Alcohol, or Tobacco by 15%**



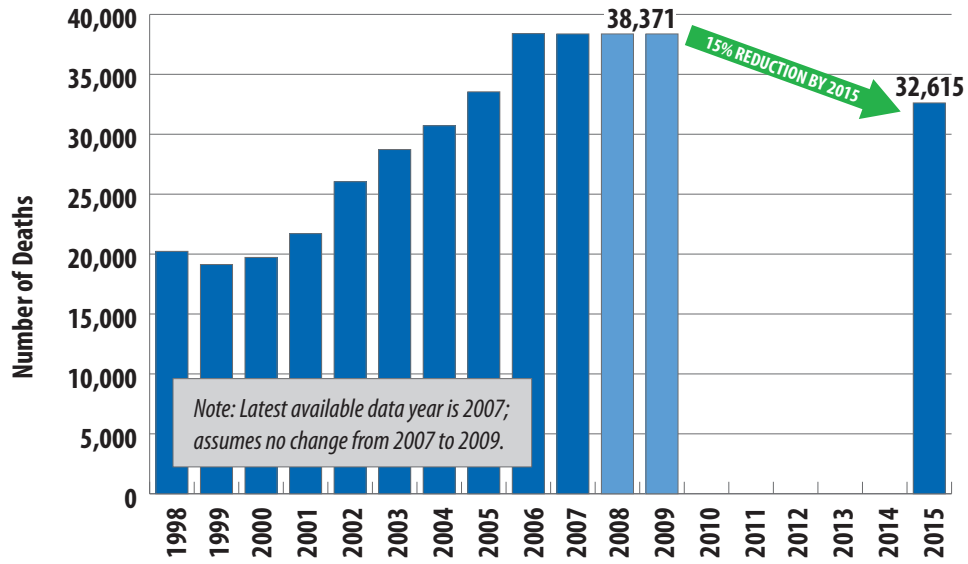
Source: University of Michigan, 2010 Monitoring the Future study (December 2010).

Figure A3. **Goal 1C—Decrease the 30-Day Prevalence of Drug Use Among Adults by 10%**



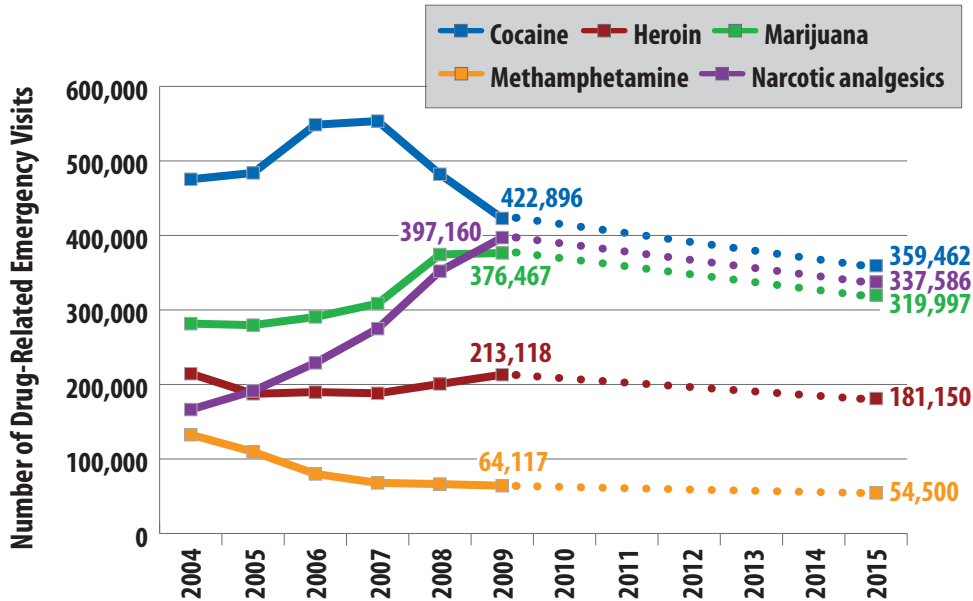
Source: SAMHSA, 2009 National Survey on Drug Use and Health (September 2010).

