National Drug Control Strategy Performance Review System Report

MARCH 2023

THE WHITE HOUSE
EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL STRATEGY

Table of Contents

Executive Summary **1**

Introduction **5**

Goals, Objectives and Targets **6**

Goal 1: Illicit substance use is reduced in the United States. 6

Objective 1: The number of drug overdose deaths is reduced by 13 percent by 2025. 6

Objective 2: The percentage of people meeting criteria for cocaine, opioid, and methamphetamine use disorders are each respectively reduced by 25 percent by 2025. 8

Goal 2. Prevention efforts are increased in the United States. 11

Objective 1: Past 30-day alcohol use among young people aged 12-17 is reduced by 10 percent by 2025. 11

Objective 2: Past 30-day use of an e-cigarette among middle and high school students is reduced by 15 percent by 2025. 13

Goal 3. Harm Reduction efforts are increased in the United States. 15

Objective 1: The number of counties with high overdose death rates which have at least one Syringe Services Program (SSP) is increased by 85 percent by 2025. 16

Objective 2: The percentage of SSPs that offer some type of drug safety checking support service, including, but not limited to Fentanyl Test Strips, is increased by 25 percent by 2025. 18

Goal 4. Treatment efforts in the United States are increased. 20

Objective 1: Treatment Admissions for the populations most at risk of overdose death is increased by 100 percent by 2025. 20

Objective 2: The projected shortfall in the qualified workforce of behavioral health providers (including addiction professionals) funded by federal programs in the United States is reduced by 70 percent by 2025. 21

Goal 5. Recovery efforts in the United States are increased. 23

Objective 1: The number of states operating a recovery-ready workplace initiative is increased 75 percent by 2025. 24

Objective 2: The number of peer-led recovery community organizations is increased by 25 percent by 2025. 25

Objective 3: The number of recovery high schools is increased by 10 percent by 2025. 28

Objective 4: The number of collegiate recovery programs is increased by 25 percent by 2025. 29

Objective 5: The number of certified recovery residences is increased by 25 percent by 2025. 31

Goal 6. Criminal Justice reform efforts include drug policy matters. 33

Objective 1: Eighty percent of all treatment courts will be trained and will implement practices to increase equity by 2025. 33

Objective 2: The percentage of BOP inmates diagnosed with an opioid use disorder who are given access to medications for opioid use disorders (MOUD) is increased to 100 percent by 2025; the percentage of both state prison programs and local jail facilities offering MOUD is increased by 50 percent. 35

Goal 7. The supply of illicit substances into the United States is reduced. 39

Objective 1: The number of targets identified in counternarcotics Executive Orders and related asset freezes and seizures made by law enforcement is increased by 365 percent by 2025. 39

Objective 2: The number of defendants convicted in active OCDETF investigations that incorporate FinCEN data is increased by 14 percent by 2025. 41

Objective 3: The percentage of active priority OCDETF investigations linked to the Sinaloa or Jalisco New Generation (CJNG) cartels, or their enablers (such as illicit financiers) is increased by 25 percent by 2025. 43

Objective 4: Potential production of cocaine is decreased by 10 percent, and heroin is decreased by 30 percent by 2025. 45

Objective 5: The number of incident reports for precursor chemicals sourced from China or India reported by North American countries increases by 125 percent by 2025. 48

Appendix A: Objectives' data sources, baseline and targets 51

Appendix B: Acronyms 55

Executive Summary

Addressing addiction and the overdose epidemic is an urgent priority for the Biden-Harris Administration. In April 2022, the Administration released the 2022 *National Drug Control Strategy (Strategy)* and the *Performance Review Summary (PRS)* report*,* which called for immediate short-term actions that will save lives, and outlined long-term solutions to reduce drug use and its associated harms, including overdose. The *Strategy* aggressively targets the two main drivers of the overdose epidemic: untreated addiction and drug trafficking.

To evaluate the effectiveness of the Nation's drug policy efforts, and assess the progress in implementing the *Strategy*, the Biden-Harris Administration established seven goals to be achieved by 2025. These goals are measured against a baseline of 2020, and cross the gamut of drug policy issues, including a general goal to reduce illicit substance use, as well as other specific public health, public safety, and supply reduction issues. Each of these long-range, comprehensive goals are accompanied by quantifiable and measurable objectives, with specific annual targets.

The following is a summary of the progress in 2021 on each of the specific strategic goals and objectives for the Nation to reduce the demand for and availability of illicit drugs and their consequences. Delta percentages in parentheses denote actuals moving away from the 2025 target.

Objective	2021 Target	2021 Actual	Delta %	Status
Goal 1: Illicit substance use is reduced in the United States.				
Objective 1: The number of drug overdose deaths is reduced by 13 percent by 2025.	100,300	106,699	(6.4%)	Progressing, but accelerated progress required to meet 2025 target.
Objective 2A: The percentage of people meeting criteria for cocaine use disorders are reduced by 25 percent by 2025.	0.48%	0.5%	0%	Progressing, but accelerated progress required to meet 2025 target.
Objective 2B: The percentage of people meeting criteria for opioid use disorders are reduced by 25 percent by 2025.	0.95%	2.0%	(100%)	Significant progress required to meet 2025 target.
Objective 2C: The percentage of people meeting criteria for methamphetamine use disorders are reduced by 25 percent by 2025.	0.57%	0.6%	0%	Progressing, but accelerated progress required to meet 2025 target.

Objective	2021 Target	2021 Actual	Delta %	Status
Goal 2: Prevention efforts are increased in the United States.				
Objective 1: Past 30-day alcohol use among young people aged 12-17 is reduced by 10 percent by 2025.	8.0%	7.0%	12.5%	The 2025 target has already been met.
Objective 2: Past 30-day use of an e-cigarette among middle and high school students is reduced by 15 percent by 2025.	12.7%	7.6%	40%	The 2025 target has already been met.
Goal 3: Harm Reduction efforts are increased in the United States.				
Objective 1: The number of counties with high overdose death rates which have at least one Syringe Service Program (SSP) is increased by 85 percent by 2025.	152	174	14%	Progress sufficient to enable meeting 2025 target.
Objective 2: The percentage of SSPs that offer some type of drug safety checking support service, including, but not limited to Fentanyl Test Strips, is increased by 25 percent by 2025.	17.9%	26.4%	48%	The 2025 target has already been met.
Goal 4: Treatment efforts are increased in the United States.				
Objective 1: Treatment admissions for the populations most at risk of overdose death is increased by 100 percent by 2025.	744,584	TBD[1]	TBD	Data not yet available in order to assess progress.
Objective 2: The projected shortfall in the qualified workforce of behavioral health providers (including addiction professionals) funded by federal programs in the United States is reduced by 70 percent by 2025.	30%	32%	7%	Progress sufficient to enable meeting 2025 target.

[1] The 2021 TEDS data is not yet available.

Objective	2021 Target	2021 Actual	Delta %	Status
Goal 5: Recovery efforts are increased in the United States.				
Objective 1: The number of states operating a recovery-ready workplace initiative is increased 75 percent by 2025.	9	13	41%	Progress sufficient to enable meeting 2025 target.
Objective 2: The number of peer-led recovery community organizations is increased by 25 percent by 2025.	156	221	42%	The 2025 target has already been met.
Objective 3: The number of recovery high schools is increased by 10 percent by 2025.	43	43	0%	Progress sufficient to enable meeting 2025 target.
Objective 4: The number of collegiate recovery programs is increased by 25 percent by 2025.	139	145	5%	Progress sufficient to enable meeting 2025 target.
Objective 5: The number of certified recovery residences is increased by 25 percent by 2025.	7,225	7,448	3%	Progress sufficient to enable meeting 2025 target.
Goal 6: Criminal Justice reform efforts in the United States include drug policy matters.				
Objective 1: Eighty percent of all treatment courts will be trained and will implement practices to increase equity by 2025.	16%	9%	(43%)	Progressing, but accelerated progress required to meet 2025 target.
Objective 2A: The percentage of Federal Bureau of Prisons inmates diagnosed with an opioid use disorder who are given access to MOUD is increased to 100 percent by 2025.	5%	50%	900%	Progress sufficient to enable meeting 2025 target.
Objective 2B: The percentage of state prison programs offering MOUD is increased by 50 percent.	53%	56%	6%	Progress sufficient to enable meeting 2025 target.
Objective 2C: The percentage of local jail facilities offering MOUD is increased by 50 percent.	32%	TBD[2]	TBD	Data not yet available in order to assess progress.

[2] 2021 data not available; 2022 data should be available in 2023.

Objective	2021 Target	2021 Actual	Delta %	Status
Goal 7: The supply of illicit substances into the United States is reduced.				
Objective 1: The number of targets identified in counternarcotics Executive Orders and related asset freezes and seizures made by law enforcement is increased by 365 percent by 2025.	38	61	60%	Progress sufficient to enable meeting 2025 target.
Objective 2: The number of defendants convicted in active OCDETF investigations that incorporate FinCEN/SAR data is increased by 14 percent by 2025.	5,390	5,394	0.10%	Progress sufficient to enable meeting 2025 target.
Objective 3: The percentage of active priority OCDETF investigations linked to the Sinaloa or Jalisco New Generation (CJNG) cartels, or their enablers (such as illicit financiers) is increased by 25 percent by 2025.	59%	59%	0%	Progress sufficient to enable meeting 2025 target.
Objective 4A: Potential production of cocaine is decreased by 10 percent. (Metric Tons)	2,089	2,074	0.70%	Progress sufficient to enable meeting 2025 target.
Objective 4B: Potential production of heroin is decreased by 30 percent by 2025. (Metric Tons)	53	72	(36%)	Significant progress required to meet 2025 target.
Objective 5: The number of incident reports for precursor chemicals sourced from China or India reported by North American countries increases by 125 percent by 2025.	8	9	13%	Progress sufficient to enable meeting 2025 target.

Progress towards a majority of the 2025 targets is evident. Of the total 25 Strategy objectives, 15 targets (60 percent), were met or had made sufficient progress toward achieving their 2025 target. There were four measures that had not yet made progress, and another four which will require significant progress. Finally, there were two measures where progress could not be assessed due to pending data updates. Each of the objectives and their results are discussed in detail in the main body of the report.

Introduction

The Office of National Drug Control Policy's (ONDCP) authorization (detailed in 21 U.S. Code § 1705, "Development, submission, implementation, and assessment of National Drug Control Strategy") requires:

- Comprehensive, research-based, long-range, quantifiable goals for reducing illicit drug use, and the consequences of illicit drug use in the United States.
- Annual quantifiable and measurable objectives and specific 2-year and 5-year targets to accomplish the *Strategy's* long-term quantifiable goals.
- A description of how each *Strategy* goal was determined, as well as a discussion of any anticipated challenges to achieving them.
- The sources of information and data that will be used for each goal and objective.
- A list of the relevant stakeholders and each such stakeholder's role in achieving the *Strategy's* goals.
- A list of the existing or new coordinating mechanisms needed to achieve the *Strategy's* goals.

The *PRS Report* is a performance assessment tool for evaluating the effectiveness of the Nation's efforts. It serves as an indicator, alerting when the *Strategy* is on track, and when and where further attention or efforts are needed. However, the *PRS* is just one part of the broader Performance Measurement System, as required by 21 U.S. Code § 1705(h). Besides the *PRS*, this includes the *National Drug Control Assessment (Assessment)*, and the *Strategy's* annual *Budget Summary*.

The *PRS* focuses on the overall progress toward achieving the goals and objectives of the *Strategy;* it is complemented by the *Assessment*, which is a summary of the progress of each National Drug Control Program agency's (NDCPA) efforts towards meeting the *Strategy's* goals. The *Assessment* establishes each NDCPA's specific performance measures and includes an evaluation of the progress of meeting the annual targets of those performance measures.

Additionally, the *Budget Summary* ensures that each agency's goals and budgets support and are fully consistent with the *Strategy*. It identifies the major programs and activities of the NDCPAs that support the goals and objectives of the *Strategy*, and includes the related programs, activities, and available assets, discusses the role of each such program, activity, and asset in achieving the *Strategy's* goals, and provides an estimate of Federal funding and other resources needed.

Goals, Objectives and Targets

Goal 1: Illicit substance use is reduced in the United States.

As established in ONDCP's Congressional authorization, the *Strategy's* main purpose is to reduce illicit drug use and the consequences of such illicit drug use in the United States. Between 2015 and 2020, overdose deaths grew 75 percent, reaching an all-time high of 91,799 deaths in 2020[3]. During the same time period, the rate of untreated substance use disorders (SUD), which affect the health, social, and educational systems of our Nation, also grew. This first *Strategy* goal reflects the culmination of all of the Nation's efforts reflected in the *Strategy*. Every private and each local, State, Tribal and federal stakeholder shares the same desire to see a sustained reduction in illicit substance use. Achievement of the other *Strategy* goals and objectives should significantly reduce the number of drug-related deaths and the number of adults with a substance use disorder in the United States.

Objective 1: The number of drug overdose deaths is reduced by 13 percent by 2025.

Over the past two decades, the number of drug overdose deaths has risen steadily, but it increased markedly in the past five years. Though overdose death numbers were increasing prior to the COVID pandemic, it is clear that the pandemic further exacerbated the crisis, creating an environment (forced isolation, interrupted access to SUD treatment, increased mental health strains, and severe financial concerns) that accelerated the increase in the number of deaths.

The objective seeks to reduce drug overdose deaths by 13 percent between 2020 and 2025. This objective's measure is the number of drug overdose deaths. The baseline data is from the Final Multiple Cause of Death Data from the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS).

The Biden-Harris Administration is aiming for an aggressive, but realistic goal, one that that is derived from an understanding of complexity of the overdose crisis. Modeling the future of the overdose epidemic may be in its infancy with much room for improved accuracy.[4] Past public health experts used an epidemic analogy to describe the exponential growth trajectory early in the prescription opioid epidemic[5] and at least one team applying Farr's law predicted the epidemic would burn itself out by this time.[6] But those models did not account for drug traffickers importing more lethal forms of opioids such as illicitly manufactured fentanyl and its analogues, the resurgence of methamphetamine, or the contamination of the supply chain leading

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[3] Provisional (not yet final) data from CDC's NCHS indicate there were an estimated 107,622 drug overdose deaths in the United States during 2021.

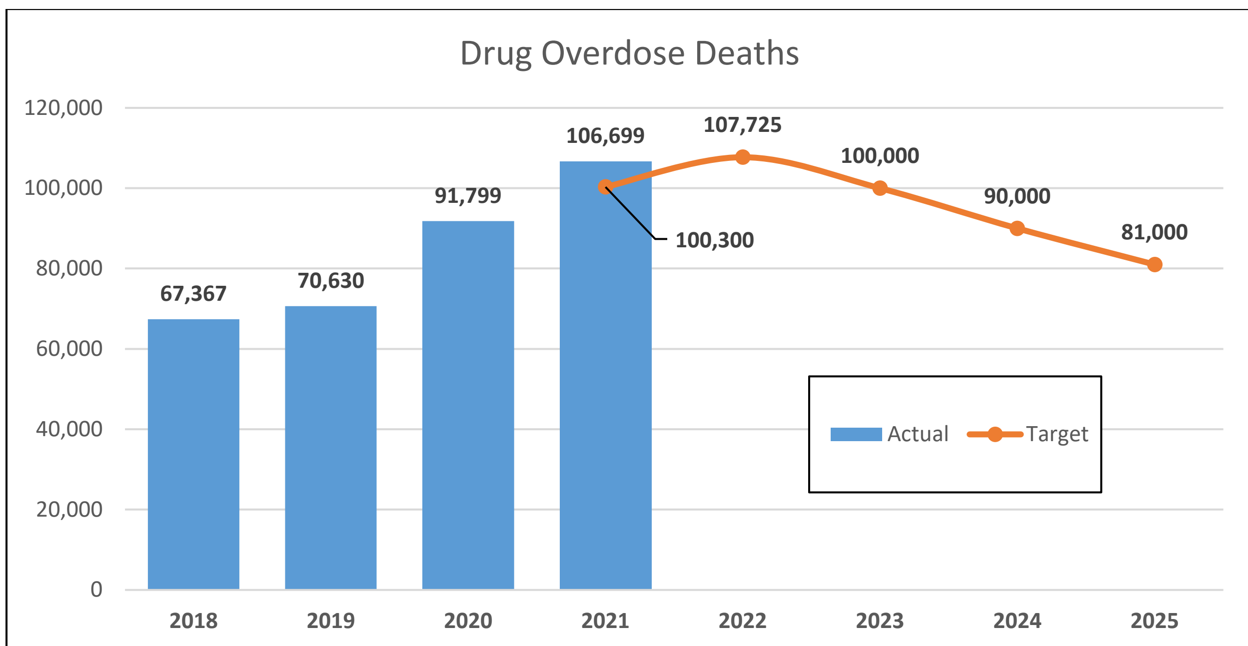
[4] Lowder EM. Pushing the boundaries of prediction to address the opioid crisis. Lancet Public Health. 2021;6(10):e697-e698. doi:10.1016/S2468-2667(21)00104-3 https://reader.elsevier.com/reader/sd/pii/S2468266721001043?token=85990074B1621A82DD101854127A01DBF87D06C42D7B70A201539C9797AD4E28705353273736BEA8731410E409A85C31&originRegion=us-east-1&originCreation=20211217121855

[5] Prescription painkiller overdoses at epidemic levels. CDC Press Release. November 1, 2021. https://www.cdc.gov/media/releases/2011/p1101_flu_pain_killer_overdose.html

[6] Darakjy S, Brady JE, DiMaggio CJ, Li G. Applying Farr's Law to project the drug overdose mortality epidemic in the United States. Inj Epidemiol. 2014;1(1):31. doi:10.1186/s40621-014-0031-2 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5005643/pdf/40621_2014_Article_31.pdf

to overdoses in instances of polysubstance use. At least one research team examining forty years of past overdose data showed that the curve of America's overdose death epidemic over a 40-year timespan is unique, and it does not appear to follow a traditional "Farr's Law type" trajectory.[7] Rather than leveling off and declining like an infectious disease epidemic, it has been increasing exponentially with no signs of dropping substantially, barring a drastic intervention and infusion of resources.

In the face of academic and expert modeling that shows exponential growth in overdose rates, the *Strategy* outlines a multi-pronged evidence-based approach to reduce overdoses. It is clear that no one intervention alone can immediately reduce overdoses. Rather, this is a long-term, epidemic—where meeting our marks on reducing overdoses will require full implementation of the *Strategy*, a substantial increase in public health and public safety investments, and a long-term commitment to follow the evidence on what works to help keep people alive.



Source: Spencer MR, Miniño AM, Warner M. Drug overdose deaths in the United States, 2001–2021. NCHS Data Brief, no 457. Hyattsville, MD: National Center for Health Statistics. 2022.

In 2021, the number of drug overdose deaths was 106,699; the target was 100,300, meaning the 2021 actual is roughly 6.4 percent behind the target. Final estimates for 2021 saw the number of deaths continued to rise due to increases in deaths involving illicitly manufactured fentanyl, but this data is showing a slowing down of deaths in 2022, CDC's provisional data predicted 107,735 overdose deaths in the 12-month period ending in July 2022, representing a steady slowing of the rate of increase in overdose deaths for the ninth month in a row, and a decrease in 12-month rolling totals for the fourth month in a row[8]. Based upon this provisional data, there has been a 2.3 percent decrease from the 110,236 fatal drug overdoses provisionally estimated for the 12-month period ending March 2022. The age-adjusted rate of drug overdose deaths

[7] Jalal H, Buchanich JM, Roberts MS, Balmert LC, Zhang K, Burke DS. Changing dynamics of the drug overdose epidemic in the United States from 1979 through 2016. Science. 2018;361(6408):eaau1184. doi:10.1126/science.aau1184
[8] https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

involving heroin decreased 32% from 2020 to 2021[9]. Given the data available at this time, accelerated progress is required to meet the 2025 target; however, we are hopeful this steady slowing will continue and be reflected in the final 2022 drug overdose estimates published in the 2024 *PRS* report.

Objective 2: The percentage of people meeting criteria for cocaine, opioid, and methamphetamine use disorders are each respectively reduced by 25 percent by 2025.

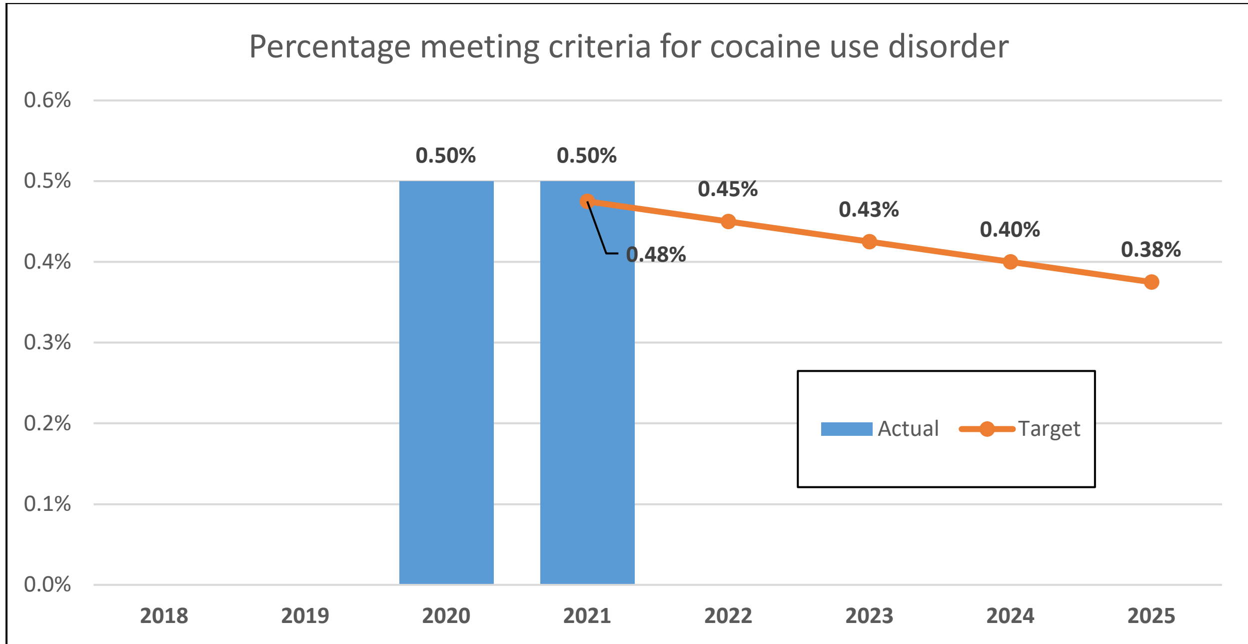
According to the American Psychiatric Association, SUD is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems.[10] Preventing and effectively treating SUD will improve productivity, increase employment, improve physical and mental health, improve the quality of life, and enhance individual, community, and collective public safety outcomes. However, reducing SUD will not occur simply by treating addiction, but by reducing substance use initiation, increasing primary prevention efforts, and reducing the supply of illicit drugs—all efforts central to the *Strategy*. As the *Strategy* works to improve prevention and increase treatment for SUD, the percentage of those meeting the criteria for cocaine, opioid, and methamphetamine use disorders should decrease. ONDCP will work to develop approaches to increasing treatment access and will work with states on spending opioid settlement funds, including expanding evidence-based treatments (EBTs) to their residents.

The data for this objective comes from the National Survey on Drug Use and Health (NSDUH), which provides the annual percentages for persons meeting criteria for cocaine, opioid and methamphetamine use disorders. In 2020, the percentage of those 12 and older meeting the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnostic criteria for cocaine use disorder was 0.5 percent; for opioid use disorder, it was 1.0 percent, and for methamphetamine use disorder, it was 0.6 percent. This objective seeks to reduce each prevalence estimate by 25 percent by 2025. It should be noted that in 2020, NSDUH changed not only the diagnostic criteria from DSM-IV to DSM-5 for classifying SUDs but also the data collection modes during the COVID pandemic. Also, beginning with the 2021 NSDUH, questions on prescription drug use disorder were asked of all past year users of prescription drugs, regardless of whether they misused prescription drugs. These estimates include prescription drug use disorder data from all past year users of prescription drugs. Thus, the prevalence estimates based on the 2019 or earlier NSDUH data is not comparable to those from the 2020, 2021, and later NSDUH surveys. Due to these methodological differences, 2018 and 2019 are not shown, and 2020 and 2021 cannot be compared to one another.

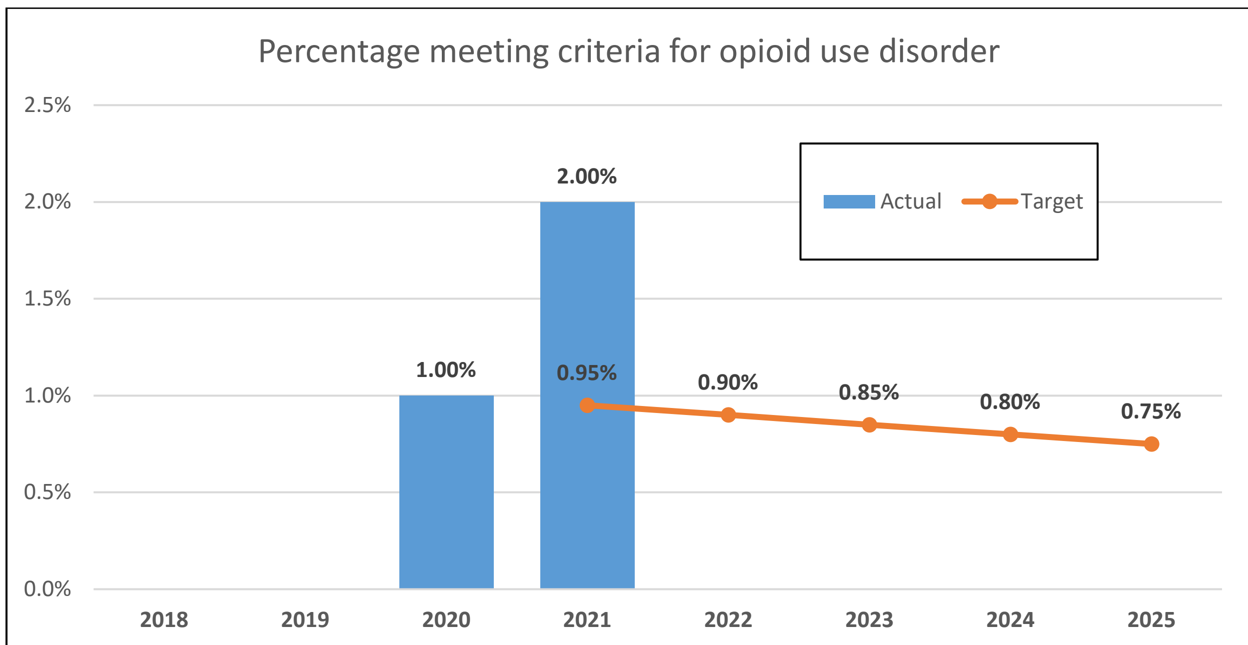
There are several challenges in meeting this objective, including that many of strategies that could help expand access to treatment may require legislative or regulatory actions. Pursuing these strategy will require consensus on the most effective approaches. Furthermore, given that some social determinants of health (such as housing stability and poverty) may be related to treatment access, addressing these important factors will take long-term multi-faceted initiatives. Other elements of the *Strategy* that focus on widespread screening for SUD and increasing the number of people who have access to treatment could reduce harmful drug use behaviors among

[9] https://www.cdc.gov/nchs/products/databriefs/db457.htm
[10] American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington D.C.: 2013.

future generations, and subsequently decrease the rates of people meeting the criteria for cocaine, opioid and methamphetamine use disorders.



Source: Table 5.1B Substance Use Disorder for Specific Substances in Past Year: Among People Aged 12 or Older. Center for Behavioral Health Statistics and Quality. (2021). Results from the 2018-2020 NSDUH: Detailed tables. Rockville, MD: SAMHSA. Due to methodological differences, 2020 and 2021 are not comparable to one another.