Figure A4. **Goal 2A—Reduce Drug-Induced Deaths by 15%**



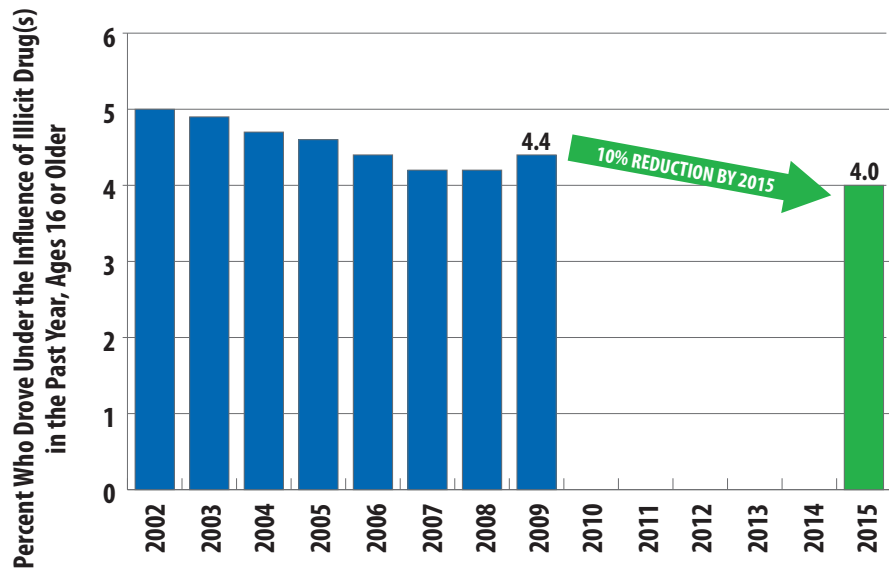
Source: National Center for Health Statistics/CDC, *National Vital Statistics Report, Deaths*, Final Data for 2007 (May 2010).

Figure A5. **Goal 2B—Reduce Drug-Related Morbidity by 15%**



Source: SAMHSA, *Drug Abuse Warning Network, 2004-2008 National Estimates of Drug-Related Emergency Department Visits* (December 2010).

Figure A6. **Goal 2C—Reduce the Prevalence of Drugged Driving by 10%**



Source: SAMHSA, *National Survey on Drug Use and Health 2002-2009*. Unpublished special tabulations (February 2011).



Appendix Two

List of Acronyms

ACYF	Administration for Children, Youth, and Families [HHS]
ADAM	Arrestee Drug Abuse Monitoring program
AFP	Australian Federal Police
ARIDE	Advanced Roadside Impaired Driving Enforcement
ARQ	United Nations Annual Reports Questionnaire
ATF	Bureau for Alcohol, Tobacco, Firearms, and Explosives [DOJ]
ATI	Above the Influence [ONDCP]
ATR	Access to Recovery
AVIPA	Afghanistan Vouchers for Increased Production in Agriculture
BEST	Border Enforcement Security Team
BJA	Bureau of Justice Assistance [DOJ]
BJS	Bureau of Justice Statistics [DOJ]
BOP	Bureau of Prisons [DOJ]
CADCA	Community Anti-Drug Coalitions of America
CARSI	Central American Regional Security Initiative
CBP	Customs and Border Protection [DHS]
CBSI	Caribbean Basin Security Initiative
CDC	Centers for Disease Control and Prevention [HHS]
CHC	Community Health Center
CICAD	Inter-American Drug Abuse Control Commission
CMEA	Combat Methamphetamine Epidemic Act of 2006
CMS	Centers for Medicare & Medicaid Services [HHS]
CND	Commission on Narcotic Drugs
DAWN	Drug Abuse Warning Network
DEA	Drug Enforcement Administration [DOJ]
DEC	Drug Endangered Children

DFC	Drug Free Communities program [ONDCP]
DHE	Domestic Highway Enforcement
DHS	U.S. Department of Homeland Security
DMI	Drug Market Interventions
DOD	U.S. Department of Defense
DOJ	U.S. Department of Justice
DOT	U.S. Department of Transportation
DTO	Drug Trafficking Organization
Education	U.S. Department of Education
EHR	Electronic Health Record
EOP	Executive Office of the President
EPIC	El Paso Intelligence Center
EU	European Union
FBI	Federal Bureau of Investigations [DOJ]
FDA	Food and Drug Administration [HHS]
FDSS	Federal Drug Seizure System
FinCEN	Financial Crimes Enforcement Network [Treasury]
FIT	Financial Investigation Teams [DEA]
FQHC	Federally Qualified Health Center
FSKN	Russian Federal Drug Control Service
GangTECC	Gang Targeting, Enforcement, and Coordination Center [DOJ]
GBHI	Grants for the Benefit of Homeless Individuals [HHS]
GROW	Guiding the Recovery of Women
HHS	U.S. Department of Health and Human Services
HIDTA	High Intensity Drug Trafficking Area [ONDCP]
HIT	Health Information Technology
HOPE	Hawaii's Opportunity Probation with Enforcement
HRPDMP	Harold Rogers Prescription Drug Monitoring Program
HRSA	Health Resources and Services Administration [HHS]
HUD	U.S. Department of Housing and Urban Development