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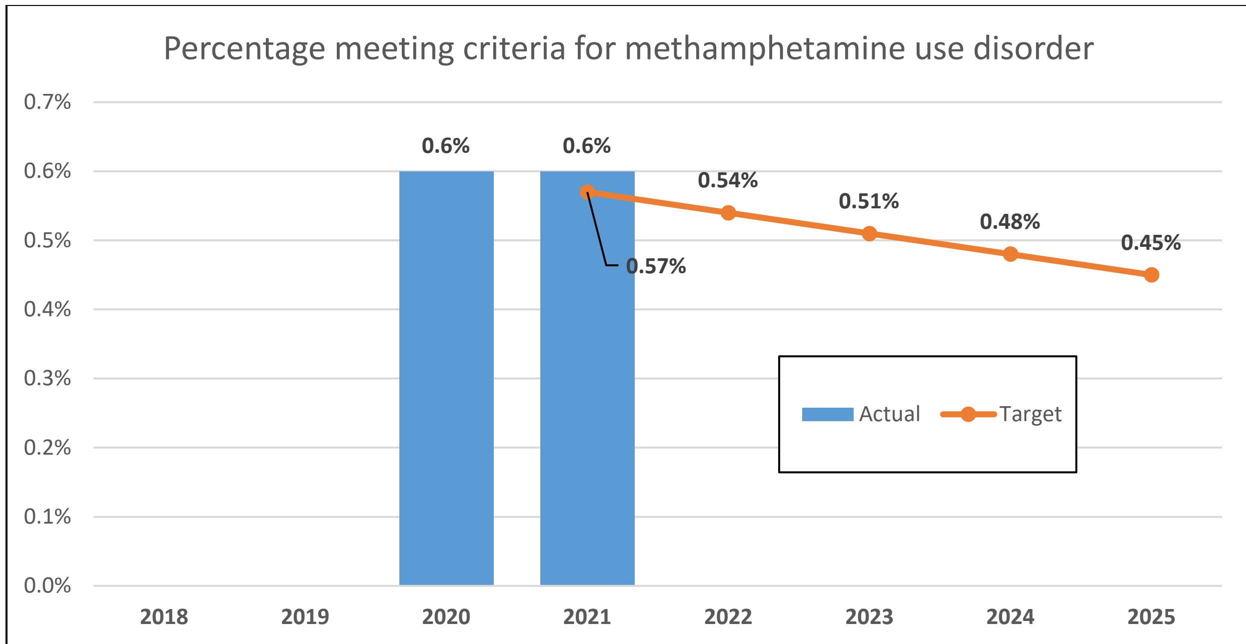

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In 2021, the percentage of people meeting criteria for cocaine use disorders number was 0.5 percent; the target was effectively 0.5 percent, meaning the 2021 actual is on target. The percentage of people meeting criteria for opioid use disorders was 2.0 percent; the target was effectively 1.0 percent, meaning the 2021 actual is 100 percent behind the target. Finally, the percentage of people meeting criteria for methamphetamine use disorders was 0.6 percent; the target was effectively 0.6 percent, meaning the 2021 actual is on target. The 2021 NSDUH data found that 94 percent of people aged 12 or older with a SUD did not receive any treatment, and nearly all people with a SUD who did not get treatment at a specialty facility did not think they needed treatment. However, as noted, reducing SUD will not occur simply by treating addiction – the interventions of other critical *Strategy* efforts, including reducing substance use initiation, increasing primary prevention efforts, and reducing the supply of illicit drugs will need time to take hold. Given the data available at this time, accelerated progress is required to meet the 2025 targets for cocaine and methamphetamine use disorders, and significant progress is required to meet the 2025 target for opioid use disorder.

Goal 2. Prevention efforts are increased in the United States.

Research supported by the Department of Health and Human Services' (HHS) National Institute on Drug Abuse (NIDA) and National Institute on Alcohol Abuse and Alcoholism (NIAAA), both of which are a part of the National Institutes of Health (NIH), and CDC have shown that preventing drug use before it starts is an essential element of a comprehensive approach to protect school aged children and young adults from the potentially dangerous consequences of drug use. Data sets such as the NSDUH[11], the Monitoring the Future[12], the Youth Risk Behavior Surveillance System[13], and the National Youth Tobacco Survey[14] provide useful information in understanding youth use patterns and trends. During consultations with organizations such as Community Anti-Drug Coalitions of America, National Association of State Alcohol and Drug Abuse Directors (NASADAD), the Single State Agencies (SSAs) for SUD prevention services, the Drug Free Community (DFC) and Comprehensive Addiction and Recovery Act (CARA) grant recipients, and other community stakeholders, ONDCP confirmed that these organizations will be essential in assessing state and local circumstances and developing responsive initiatives. ONDCP will work with its federal stakeholders, including the Departments of Education and HHS (through, for example, the Health Resources and Services Administration's (HRSA) Bright Futures Program and the Pediatric Mental Health Care Access Program), to provide funding and programmatic support, and will conduct and disseminate continuing research.

Objective 1: Past 30-day alcohol use among young people aged 12-17 is reduced by 10 percent by 2025.

In order to effectively increase prevention efforts across the United States, evidence-based prevention strategies focused on youth must be implemented, and the substances most commonly used by them addressed. By 12th grade, about two-thirds of students have tried alcohol, and although it is illegal for people under 21 years of age to drink alcohol, the findings show that people from 12 to 20 years of age consume about one-tenth of all alcohol consumed in the United States[15].

Underage drinking obviusly poses a range of risks and negative consequences, including being a significant factor in the deaths of people younger than age 21, and a leading cause of youth injuries[16]; it impairs judgment, increases the risk of physical and sexual assault[17], increases the risk of alcohol problems later in life[18], and interferes with brain development.[19]

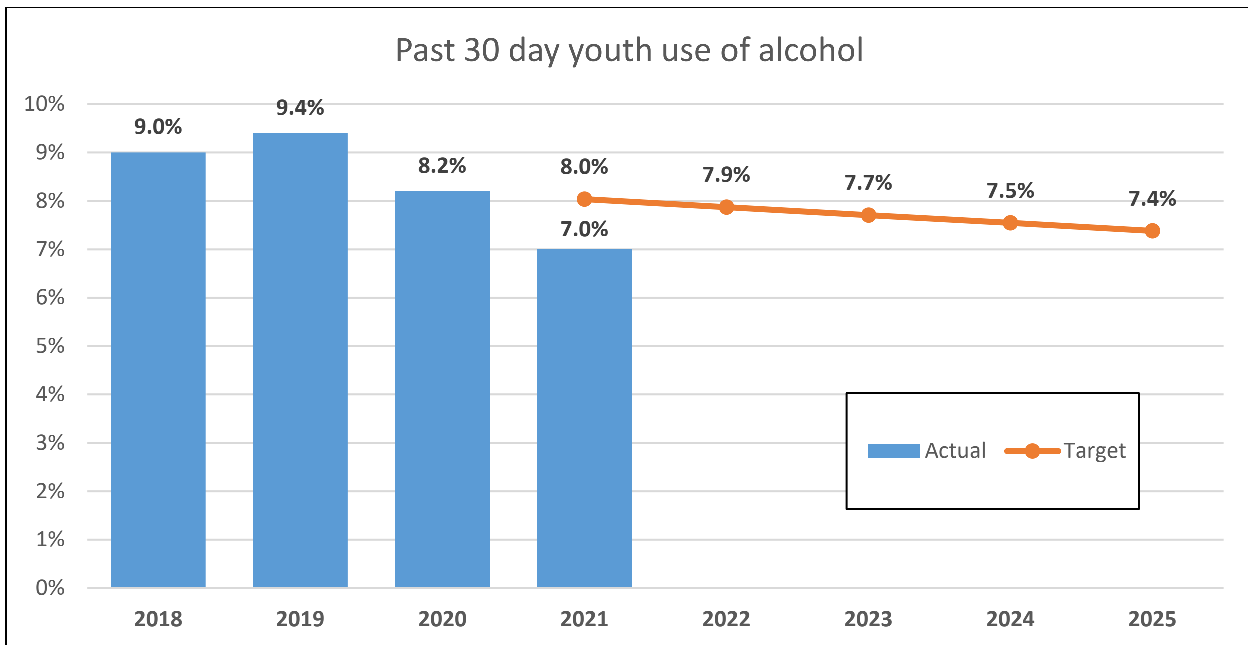
ONDCP will continue to work with external stakeholders and federal partners to reach school-aged children with a goal to disrupt and prevent at their most critical period for substance use

[11] https://nsduhweb.rti.org/respweb/homepage.cfm
[12] https://www.src.isr.umich.edu/projects/monitoring-the-future-drug-use-and-lifestyles-of-american-youth-mtf/
[13] https://www.cdc.gov/healthyyouth/data/yrbs/index.htm
[14] https://www.cdc.gov/tobacco/data_statistics/surveys/nyts/index.htm
[15] Calculated using past 30-day quantity and frequency of alcohol use from the 2019 National Survey on Drug Use and Health public-use data file. SAMHSA, CBHSQ. 2019 National Survey on Drug Use and Health (NSDUH-2019-DS0001).
[16] SAMHSA, CBHSQ. *The DAWN Report: Alcohol and Drug Combinations Are More Likely to Have a Serious Outcome Than Alcohol Alone in Emergency Department Visits Involving Underage Drinking*. Rockville, MD: SAMHSA, 2014.
[17] Waterman, E.A.; Lee, K.D.M.; Edwards, K.M. Longitudinal associations of binge drinking with interpersonal violence among adolescents. Journal of Youth and Adolescence 48:1342–1352, 2019. PMID: 31079263
[18] The estimates are weighted by the person-level analysis weight and derived from the CBHSQ 2019 NSDUH.
[19] Squeglia, L.M.; Tapert, S.F.; Sullivan, E.V.; Jacobus, J.; Meloy, M.J.; Rohlfing, T.; and Pfefferbaum, A. Brain development in heavy-drinking adolescents. American Journal of Psychiatry 172(6):531–542, 2015.

initiation. Through its DFC Support Program, ONDCP administers, in partnership with CDC, the Nation's leading effort to mobilize communities to prevent youth substance use. The DFC Program provides grants to community coalitions to strengthen the infrastructure among local partners to create and sustain a reduction in local youth substance use, including alcohol.

Data for this measure comes from the NSDUH, which is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) and provides nationally and state representative data on use of tobacco, alcohol, and illicit drugs, misuse of prescription medications, substance use disorders, mental health status, and use of related treatments among the civilian, noninstitutionalized population aged 12 or older in the United States. In 2020, the percentage of youth aged 12-17 who used alcohol in the past 30 days was 8.2 percent. The objective seeks to reduce past 30-day youth alcohol use by 10 percent by 2025.

One of the significant challenges for reducing youth use of alcohol is that alcohol is widely marketed, affordable, and commonly available in the United States. Research supported by NIAAA and CDC have provided valuable information about how to effectively prevent underage use and intervene if underage use has been initiated. A range of efforts at the State, community, family, institutional, academic, and individual levels will need to be implemented to reduce underage alcohol use.



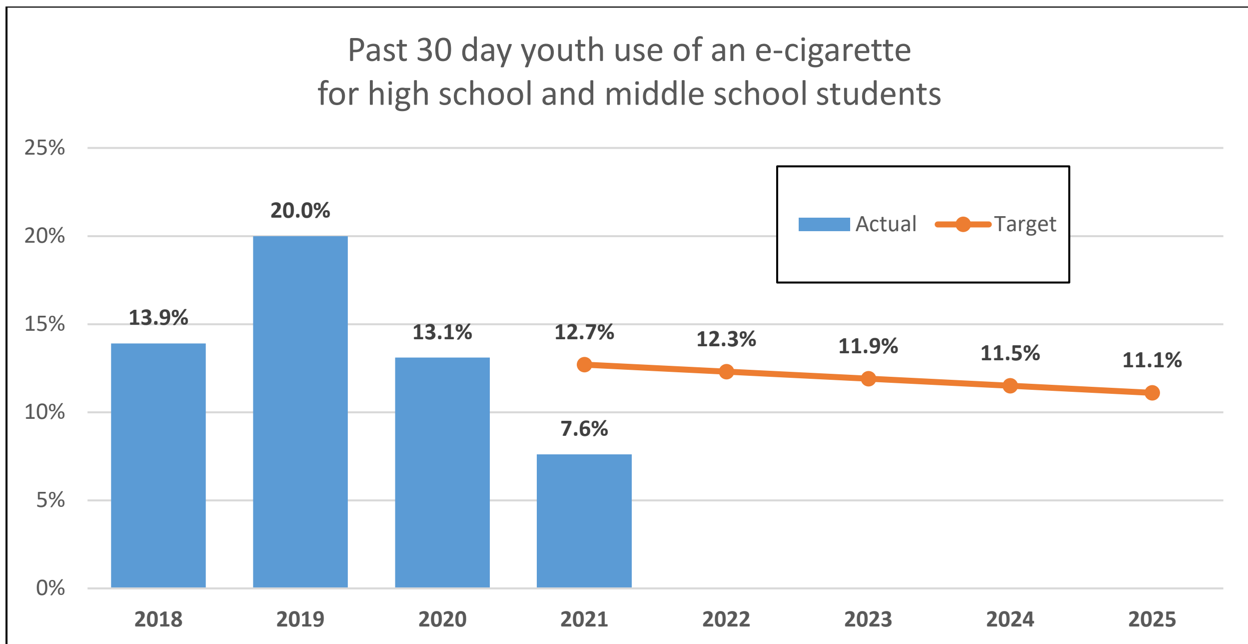
Source: Table 2.1B Tobacco Product and Alcohol Use in Lifetime, Past Year, and Past Month among Persons Aged 12 or Older, by Age Group: Percentages, 2018-2021 SAMHSA, Center for Behavioral Health Statistics and Quality. 2018-2021 NSDUH, Rockville, MD:

In 2021, the percentage of past 30-day use alcohol use among young people aged 12-17 was 7.0 percent; the target was 8.0 percent, meaning the 2021 actual is 12.5 percent ahead of the target. As noted previously about the NSDUH, estimates based on the 2018 and 2019 NSDUH data are for illustrative purposes only, and cannot be compared to 2020 and 2021. Given the data available at this time, the 2025 target has already been met. The Administration will continue its efforts to maintain this significant progress.

Objective 2: Past 30-day use of an e-cigarette among middle and high school students is reduced by 15 percent by 2025.

Most e-cigarettes contain nicotine—the addictive drug in regular cigarettes, cigars, and other tobacco products. Nicotine is highly addictive, and can harm adolescent brain development, which continues into the early to mid-20s. Additionally, young people who use e-cigarettes may be more likely to smoke cigarettes in the future.[20] Similar to the other youth use objectives, ONDCP will continue to work with external and federal partners to reach school-aged children, and to mobilize communities to prevent youth vaping. Data for this measure is from the National Youth Tobacco Survey (NYTS) Morbidity and Mortality Weekly Report[21]. In 2020, the percentage of past 30-day use of an e-cigarette among high school and middle school students was 13.1 percent. The objective seeks to reduce past 30-day use of an e-cigarette by 15 percent by 2025.

The challenge to reducing vaping is similar to that for alcohol. Marketing for vaping has been directed to appeal to youth, attempting to normalize vaping behavior; the effect is youth experimentation driven by curiosity and the marketed flavors.[22] Tobacco product advertising for e-cigarettes has increased rapidly since 2011. An estimated four in five U.S. youths were exposed to e-cigarette advertisements.[23] In addition, vaping devices are commonly available, generally inexpensive, and easily disguised to look like everyday products.



Source: Gentzke AS, Wang TW, Cornelius M, et al. Tobacco Product Use and Associated Factors Among Middle and High School Students — National Youth Tobacco Survey, United States, 2021. MMWR Surveill Summ 2022;71(No. SS-5):1–29.

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[20] HHS. E-cigarette Use Among Youth and Young Adults: A Report of the Surgeon General. Atlanta, GA: CDC; 2016.
[21] The original 2022 PRS used the National Youth Tobacco Survey. ONDCP decided to utilize estimates published in the annual NYTS MMWR as the source for this PRS measure. This data source provides more reliable and consistent estimates compared to the survey's methodology report which was used as the previous source.
[22] HHS. E-cigarette Use Among Youth and Young Adults: A Report of the Surgeon General. Atlanta, GA: CDC; 2016.
[23] Marynak K, Gentzke A, Wang TW, Neff L, King BA. Exposure to Electronic Cigarette Advertising Among Middle and High School Students — United States, 2014–2016. MMWR Morb Mortal Wkly Rep 2018;67:294–299. DOI:http://dx.doi.org/10.15585/mmwr.mm6710a3

In 2021, the percentage of past 30-day use of an e-cigarette among high school and middle school students was 7.6 percent; the target was 12.7 percent, meaning the 2021 actual is roughly 40 percent ahead of the target. While this appears lower than previously reported estimates of e-cigarette use in 2020,[24] any comparison of results between survey years, including the direct attribution of any potential changes in tobacco product use, is not possible because of the modifications to the fielding procedures in 2021 as a result of the COVID-19 pandemic.

Specifically, approximately half of students taking the 2021 NYTS reported doing so from outside of a school building or classroom; students participating in the survey in a school building or classroom reported a higher prevalence of ever and current use of any tobacco product, including e-cigarettes[25], compared with students participating at home or some other place. However, declines in e-cigarette use during the COVID-19 pandemic compared with a pre-pandemic period have been observed in other studies of young persons.[26,27] Differences in tobacco product use by survey completion setting might be caused by potential underreporting of behaviors, reduced access to tobacco products while at home, or other unmeasured characteristics among students participating outside of the classroom.

Therefore, the 2021 NYTS results cannot be compared with previous NYTS survey results that were primarily conducted on school campuses.[28] However, given the data available at this time, the 2025 target has already been met. The Administration will continue its current efforts to maintain this significant progress.

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[24] Gentzke AS, Wang TW, Jamal A, et al. Tobacco product use among middle and high school students—United States, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1881–8. https://doi.org/10.15585/mmwr.mm6950a1

[25] Park-Lee E, Ren C, Sawdey MD, et al. Notes from the field: e-cigarette use among middle and high school students—National Youth Tobacco Survey, United States, 2021. MMWR Morb Mortal Wkly Rep 2021;70:1387–9 https://doi.org/10.15585/mmwr.mm7039a4

[26] Kreslake JM, Simard BJ, O'Connor KM, Patel M, Vallone DM, Hair EC. E-cigarette use among youths and young adults during the COVID-19 pandemic: United States, 2020. Am J Public Health 2021;111:1132–40. https://doi.org/10.2105/AJPH.2021.306210

[27] Gaiha SM, Lempert LK, Halpern-Felsher B. Underage youth and young adult e-cigarette use and access before and during the coronavirus disease 2019 pandemic. JAMA Netw Open 2020;3:e2027572. https://doi.org/10.1001/jamanetworkopen.2020.27572

[28] Gentzke AS, Wang TW, Cornelius M, et al. Tobacco Product Use and Associated Factors Among Middle and High School Students — National Youth Tobacco Survey, United States, 2021. MMWR Surveill Summ 2022;71(No. SS-5):1–29. DOI:http://dx.doi.org/10.15585/mmwr.ss7105a1.

Goal 3. Harm Reduction efforts are increased in the United States.

Harm reduction strategies, including syringe services programs (SSPs), distribution of fentanyl test strips, and naloxone, help to meet people where they are and save lives. By increasing legally authorized harm reduction efforts, the *Strategy* will decrease health harms beyond addiction—such as infection transmission and overdose—that are associated with drug use, as well as provide opportunities for low-threshold access to treatment. There is strong evidence that SSPs increase treatment entry,[29,30] reduce the transmission rates of infectious diseases (e.g., HIV, hepatitis B and C), function as a cost-effective prevention intervention,[31] and serve as an effective platform to link people who use drugs to health care and social services.[32]

Stakeholders for this goal include federal departments, law enforcement organizations, harm reduction advocates, persons with lived experiences of substance use and infectious diseases such as HIV and hepatitis, and treatment and recovery organizations. The major federal partners include AmeriCorps, HHS, and the Departments of Veterans Affairs (VA), Justice (DOJ), and Housing and Urban Development (HUD). Law enforcement-related organizations with an interest include the International Association of Chiefs of Police (IACP), the National Sheriff's Association (NSA), the Police Executive Research Forum (PERF), the Police, Treatment, and Community Collaborative (PTACC), the Police Assisted Addiction and Recovery Initiative (PAARI), Treatment Alternatives for Safe Communities (TASC) and the National Association of Drug Court Professionals (NADCP). Harm Reduction organizations include the National Harm Reduction Coalition, Housing Works, the Center for Optimal Living, the Levenson Foundation, and the National Coalition for Harm Reduction Funding. Finally, treatment and recovery organizations include NASADAD, the National Alliance of State and Territorial AIDS Directors, the National Council for Mental Wellbeing, the Pew Charitable Trusts, the SAFE Project, the National Association of Addiction Professionals (NAADAC), the American Society for Addiction and the National Association of Addiction Treatment Providers.

Consultations were held informally and formally with these agencies, organizations and institutions. Discussions included the importance of incorporating specialized case management to foster pre-arrest diversion and deflection, and reimbursement for harm reduction services.

The law enforcement, harm reduction, and treatment organizations are all important partners in communicating the importance of working with and supporting legally allowable harm reduction programs, organizations, and initiatives. Engagement and collaboration with them will facilitate a more rapid acceptance of harm reduction interventions. HHS (through the CDC) plays a critical role in directly funding legally allowable harm reduction services and collaborating with

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[29] Heimer R. Can syringe exchange serve as a conduit to substance abuse treatment? J Subst Abuse Treat. 1998;15(3):183-191. doi:10.1016/S0740-5472(97)00220-1

[30] Kidorf M, King VL, Neufeld K, Pierce J, Kolodner K, Brooner RK. Improving substance abuse treatment enrollment in community syringe exchangers. Addiction. 2009;104:786–795

[31] Holtgrave DR; Pinkerton SD; Jones TS; Lurie P; Vlahov D; (1998). Cost and cost-effectiveness of increasing access to sterile syringes and needles as an HIV prevention intervention in the United States. Journal of acquired immune deficiency syndromes and human retrovirology: official publication of the International Retrovirology Association. https://pubmed.ncbi.nlm.nih.gov/9663636/

[32] Open Society Foundations. Harm Reduction at Work: A GUIDE FOR ORGANIZATIONS EMPLOYING PEOPLE WHO USE DRUGS. https://www.opensocietyfoundations. org/uploads/170e646d-bcc0-4370-96d7-7cf2822a1869/workharmreduction-20110314.pdf

the syringe services programs to collect data needed to assess progress towards the objective, as well as additional information about services provided by specific SSPs around the country. Additionally, HRSA provides funding through the Rural Communities Opioid Response Program to support rural communities in naloxone training, distribution, and administration. SAMHSA, in addition to serving as the lead for the distribution of harm reduction funding, administers the two large federal SUD grant programs (the Substance Use Prevention, Treatment and Recovery Services (SUPTRS) block and State Opioid Response (SOR) grants). It will be important for SAMHSA to work with state drug and alcohol directors closely to increase utilization of legally allowable harm reduction programs through these grants.

Objective 1: The number of counties with high overdose death rates which have at least one Syringe Services Program (SSP) is increased by 85 percent by 2025.

Increasing the number of counties with high overdose death rates that have legally allowable SSPs will extend the benefits of disease prevention intervention and health care and social services to much more people who use drugs (PWUD), while concurrently offering new treatment entry points to those ready to initiate some level of SUD treatment. Although many PWUD actively seek addiction treatment, the majority do not, as highlighted by the latest NSDUH report, which found that nine out of ten PWUD do not seek treatment. These individuals benefit from not just the health and disease prevention services provided by SSPs, they also benefit from the relationships built with SSP staff and volunteers. This connectivity to current drug users allows SSPs to offer additional services, including substance use disorder treatment, including medications for opioid use disorders. Thus, SSPs do not just reduce overdoses and improve health, they also serve as a vital platform for entry into evidence-based substance use disorder treatment. Some states do not have any SSPs while other regions of the country are vastly underserved. In these jurisdictions that do not prohibit SSPs, there exists capacity to reduce overdoses, improve the health of people who use drugs, reduce infectious complications of injection drug use, and expand the ways in which individuals can initiate treatment.

The Harm Reduction chapter in the *Strategy* calls for the creation of several new coordinating and communication mechanisms and partnerships designed to foster increased utilization of a harm reduction approach to help those PWUD. All of these efforts would support SSPs where legally allowed as the key platform for providing harm reduction and related substance use and mental health services, including access to low-threshold treatment.

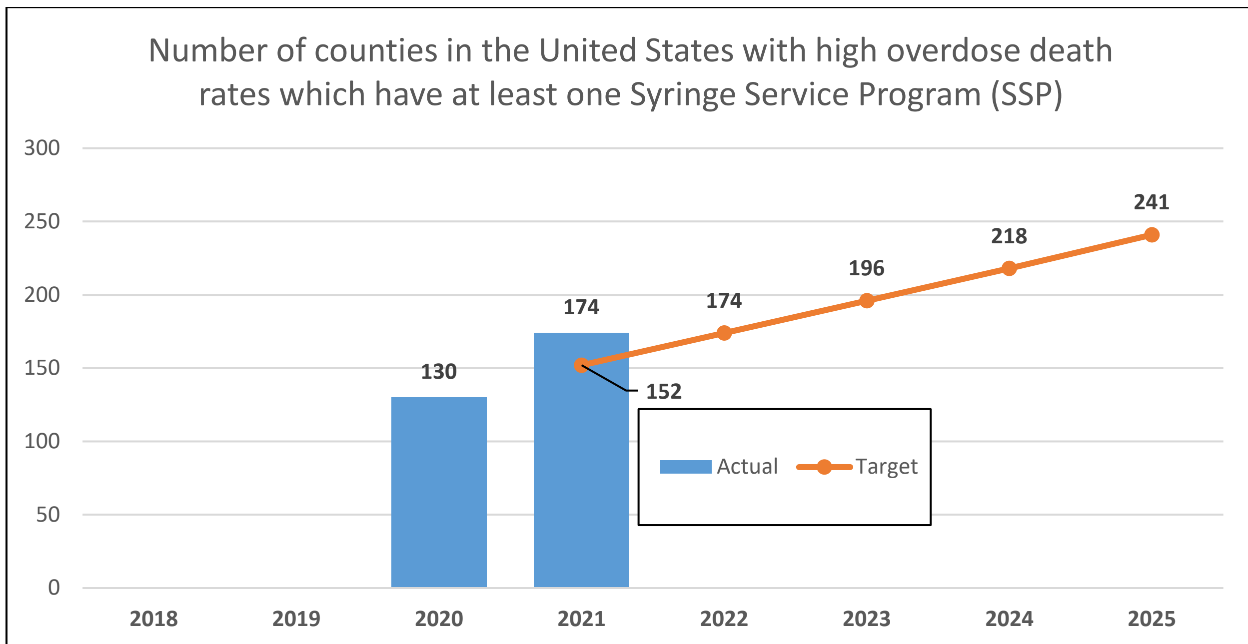
Continued collaboration between ONDCP and HHS (especially CDC and SAMHSA) supports SSPs to provide a robust range of services. Federal efforts intend to be complementary to existing advocacy organizations, and seek to develop dialogues on harm reduction with law enforcement associations and the 12-step recovery community.

ONDCP is utilizing its convening power to host exchanges, meetings, and dialogues that explain the value of harm reduction, in particular focusing on research that shows the effectiveness of SSPs. ONDCP is working with key constituency groups to address or mitigate any concerns they have about harm reduction.

Although the overdose epidemic is a national priority, some counties in the country face greater challenges. Ensuring that SSPs are established and able to operate effectively in these high-risk

counties that do not prohibit them by law will drive down overdose rates nationally. The CDC's NCHS' small area estimates (which are modeled drug overdose death rates by county) served as the basis for identifying the counties most at risk. ONDCP used a publicly available database that specifically lists the number of SSPs in the country as well as the services they provide to establish a baseline. In 2020, the number of high-risk counties in the United States with at least one SSP was 130; the objective seeks to raise this number in jurisdictions that do not prohibit them by law by 85 percent by 2025.

Concerns about SSPs at the State and local levels is one of the biggest obstacles to achieving the objective's targets. The *Strategy* works to mitigate this problem and encourage adoption of SSPs. The increasing availability of Federal funds should allow SSPs in jurisdictions that do not prohibit them by law to upgrade their capacity across the board, improve their communications strategies, and increase their ability to engage more PWUD both in harm reduction programs and in SUD treatment programs.



Sources: University of Washington; CDC WONDER Online Database

In 2021, the number of counties with high overdose death rates that had at least one syringe service program was 174; the target was 152, meaning the 2021 actual is 14.5 percent ahead of the target. This progress is most likely the result of increasing support for and understanding of the role of harm reduction programs both at the federal and State level. In 2021, the federal government provided, through the American Rescue Plan, the first direct financial support for legally allowable harm reduction services, through a program run by SAMHSA with support from CDC. These funds, combined with the engagement and communications efforts associated with this new grant program, and the continued work of families impacted by addiction and harm reduction advocacy groups created a better environment for those states and communities seeking to establish SSPs. Given the data available at this time, there is a reasonable expectation that the 2025 target will be met.

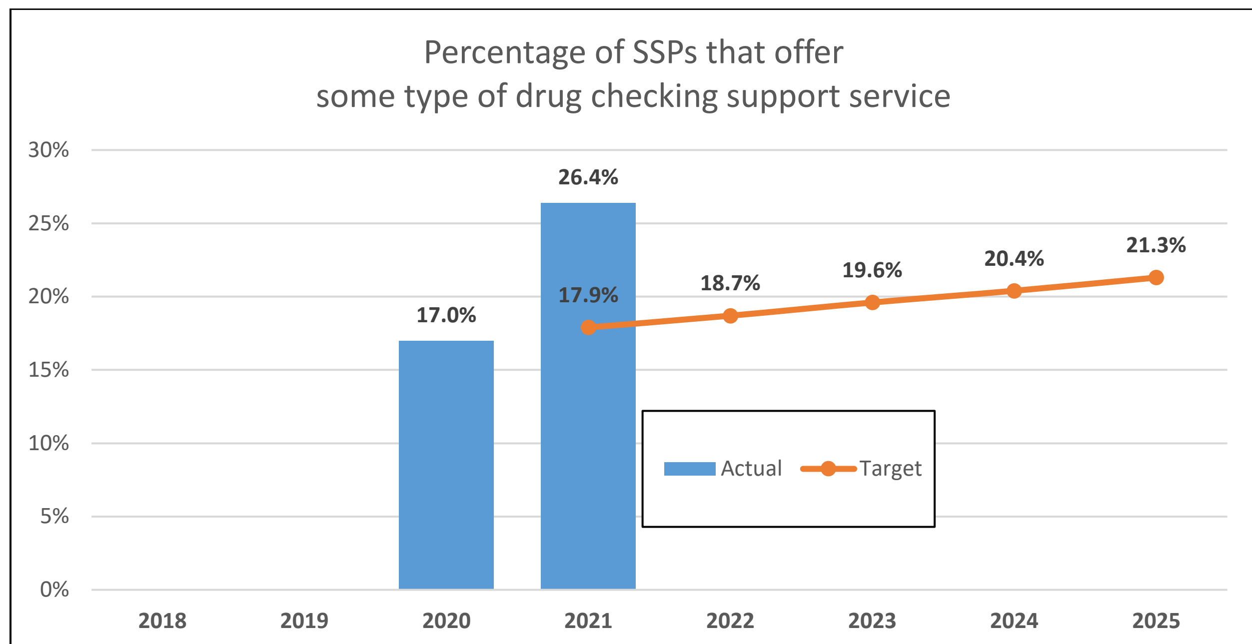
Objective 2: The percentage of SSPs that offer some type of drug safety checking support service, including, but not limited to Fentanyl Test Strips, is increased by 25 percent by 2025.