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IBET	Integrated Border Enforcement Team
ICANN	Internet Corporation for Assigned Names and Numbers
ICE	Immigration and Customs Enforcement [HHS]
ICSCU	Indian Country Special Crimes Unit
IED	Improvised Explosive Device
IDU	Injection Drug User
IHS	Indian Health Service [HHS]
IISC	Intelligence and Investigative Support Center
IOM	Institute of Medicine
IRS	Internal Revenue Service [Treasury]
JIATF-South	Joint Interagency Task Force South
JMATE	Joint Meeting on Adolescent Treatment Effectiveness
MASBIRT	Massachusetts Screening, Brief Intervention, and Referral to Treatment
MCN	Afghan Ministry of Counter Narcotics
MDMA	Ecstasy
Media Campaign	National Youth Anti-Drug Media Campaign [ONDCP]
MTF	Monitoring the Future study
NASPER	National All Schedules Prescription Electronic Reporting program
NCSACW	National Center on Substance Abuse and Child Welfare [HHS]
NHTSA	National Highway Traffic Safety Administration [DOT]
NIC	National Institute of Corrections [DOJ]
NIDA	National Institute on Drug Abuse [HHS]
NIJ	National Institute of Justice [DOJ]
NMPI	National Methamphetamine and Pharmaceutical Initiative
NSDUH	National Survey on Drug Use and Health
NSS	National Seizure System
NY/NJ	New York/New Jersey High Intensity Drug Trafficking Area
OAS	Organization of American States
OCDEF	Organized Crime Drug Enforcement Task Force [DOJ]

OJJDP	Office of Juvenile Justice and Delinquency Prevention [DOJ]
OJP	Office of Justice Programs [DOJ]
ONDCP	Office of National Drug Control Policy
PACT360	Police and Communities Together
PDMP	Prescription Drug Monitoring Program
PEPFAR	President's Emergency Plan for AIDS Relief
PPC	Prevention Prepared Communities
PRS	Performance Reporting System
PTSD	Post Traumatic Stress Disorder
ROSC	Recovery-Oriented Systems of Care
RSAT	Residential Substance Abuse Treatment
RSS	Recovery Support Services
RTC	The Next Door Residential Transition Center
SADD	Students Against Destructive Decisions
SAMHSA	Substance Abuse and Mental Health Services Administration [HHS]
SASPG	Substance Abuse State Prevention Grant
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SOD	Special Operations Division
SPF-SIG	Strategic Prevention Framework State Incentive Grants
STABO	Short Term Airborne Operations
State	U.S. Department of State
STRIDE	System to Retrieve Information from Drug Evidence
TASC	Treatment Alternatives for Safe Communities
TCE	Targeted Capacity Expansion
THC	Tetrahydrocannabinol, the active ingredient in marijuana
TIC	The Interdiction Committee
Treasury	U.S. Department of the Treasury
TRICARE	Healthcare program serving current and former military and their families
UNODC	United Nations Office on Drugs and Crime
USAID	U.S. Agency for International Development [State]

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USMLE	U.S. Medical Licensing Examination
USPS	United States Postal Service
VA	U.S. Department of Veterans Affairs
VHA	Veterans Health Administration [VA]
YRBS	Youth Risk Behavior Survey



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ENDNOTES

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107. Event deconfliction ensures law enforcement agencies working in close proximity of each other are immediately notified when enforcement actions are planned in a manner that threatens effective coordination or that compromises enforcement operations. Notification of such conflicts enhances officer safety and promotes the coordination of operations in a multi-agency environment. Similarly, target deconfliction alerts investigators when there is an investigatory cross-over by enforcement agencies. Notification of duplicate targets encourages investigators to share information and resources.
108. A six-million-square-mile area, including the Caribbean, Gulf of Mexico and Eastern Pacific. The path(s) used by drug traffickers to transport illicit drugs to their market. Geographically, these paths normally connect, but do not include, the source and arrival zones. (Source – National Interdiction Command and Control Plan – March 17, 2010, Glossary of Terms).
109. See NIJ's Drugs and Crime Research: Arrestee Drug Abuse Monitoring Programs at <http://www.nij.gov/topics/drugs/markets/adam/#meetings>.
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112. Visit NIJ's webpage for more information at <http://www.nij.gov/nij/topics/corrections/community/drug-offenders/hawaii-hope.htm>.

113. Visit NIJ's webpage for more information at <http://www.nij.gov/nij/topics/corrections/community/drug-offenders/decide-your-time.htm>.