Increasing the percentage of SSPs which offer drug checking support services, including Fentanyl Test Strips (FTS), in jurisdictions that do not prohibit them by law will contribute to reducing overdoses. PWUD who have access to FTS can prevent overdoses by either refusing to consume the drug once synthetic opioids (other than methadone) are detected or altering how they consume the drugs to protect themselves. Simple behavior changes, such as using more slowly, or making sure they are not using alone and have naloxone nearby, can literally save lives. FTS are a simple, inexpensive tool that should be made available to those who can benefit from them in jurisdictions that do not prohibit them by law.

As noted above, the *Strategy* calls for the creation of several new coordinating or communication mechanisms designed to foster increased utilization of harm reduction programs, including the formation of an advisory group on harm reduction. Due to the high penetration of synthetic opioids (other than methadone) in the drug supply, providing drug checking services in jurisdictions that do not prohibit them by law is an increasingly urgent priority.

The North American Syringe Exchange Network (NASEN) database, based upon a survey of SSPs, lists the number of SSPs in the country providing drug checking services. In 2020, 17 percent of SSPs offered some type of drug checking support services.

Challenges for this objective will center on State and local concerns regarding drug checking services (e.g., FTS). ONDCP and the interagency will work with provider organizations to help them communicate the need for and effectiveness of drug checking services.



Source: University of Washington

In 2021, the percentage of SSPs that offered fentanyl test strips was 26.4 percent; the target was 17.9 percent, meaning the 2021 actual is 48 percent ahead of the target. The increase in drug

checking with fentanyl test strips was primarily driven by growing awareness, due to media and government reporting, of the potentially lethal presence of fentanyl or other synthetic opioids in a variety of drugs sold on the black market, including counterfeit prescription drugs and stimulants. In addition, the utility of drug checking was highlighted in public remarks by senior Biden Administration officials and, for the first time in ONDCP's history, within the *Strategy*. Given the data available at this time, the 2025 target has already been met. The Administration will continue its efforts to maintain this significant progress in jurisdictions that do not prohibit them by law.

Goal 4. Treatment efforts in the United States are increased.

EBTs for addiction have been shown to reduce overdose risk and mortality. However, many treatment programs have not implemented EBT, many people who need EBTs do not go to treatment, and many communities lack treatment options. The social determinants of health (such as housing instability and unemployment) can also play important roles in lack of sustained access to needed treatment services.

CDC's mortality data from 2020 shows that most drug involved deaths involved opioids, cocaine, or psychostimulants. The *Strategy* emphasizes that EBTs, including medications for opioid use disorder (MOUD), contingency management, and other behavioral & psychosocial treatments like the Therapeutic Education System (a form of Cognitive Behavioral Therapy) are all intended for treating the SUD that put people most at risk for overdose.

ONDCP coordinates action on this objective with a number of federal partners including numerous agencies within HHS, VA and DOJ. Non-governmental stakeholders include NASADAD, the American Medical Association, the American College of Emergency Physicians, the American Society of Addiction Medicine, and the National Academies of Sciences, Engineering, and Medicine (NASEM). ONDCP held listening sessions during the 2021 Policy Priority development process, which informed these goals and had a variety of contacts to better understand possible policy barriers.

Interagency partners will assist in developing and requesting authorities to increase access to EBTs. They were also involved in exploring the benefit of continuing initiatives for opioid treatment medication begun during the COVID pandemic public health emergency. ONDCP has engaged NASEM to assess potential changes in the use of methadone.

Objective 1: Treatment Admissions for the populations most at risk of overdose death is increased by 100 percent by 2025.

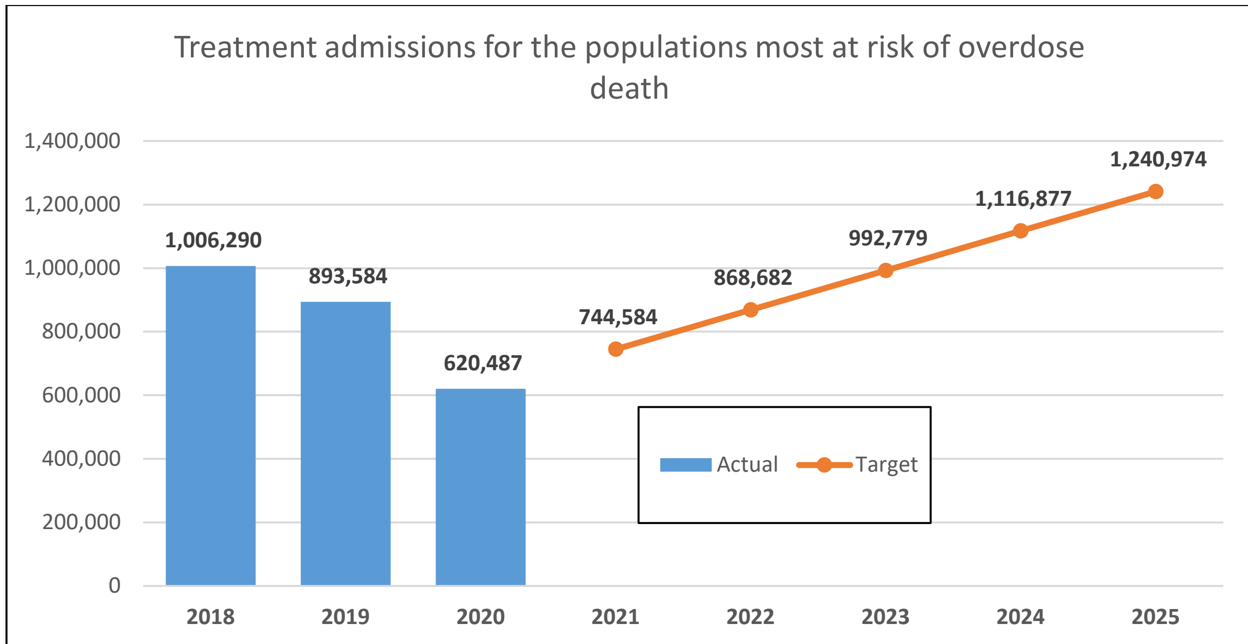
The *Strategy's* efforts to reduce overdoses include improving access to overdose prevention skills training and naloxone distribution. Additionally, it includes initiatives to ensure that more of the people at most risk of overdose (e.g., people with opioid, methamphetamine, and/or cocaine use disorder) receive treatment that should help reduce their overdose risk.

The coordinating mechanisms for this objective are similar to those for Goal 1, Objective 2 ("The percentage of people meeting criteria for cocaine, opioid, and methamphetamine use disorder are each respectively reduced by 25 percent by 2025."). ONDCP works with the interagency to develop approaches to increasing treatment access, will work with states on leveraging opioid settlement funds, including for expanding EBTs to their residents, and will explore possible additional reforms. The objective seeks to increase treatment admissions by 100 percent by 2025.

The data for this measure come from the SAMHSA's Treatment Episode Data Set (TEDS). TEDS collects demographic and substance use data on admissions to and discharges from primarily publicly-funded substance use disorder treatment facilities. To assess the population at most risk of overdose death, this objective measures the total number of primary opioid, cocaine, and methamphetamine admissions to substance use treatment facilities in the past year.

As discussed in the *Strategy's* Data Systems and Research Chapter, "our data systems have not kept up and lack the timeliness, scope and precision required for the most impactful national response" to the current addiction epidemic.

The challenges for this objective are also similar to those of Goal 1, Objective 2. Most of the changes will involve new strategies, and will require consensus amongst all stakeholders. Furthermore, addressing social determinants of health will require long-term proposals.



Source: Table 1.1A TEDS Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Treatment Episode Data Set (TEDS):2020. Admissions to and Discharges From Publicly Funded Substance Use Treatment. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2021.

TEDS is typically only available with an 18-month lag because, in part, measuring involvement in treatment participation occurs over time, and because TEDS relies on data reporting for each individual state. The 2020 TEDS data was only released in November 2022[33], allowing the establishment of the 2020 baseline and the 2025 target; the 2021 TEDS data is not yet available. ONDCP will release an amended *PRS* once the data is available.

Objective 2: The projected shortfall in the qualified workforce of behavioral health providers (including addiction professionals) funded by federal programs in the United States is reduced by 70 percent by 2025.

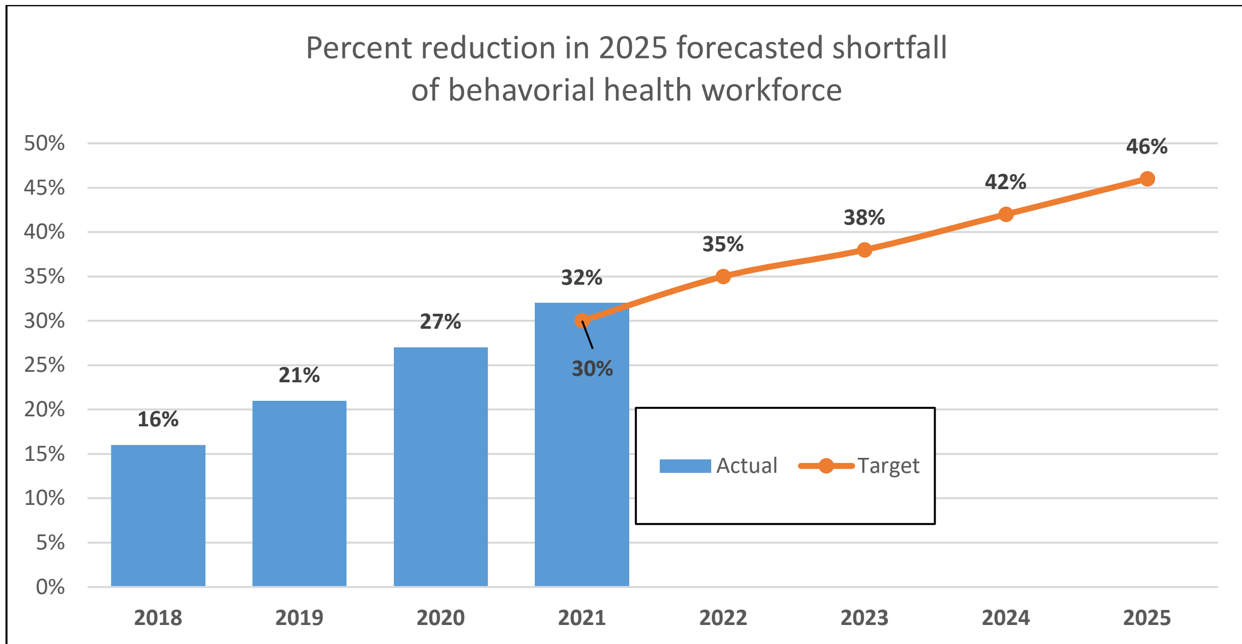
A properly trained workforce of addiction professionals is needed to increase treatment access in the United States. In the 2016 National Behavioral Health Practitioner Projections Report, HRSA estimated that by 2025, there will be significant shortages of psychologists, social workers, school counselors, and marriage and family therapists that equal over 41,000 behavioral health

[33] SAMHSA's 2020 TEDS report slightly revised the 2018 and 2019 actuals previously reported in the 2022 *PRS*.

full-time equivalents (FTE), regardless of employment setting.[34] Since the release of this report, HRSA has reduced this projected shortage by 27 percent, and the objective seeks to eliminate 46 percent of the projected national shortfall of behavioral health providers by 2025.

Data for this measure is from HRSA's Behavioral Health Workforce Education and Training (BHWET) Program. The BHWET program contributes thousands of new paraprofessionals and professionals to enhance the Nation's behavioral health workforce capacity in critical areas of need. In addition to the BHWET program, HRSA is growing the substance use disorder workforce through the Graduate Psychology Education, Opioid-Impacted Family Support Program, Addiction Medicine Fellowship, Integrated Substance Use Disorder Training Program as well as the loan repayment and scholarship programs. These programs provide financial incentive to professionals and paraprofessionals to train and provide direct care services in community-based settings in rural and underserved areas.

The main challenge to meeting the objective is ensuring a steady program, which will contribute thousands of new professionals and paraprofessionals to enhance the Nation's behavioral health workforce capacity in critical areas of need. ONDCP will work with HHS and HRSA to ensure this program is adequately supported.



Source: Health Professions Training Programs Dashboards (available at https://data.hrsa.gov/topics/health-workforce/training-programs)

In 2021, the projected shortage had been decreased by 32 percent; the target was 30 percent, meaning the 2021 actual is seven percent ahead of the 2021 target. While HRSA's Health Workforce Simulation Model continues to project shortages of behavioral health workers, the nation's health workforce capacity continues to grow. Given the data available at this time, there is a reasonable expectation that the 2025 target will be met.

[34] National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025 November 2016. U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Health Workforce, National Center for Health Workforce Analysis

Goal 5. Recovery efforts in the United States are increased.

Substance use disorder remains prevalent in the United States. In 2021, an estimated 46.3 million Americans aged 12 or older (or 16.5 percent of this population) had an SUD.[35] However, recovery is not only possible, but common. Among the 29 million adults in 2021 who perceived that they ever had a substance use problem, 72 percent (or nearly 21 million) considered themselves to be in recovery.[36] While addiction is a chronic condition, treatment tends to be delivered in an episodic fashion, which is not optimal for helping a patient achieve long-term recovery.

Recovery support services provide ongoing support prior to, during, after, and sometimes in lieu of treatment to increase the likelihood of successful long-term recovery while also reducing substance use-related morbidity, mortality, criminal justice system involvement, and associated costs. Additionally, when employed by recovery community organizations (RCO) and other community-based peer-led organizations, peer workers can participate in the full continuum of services and supports from primary prevention and harm reduction, to engagement of overdose survivors, linkage to treatment and ongoing recovery support; their work can precede treatment, complement it, support post-treatment recovery, and can be offered in lieu of it when not accessible or declined by the individual.

Recovery support services (RSS) not only link the various components of care systems but also provide a flexible, bi-directional bridge between community-based supports such as mutual aid or faith groups, family, and supportive peer networks and formal systems, such as the specialty SUD treatment and broader healthcare sector, law enforcement, and the criminal justice and child welfare systems. Moreover, the majority of people with a past-year SUD report not having received treatment in the past year[37], whereas the majority of people who report having received treatment in the past year resolved an alcohol or other drug problem. This underscores the importance of ensuring access to the continuing resources needed to support multiple pathways to recovery and remission, including those that do not involve treatment. The recovery support services infrastructure is indispensable to accomplishing this.

This goal is especially important because, compared to our specialty treatment and broader healthcare sectors, our Nation's RSS infrastructure is still nascent and unevenly available. In fact, the traditional prevention and treatment funding categories do not even recognize it. While there are no data available to routinely estimate local recovery support services' needs or capacity, it is clear that these services are unevenly available and receive an extremely small percentage of government and private sector substance use services funding. While still limited, research on recovery support services has yielded promising results. For example, one study found that receipt of services at a recovery community center (RCC) is associated with greater

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[35] Substance Abuse and Mental Health Services Administration. *Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health*. 2022:162. https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report

[36] Center for Behavioral Health Statistics and Quality. *Results from the 2021 National Survey on Drug Use and Health: Detailed tables*. Substance Abuse and Mental Health Services Administration. 2022. Table 5.7A, p. 835.

[37] Center for Behavioral Health Statistics and Quality. Results from the 2020 National Survey on Drug Use and Health: Detailed tables. Rockville, MD: Substance Abuse and Mental Health Services Administration. 2021. Retrieved from https://www.samhsa.gov/data/.

duration of abstinence, reduced substance use problems, and improved psychological well-being and quality of life.[38]

Stakeholders in this goal include both federal Departments and treatment and recovery-related groups and associations. The Departments of Commerce, Labor, State, Education, HHS, DOJ, VA, and HUD, AmeriCorps, and the Equal Employment Opportunity Commission will all have a role in achieving the objectives, as well as non-governmental organizations such as NASADAD, NAADAC, Faces and Voices of Recovery, the Global Recovery Initiatives Foundation, the Foundation for Opioid Recovery Efforts, the National Alliance for Recovery Residences (NARR), Oxford House, Inc., the Association of Recovery in Higher Education, the Association of Recovery Schools, the Association of Alternative Peer Groups, the International Certification and Reciprocity Consortium, the Global Centre for Credentialing and Certification, the International Society of Substance Use Professionals, the Addiction Policy Forum, the Legal Action Center (LAC), and diverse institutions of higher education as well as research centers, such as the Harvard/Massachusetts General Recovery Research Institute and the Virginia Tech Addiction Recovery Research Center. ONDCP reached out to all of these partners, conducting individual and group consultations (including with people with lived experience), and consolidating their input into both the *Strategy* and these goals.

Objective 1: The number of states operating a recovery-ready workplace initiative is increased 75 percent by 2025.

The majority of Americans with SUD are employed[39]. Employment is critical to successful long-term recovery and reducing the risk of recidivism. Many people in recovery face barriers to employment due to periods of unemployment and/or prior substance use-related criminal justice system involvement. Workplace policies that encourage help-seeking and foster cultures that are supportive of recovery will reduce substance use, increase the number of Americans in recovery, improve the bottom line of employers that adopt such policies, and enhance public safety.

Accomplishing this objective will require outreach to both the federal and private/non-federal sectors. ONDCP will create an interagency policy committee with subgroups dedicated to the external and internal components of this task. While there is no single data source available, most state-level recovery-ready workplace initiatives offer a certification, as such certification may qualify the employer for tax credits or other benefits.

Monitoring of progress toward this goal is challenging, as there is no central list of employers or facilities adopting recovery-ready workplace policies, nor nationally recognized criterion for achieving certification or other official recognition as a recovery-ready workplace. It is for this reason that ONDCP has chosen to track the number of states that certify or otherwise formally recognize employers or workplaces that meet predetermined criteria through their policies and practices. In 2020, eight states had a recovery-ready workplace initiative; working with the Departments of Labor, Commerce and HHS, the objective proposes increasing that by 75 percent by 2025.

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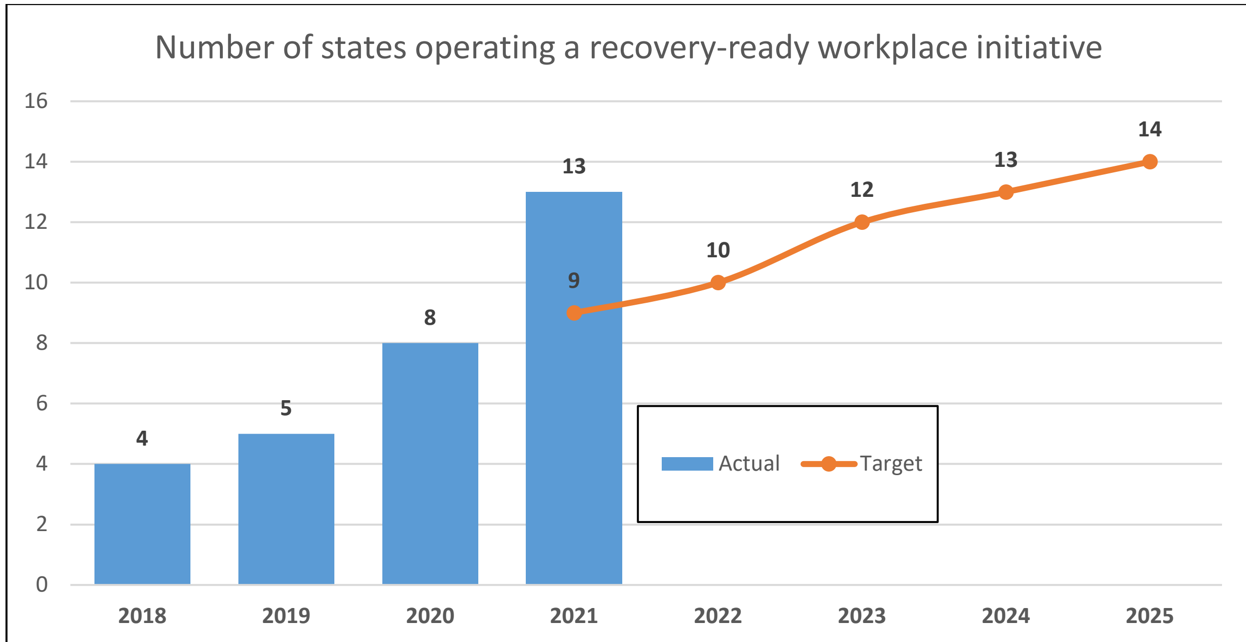
[38] Kelly JF, Fallah-Sohy N, Cristello J, Stout RL, Jason LA, Hoeppner BB. Recovery community centers: Characteristics of new attendees and longitudinal investigation of the predictors and effects of participation. *Journal of Substance Abuse Treatment.* 2021;124:108287.

[39] Center for Behavioral Health Statistics and Quality. (2022). Results from the 2021 NSDUH: Detailed tables. Substance Abuse and Mental Health Services Administration. Table 5.7a; Table 8.41a.

A key challenge to meeting this objective is that where statutes and regulations govern, the federal departments may not have the authority to make certain policy changes to advance toward recovery-ready workplace goals and—even where it has such authorities—it may take significant time, and potentially, regulatory revisions. Nonetheless, ONDCP and federal partners are exploring options, including the alignment of Drug-Free Workplace Program requirements and recovery-ready workplace policies, and exploring potential funding mechanisms for recovery-ready workplace initiatives.



Source: ONDCP survey of State recovery organizations

In 2021, 13 states were operating recovery-ready workplace initiatives; the target was 9, meaning the 2021 actual is 41 percent ahead of the 2021 target. An interagency workgroup jointly convened by ONDCP and the Domestic Policy Council helped drive movement by conducing outreach to key stakeholders, raising awareness of recovery-ready workplace policies and their benefits, and launching the Recovery-Ready Workplace Resource Hub[40] in partnership with the Department of Labor's Employment and Training Administration. Additionally, the workgroup is developing a Recovery-Ready Workplace Toolkit, which will be made available through the resource hub. Given the data available at this time, there is a reasonable expectation that the 2025 target will be met.

Objective 2: The number of peer-led recovery community organizations is increased by 25 percent by 2025.

Peer-led RCOs are key components of recovery-ready communities. Their mission "is to mobilize resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery from alcohol and other drug addiction." The recovery community that is engaged and mobilized by RCOs is broadly defined, including "people in long-term recovery, their

[40] https://www.dol.gov/agencies/eta/RRW-hub/

families, friends and allies, including recovery-focused addiction … professionals."[41] Through education, advocacy, and recovery support services, they can help create more resilient communities that welcome people in or seeking recovery. As recovery support service hubs, these entities bridge formal systems and community-based supports, such as family, a community of recovering peers, and mutual aid groups. These services can be provided prior to, during, after, and in lieu of treatment, and can include assistance securing housing and employment.

Because they can be flexibly staged and do not need to be limited to reimbursable treatment episodes, PRSS provide an indispensable mechanism for engaging and supporting people with or in recovery from SUD, tailoring services and supports to their needs. Additionally, they provide a connective tissue linking various sectors and systems, facilitating a comprehensive and well-coordinated approach to substance use and SUD at the local and state levels. Long-term recovery and social reintegration take place in the community, and these entities help countless individuals find and sustain a pathway to recovery, including when treatment is not available or is declined. Peer specialists employed by RCOs are playing an expanding role in engaging individuals with SUD, providing harm reduction services,[42] engaging overdose survivors in emergency departments,[43,44] offering overdose prevention education, distributing naloxone,[45] linking those they serve to treatment, facilitating access to housing and employment, and providing ongoing support during and after care.[46] Peers employed by RCOs work in and bridge the criminal justice, child welfare and other systems with community-based services and supports.

Embracing all pathways to recovery, RCOs also conduct outreach and provide services to individuals receiving MOUD through general medical settings and specialty SUD treatment settings, including opioid treatment programs. RCOs and their staffs also provide recovery coaching, mentoring, support groups, drug- and alcohol-free social and recreational events, and social support and engagement through a community of recovering peers. These services at once serve to build recovery capital,[47] the internal and external resources needed to achieve and sustain recovery from substance use disorder,[48] and to address key social determinants of health that are central to achieving and sustaining recovery, health, and wellbeing. Unfortunately, these services are nascent or non-existent in many communities. It is for this reason that the *Strategy* seeks to expand peer-led RCOs.

ONDCP works with NDCPAs to coordinate efforts to expand the number of peer-led organizations. Increasing the number of peer-led RCCs will require a combination of block and discretionary grant funding, training and technical assistance for emerging and established

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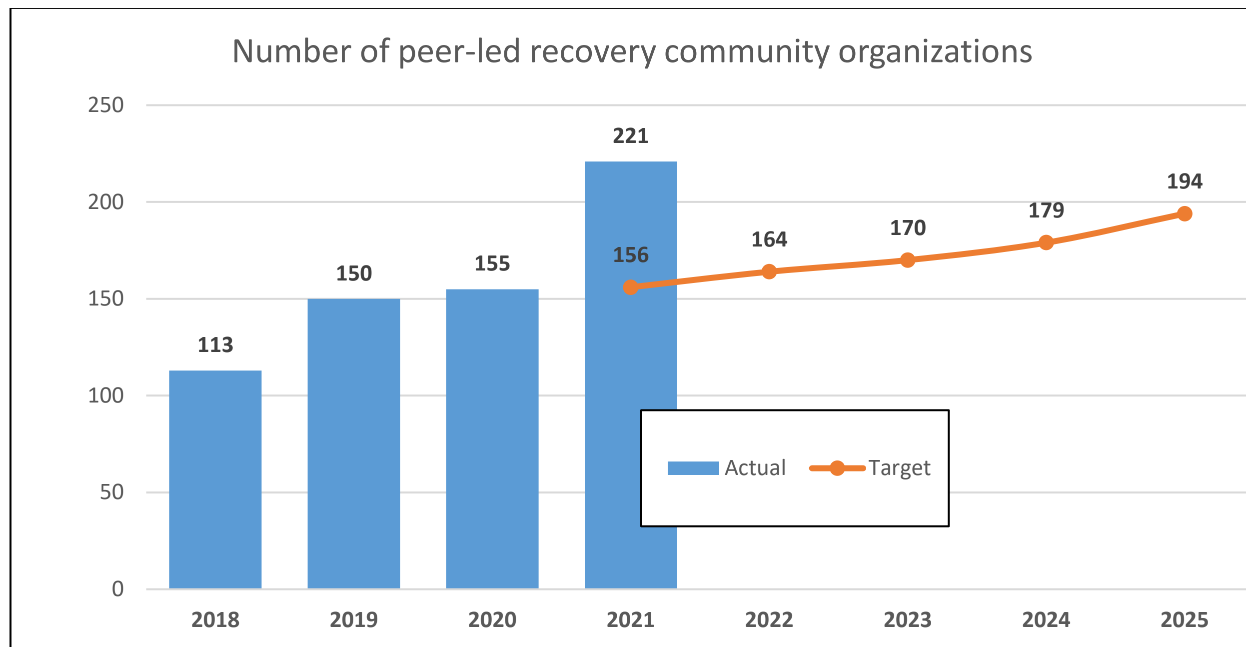
[41] Valentine P, White, W.L., Taylor, P. The Recovery Community Organization: Toward A Working Definition and Description. *Connecticut Community for Addiction Recovery.* 2007.
[42] Ashford RD, Brown AM, Dorney G, et al. Reducing harm and promoting recovery through community-based mutual aid: Characterizing those who engage in a hybrid peer recovery community organization. *Addict Behav.* 2019;98:106037.
[43] Carey CW, Jones R, Yarborough H, Kahler Z, Moschella P, Lommel KM. 366 Peer-to-Peer Addiction Counseling Initiated in the Emergency Department Leads to High Initial Opioid Recovery Rates. *Annals of Emergency Medicine.* 2018;72(4):S143-S144.
[44] Welch AE, Jeffers A, Allen B, Paone D, Kunins HV. Relay: A Peer-Delivered Emergency Department-Based Response to Nonfatal Opioid Overdose. *Am J Public Health.* 2019;109(10):1392-1395.
[45] McGuire AB, Powell KG, Treitler PC, et al. Emergency department-based peer support for opioid use disorder: Emergent functions and forms. *Journal of Substance Abuse Treatment.* 2020;108:82-87.
[46] Samuels EA, Baird J, Yang ES, Mello MJ. Adoption and Utilization of an Emergency Department Naloxone Distribution and Peer Recovery Coach Consultation Program. Acad Emerg Med. 2019;26(2):160-173
[47] Ashford RD, Brown A, Canode B, Sledd A, Potter JS, Bergman BG. Peer-based recovery support services delivered at recovery community organizations: Predictors of improvements in individual recovery capital. *Addict Behav.* 2021;119:106945.
[48] White W, Cloud W. Recovery capital: A primer for addictions professionals. *Counselor.* 2008;9:22-27.

organizations, outreach to states and local governments to identify and highlight promising approaches for providing sustainable funding at the state and local levels. Secondarily, it will involve work to improve quality and facilitate cross-jurisdictional funding by encouraging greater consistency in standards from state-to-state. This work will involve relevant accreditation and certification bodies and public and private payers, including states.

As there is no previously existing regularly updated tally of such organizations, ONDCP developed a data set by summing the number of recovery community centers operated by organizations belonging to the Association of Recovery Community Organizations (ARCO); the number of RCOs belonging to ARCO that do not operate recovery community centers, and the number of sites accredited by the Council on Accreditation of Peer Recovery Support Services operated by organizations that are not ARCO members. Selecting these proxies ensures that the tally consists of quality organizations. In 2020, there were 155 RCCs.

The primary challenge to meeting this objective will be ensuring that set-aside for recovery support services is added to the statute; without the dedicated resources, achieving the 25 percent increase in facilities may be challenging. In the future, ONDCP will explore the possibility of expanding the tally to include the number of such organizations receiving funding from SAMHSA through discretionary grants and through the SUPTRS block grant. If Congress enacts the 10 percent SUPTRS block grant recovery support services set-aside, ONDCP will work with SAMHSA to determine whether states can be required to report on the number of peer-operated recovery community centers they fund though the set-aside.



Source: Faces and Voices of Recovery—List of ARCO Members

In 2021, there were 221 peer-led recovery community organizations; the target was 156, meaning the 2021 actual is 42 percent ahead of the 2021 target. SAMHSA grants helped drive this rapid increase in the number of RCOs. For example, in FY 2021, SAMHSA awarded $5.8 million in support of 61 grants under the Building Communities of Recovery grant program. These grants support peer-led organizations providing PRSS. Additionally, SAMHSA awarded $1.8 million to six recovery community organizations under the Recovery Community Services

Program. However, not all RCOs provide peer recovery support services. Some focus on advocacy and education, and others serve as coordinating entities for statewide RCC networks. Often, emerging RCOs begin by focusing on advocacy and education, building the capacity to operate RCCs, through which PRSS are typically provided. In 2020, 126 of 155 RCOs (82 percent) operated RCCs whereas, in 2021, 162 of the 221 RCOs in 2021 (73 percent) operated RCCs. This suggests a significant number of new RCOs, many of which will begin providing recovery support services in the future. While the percentage of RCOs providing PRSS declined, the number doing so increased by nearly 30 percent. The current figures suggest continued growth. Given the data available at this time, the 2025 target has already been met. The Administration will continue its efforts to maintain this significant progress.

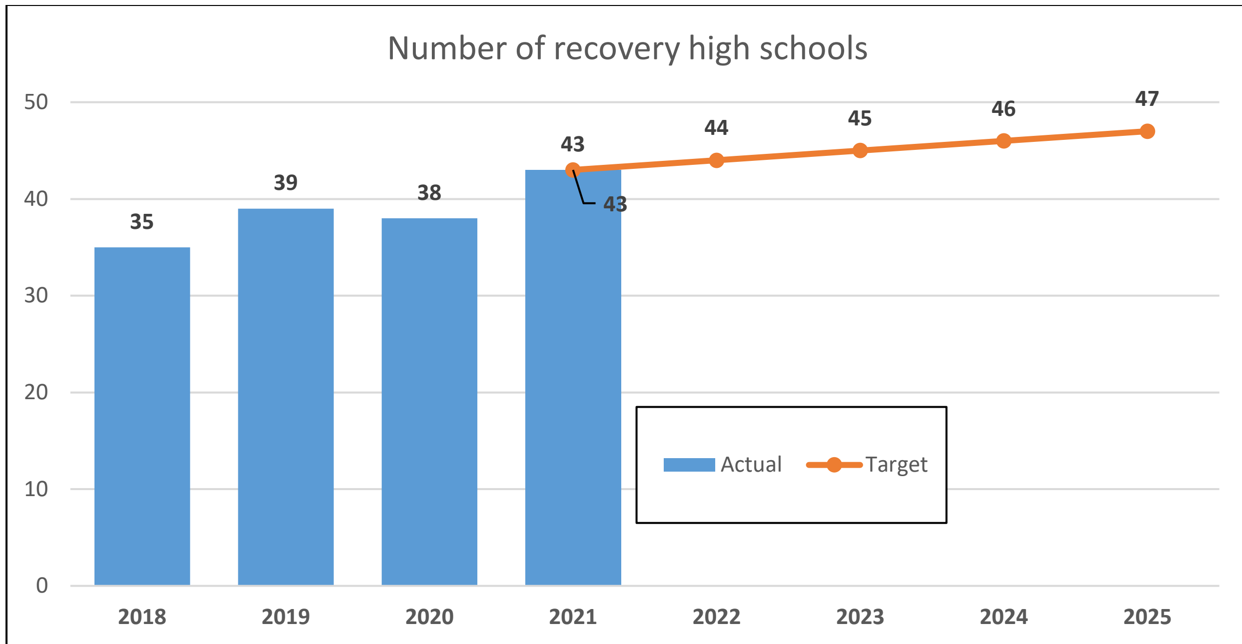
Objective 3: The number of recovery high schools is increased by 10 percent by 2025.

SUD has many developmental dimensions and impacts on youth. In 2021, an estimated 2.2 million youth age 12 to 17 had an SUD. Among youth age 12 to 17, 5.5 million (11 percent) reported lifetime illicit drug use, 3.7 million (6 percent) reported past year use, and 1.8 million (2 percent) reported past month use. That year, an estimated 1.5 million youth needed treatment for a drug use disorder, and only 3 percent received treatment while 0.9 million needed treatment for an alcohol use disorder, of whom only 3.7 percent received treatment.[49]

Unfortunately, interventions to address youth substance use typically do not occur until late adolescence at best, and often not until young adulthood or later. Moreover, secondary students who develop SUD and receive treatment often have to return to the same school milieu in which they used substances with peers. This makes a return to substance use highly likely—sometimes with deadly consequences. Recovery high schools provide a combination of clinical and peer services to youth in recovery from SUD, offering them a structured environment, counseling, and mentoring, and a supportive network of recovering peers. Recovery high schools provide adolescents with SUD a unique opportunity to achieve and sustain recovery. Unfortunately, there are only a small number of recovery high schools nationally. ONDCP will work with HHS, Education, and other federal partners to explore mechanisms for potential federal funding of recovery high schools.

Data from the Association of Recovery Schools indicates that there was a total of 43 recovery high schools in 2020. While the goal of a 10 percent increase in the number of recovery high schools may seem modest, there are special challenges associated with launching a recovery school, whether they are established as a charter school, a separate campus in a school district, or an embedded program on a campus. Because of their small size and need for specialized staff, recovery high schools can be expensive to operate, especially using standard per capita funding mechanisms. Additionally, SUD does not ever appear to have been identified as a qualifying condition for an Individual Education Plan under the Individuals with Disabilities Education Act.

[49] Center for Behavioral Health Statistics and Quality. (2022). *Results from the 2021 National Survey on Drug Use and Health: Detailed tables*. Tables 5.1. A, 1.6A, 1.6B & 5.37A, Substance Abuse and Mental Health Services.



Source: Association of Recovery Schools

In 2021, there were 43 operational recovery high schools, equaling the target. However, this figure masks a greater than anticipated rate of growth in the number of recovery high schools, as it was discovered subsequent to the release of 2022 *PRS* that the number of operating schools in 2020 was 38, rather than 43, which was the number used to establish the 2020 baseline. Use of the correct baseline would have yielded a 2025 target of 42 schools. ONDCP continues to raise awareness of the need for recovery high schools and their benefits, including through visits by the Director and associated social media posts and email updates. Additionally, ONDCP has initiated discussions with the Departments of Education and HHS about potential mechanisms for supporting recovery high schools and thereby further increasing their number. Given the data available at this time, there is a reasonable expectation that the 2025 target will be met.

Objective 4: The number of collegiate recovery programs is increased by 25 percent by 2025.

Students in recovery who participate in collegiate recovery programs (CRPs) have annual abstinence rates ranging from 75 to 100 percent, and average 92 percent. About five percent of CRP students reported past year alcohol or other drug use, a much lower rate than is found among age group peers in the first year following treatment.[50,51] CRP members have been found

[50] Laudet AB, Harris K, Kimball T, Winters KC, Moberg DP. Characteristics of students participating in collegiate recovery programs: a national survey. *Journal of substance abuse treatment.* 2015;51:38-46.
[51] Jason LA, Salomon-Amend, M., Guerrero, M., Bobak, T., O'Brien, J., Soto-Nevarez, A. The Emergence, Role, and Impact of Recovery Support Services. *Alcohol Res.* 2021;41(1):9.

to have high graduation rates and consistently higher grade-point averages than the student population as whole.[52,53,54]

CRPs vary widely in their structure and cost. In their early stages, many begin as student associations. Once these collegiate recovery communities/efforts have some level of staffing and funding and a dedicated space on campus, they are referred to as CRPs. Commonly CRPs are operated by campus counseling, health, or student affairs departments. Some have pre-admission requirements, such as completion of treatment and documentation of at least six months in recovery, (e.g., Texas Tech University) while others are open to any interested student on campus (e.g., campuses in the University of Texas System). Some offer optional drug- and alcohol-free housing to interested members, some do not offer housing, and some require that members live in a dedicated housing unit that is akin to a recovery residence (e.g., Syracuse University and Augsburg University). Some may have credentialed clinical staff, while others may not.

ONDCP is working with Education and HHS, along with key stakeholders in the higher education and collegiate recovery sectors to increase the number of CRPs by 25 percent by 2025. Based on data from the Association of Recovery in Higher Education, there were 132 collegiate recovery programs in 2020.

Although the rate of uptake among campuses appears to have increased in recent years, challenges remain in meeting the objective. Historically, some institutions have pushed back on having a CRP, saying they did not have an alcohol or drug problem on campus, or expressing the concern that actively addressing the problem would suggest to external stakeholders and prospective students and staff that there was a problem, tarnishing their reputation. In the context of the overdose epidemic, this objection seems less common. Moreover, surveillance data makes clear that any institution serving adolescents and young adults will have such a problem.

A cross-sectional study of young adult behavioral health during COVID-19 found that 30 percent reported harmful levels of alcohol use while 22 percent reported using drugs. Of these, 38 percent rated their drug use severe.[55] In 2020, the Monitoring the Future study found that 7.9 percent of college students reported daily marijuana use while 6.8 percent reported past-year cocaine use while the past-year use of prescribed stimulants without medical supervision was also common. Past-year amphetamine use was reported by 6.5 percent of students, while Adderall use was reported by 7.2 percent, and Ritalin use was reported by 1.5 percent. In addition, 24 percent of college students reported binge drinking in the past two weeks and 12 percent reported high-intensity drinking (10 or more drinks in a row).[56]

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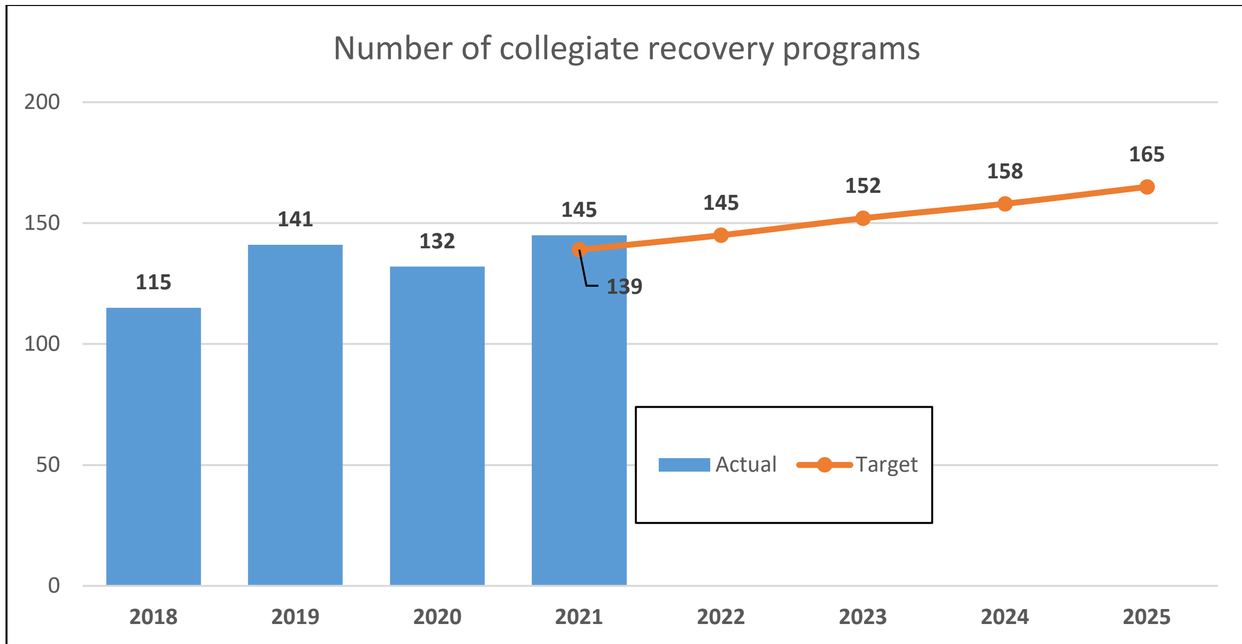
[52] Harris KS, Baker AK, Kimball TG, Shumway ST. Achieving Systems-Based Sustained Recovery: A Comprehensive Model for Collegiate Recovery Communities. *Journal of Groups in Addiction & Recovery.* 2008;2(2-4):220-237.
[53] Laudet A, Harris K, Kimball T, Winters KC, Moberg DP. Collegiate Recovery Communities Programs: What do we know and what do we need to know? *Journal of social work practice in the addictions.* 2014;14(1):84-100.
[54] Ashford RD, Brown AM, Eisenhart E, Thompson-Heller A, Curtis B. What we know about students in recovery: meta-synthesis of collegiate recovery programs, 2000-2017. *Addiction Research & Theory.* 2018;26(5):405-413.
[55] Horigian VE, Schmidt RD, Feaster DJ. Loneliness, Mental Health, and Substance Use among US Young Adults during COVID-19. *Journal of Psychoactive Drugs.* 2021;53(1):1-9.
[56] Schulenberg, J. E., Patrick, M. E., Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Miech, R. A. Monitoring the Future national survey results on drug use, 1975–2020: Volume II, College students and adults ages 19–60. 2021. Ann Arbor: Institute for Social Research, The University of Michigan.



Source: Association of Recovery in Higher Education

In 2021, there were 145 collegiate recovery programs; the target was 139, meaning the 2021 actual is 5 percent ahead of the 2021 target. While formal interagency efforts to increase the number of collegiate recovery programs have yet to begin, ONDCP has initiated discussions with the Department of Education and SAMHSA about potential joint efforts to support collegiate recovery programs. Additionally, ONDCP has remained in regular contact with the Association of Recovery in Higher Education, and has advocated the value of collegiate recovery programs. Given the data available at this time, there is a reasonable expectation that the 2025 target should be met.

Objective 5: The number of certified recovery residences is increased by 25 percent by 2025.

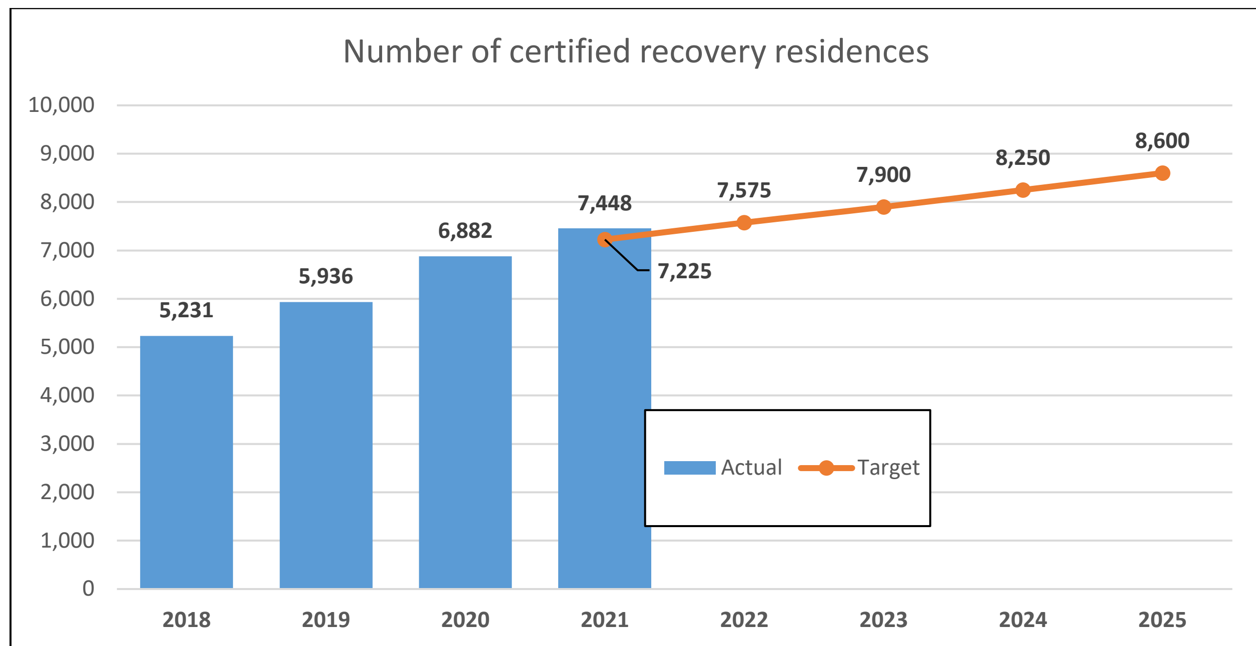
Recovery residences provide a supportive environment for individuals in early recovery who are seeking to sustain recovery and rejoin the community. Residents are part of a supportive peer community to which they are accountable. In addition to supporting recovery in the community, recovery residences can provide safe, supportive housing for individuals in recovery who are exiting homelessness or whose home environment is unsafe for them due to familial substance use, neighborhood triggers, or other factors.

Inconsistent standards or lack of regulations and standards in some states has resulted in fraud by parties holding themselves out to be recovery home operators, including patient brokering. However, research has found that recovery home residents achieve significant improvements in alcohol and drug use, employment, psychiatric symptoms, and criminal justice system involvement.[57] To ensure that federal efforts support residences that are safe and meet recognized standards, this objective seeks to increase the number of recovery residences that are certified by a nationally recognized recovery housing entity by 25 percent by 2025. The data for this objective

[57] Polcin DL, Korcha RA, Bond J, Galloway G. Sober living houses for alcohol and drug dependence: 18-month outcomes. *Journal of substance abuse treatment.* 2010;38(4):356-365.

are based upon the number of recovery residences certified by NARR or chartered Oxford House; there were 6,882 such residences in 2020.

Historically, recovery residences have received limited federal, State, and local government funding. This is likely because they are both a form of housing and a service. Funding systems for housing and services are generally distinct, with very different requirements and priorities. For example, housing funding streams may require compliance with federal housing regulations, which may not be compatible with maintaining a safe and substance-free environment for residences. Similarly, service funding streams may prohibit or strictly limit funding for housing or "room and board." ONDCP will work with HUD, HHS, DOJ, VA, and Labor to increase the number of recovery residences. ONDCP will also work these agencies, States, and other stakeholders to foster the adoption of more consistent recovery housing standards from state-to-state and to modify the various laws, regulations and policies currently create barriers to the funding of residences.



Source: National Alliance for Recovery Residences/Oxford House

In 2021, there were 7,448 recovery residences that were either Oxford House-chartered or NARR-certified; the 2021 target was 7,225, meaning the 2021 actual is 3 percent ahead of the 2021 target. Outside of the HUD Recovery Housing Program, federal funding for recovery residences is difficult to track as it may be embedded within block grants, or may be an allowable expense under certain discretionary grants. However, ongoing federal efforts to promote more consistent recovery housing efforts, including the 2021 release of the Model Recovery Residence Certification Act have likely contributed to the increase in the number of chartered and certified residences. Both Oxford House and NARR were involved in its development. In upcoming performance periods, ONDCP will be working across Drug Control agencies to identify mechanisms for funding and otherwise supporting Chartered Oxford Houses and NARR-certified recovery residences. Given the data available at this time, there is a reasonable expectation that the 2025 target will be met.

Goal 6. Criminal Justice reform efforts include drug policy matters.

Incarcerating individuals for substance use alone is a costly and ineffective way of addressing SUD and preventing overdose. The evidence is clear that such incarceration disproportionately impacts racial and ethnic minority communities and other historically marginalized groups; the Biden Harris Administration is committed to address these disparities and advancing equity more broadly.

There are other needs for reform. When appropriate in light of the fact-specific characteristics of the individual and circumstance, programs that offer individuals the opportunity to meaningfully engage in social and medical services instead of arrest without negatively impacting public safety are overwhelmingly successful, and participants are less like to be rearrested. Additionally, for individuals with an opioid use disorder who do face incarceration, treatment with MOUD has been correlated with an 85 percent lower likelihood of dying of a drug overdoses in the month following their release.[58] One study found that individuals who had received medication therapy in jail were about 30 percent less likely to be arrested, arraigned, or incarcerated again compared with those who had been incarcerated during the same time period in a neighboring jail that did not offer treatment.[59] Increasing access to evidence-based treatment for SUD for incarcerated individuals in state and local jails, state prisons, and providing evidenced-based treatment in the federal Bureau of Prisons (BOP) advances public health, public safety, and criminal justice reform goals.

ONDCP will work with a variety of federal, State and local government public health and public safety partners and non-governmental organizations. DOJ, HHS, law enforcement, prosecutor, and probation officer associations as well as advocates for incarcerated persons and the criminal defense bar will be critical to advancing and implementing these programs and ensuring their success. Consultations with local prosecutors such as the Staten Island District Attorney's Office or stakeholders such as the Center for Court Innovation and the LAC demonstrated how they will be essential to success as they will implement the systems that we are trying to support or they regulate the activities that we are trying to optimize.

Objective 1: Eighty percent of all treatment courts will be trained and will implement practices to increase equity by 2025.

Compared to similarly situated White drug users, people of color have been arrested for and served longer prison sentences for low-level drug crimes.[60] This is particularly striking because research shows that Black, Brown, and White people generally use drugs at similar rates.[61] Additionally, Black people have been arrested at higher rates than White people for cannabis possession—in 2018, Black people were about four times more likely to be arrested for cannabis

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[58] Marsden, J., Stillwell, G., Jones, H., Cooper, A., Eastwood, B., Farrell, M., Lowden, T., Maddalena, N., Metcalfe, C., Shaw, J., & Hickman, M. (2017). Does Exposure to Opioid Substitution Treatment in Prison Reduce the Risk of Death after Release? A National Prospective Observational Study in England. *Addiction (Abingdon, England), 112*(8), 1408-1418. 10.1111/add.13779

[59] Evans, E., Wilson, D., Friedmann, P. Recidivism and mortality after in-jail buprenorphine treatment for opioid use disorder. Drug and Alcohol Dependence, Vol 231, 2022, https://doi.org/10.1016/j.drugalcdep.2021.109254.

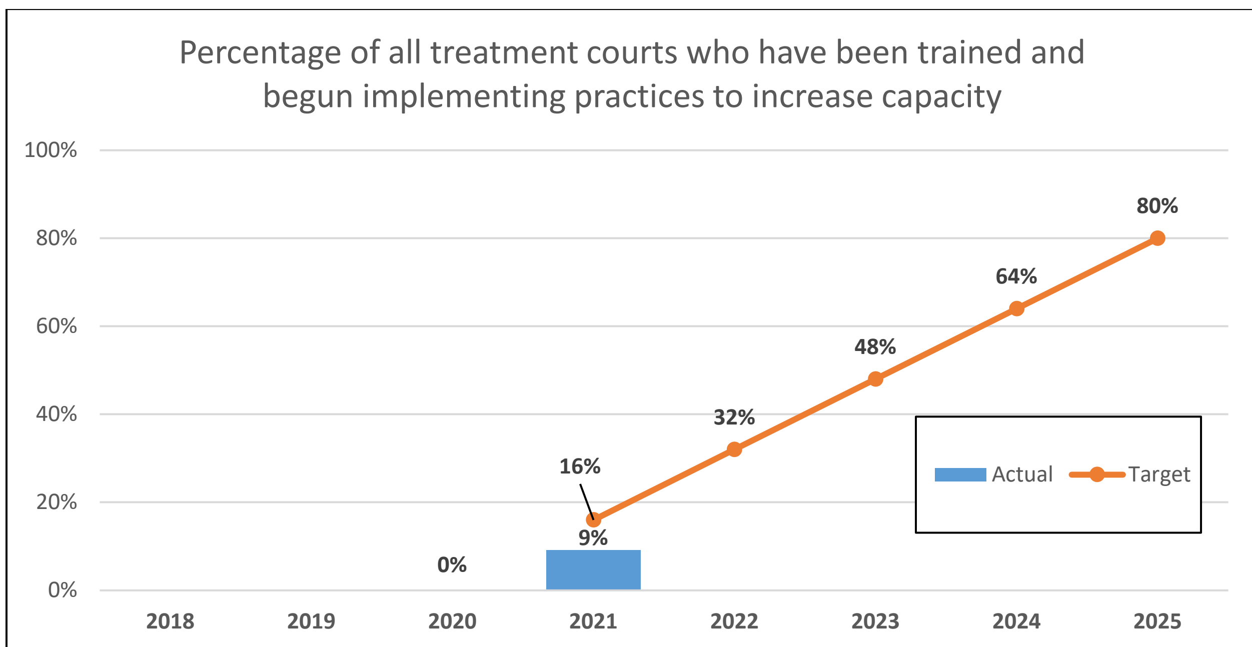
[60] American Civil Liberties Union. (2014). *War Comes Home: The Excessive Militarization of American Policing*. American Civil Liberties Union.

[61] American Civil Liberties Union. (2020). *A Tale of Two Countries: Racially Targeted Arrests in the Era of Marijuana Reform.* American Civil Liberties Union.

possession than White people.[62] Establishing and expanding treatment court programs for low-level non-violent drug offenders as an alternative to incarceration not only provides people with the underlying treatment they need for their SUD but also begins to address existing disparities in the criminal justice system in a safe and equitable fashion.

ONDCP will work to achieve this objective principally through its grantmaking authority and oversight role for the Drug Courts Training and Technical Assistance grant. The incumbent grantee, NADCP, through the National Drug Court Institute (NDCI), will be launching new training to treatment court personnel that will acquaint the administrators of those courts with evidence-based practices and approaches that increase racial equity and reduce racial disparity among clients of those courts. The collaborative relationship between ONDCP, NADCP, and NDCI is not new; however, the planned training is a new initiative.

The objective seeks to ensure that 80 percent of the nearly 3,000 treatment courts in the United States will be trained and begin implementing evidence-based practices to increase equity by 2025. Because the initiative described above is new, the 2020 baseline was zero. No significant challenges are anticipated in meeting the objective. The ONDCP grant manager is working closely with the incumbent to implement, and it is believed the target is reasonable and achievable.



Source: National Association of Drug Court Professionals

In 2021, a total of 350 courts were trained; the target was 480 courts, meaning the 2021 actual is nearly 6 percent behind the target. Two factors contributed to the 2021 target not being met. The first was that NADCP, the recipient of the fiscal year (FY) 2020-2022 ONDCP Drug Court Training and Technical Assistance (TTA) cooperative agreement, was unable to conduct in-person trainings due to the meeting and travel restrictions in place as a result of COVID-19. While NADCP converted many of their trainings to a virtual platform, this change in training modality did

[62] American Civil Liberties Union. (2020). *A Tale of Two Countries: Racially Targeted Arrests in the Era of Marijuana Reform.* American Civil Liberties Union.

not yield the level of participation needed to meet the number of courts trained within the year. The second factor was NADCP was in its second and final year of the cooperative agreement when the above target was developed, meaning that the training deliverables under that agreement had already been established, and it proved difficult to include the additional training sessions needed to achieve the target. It is anticipated that NADCP will meet the target moving forward, since they have been awarded the FY 2022-2024 Drug Court TTA cooperative agreement, and have developed a training plan within the performance period that aligns with the target. The training plan includes mostly in-person trainings as travel and meeting restrictions have eased. In addition, NADCP has implemented a rigorous marketing plan to increase participation when training is conducted virtually. Given the data available at this time, accelerated progress is required to meet the 2025 target.

Objective 2: The percentage of BOP inmates diagnosed with an opioid use disorder who are given access to medications for opioid use disorders (MOUD) is increased to 100 percent by 2025; the percentage of both state prison programs and local jail facilities offering MOUD is increased by 50 percent.

For those individuals in custody with an opioid use disorder, MOUD is an especially important part of treatment. The First Step Act requires that the federal BOP assess the availability of and capacity to treat OUDs through evidence-based programs, and Title II of the Americans with Disabilities Act protects people with disabilities from discrimination in State and local government services, programs, and activities, including law enforcement agencies, justice system entities, and juvenile and adult corrections agencies. The objective seeks to increase the percentage of BOP inmates diagnosed with an OUD who are given access to MOUD to 100 percent by 2025; the percentage of Residential Substance Abuse Treatment (RSAT) for State Prisoners Program sites offering MOUD is increased by 50 percent, and local jail facilities offering MOUD is also increased by 50 percent.

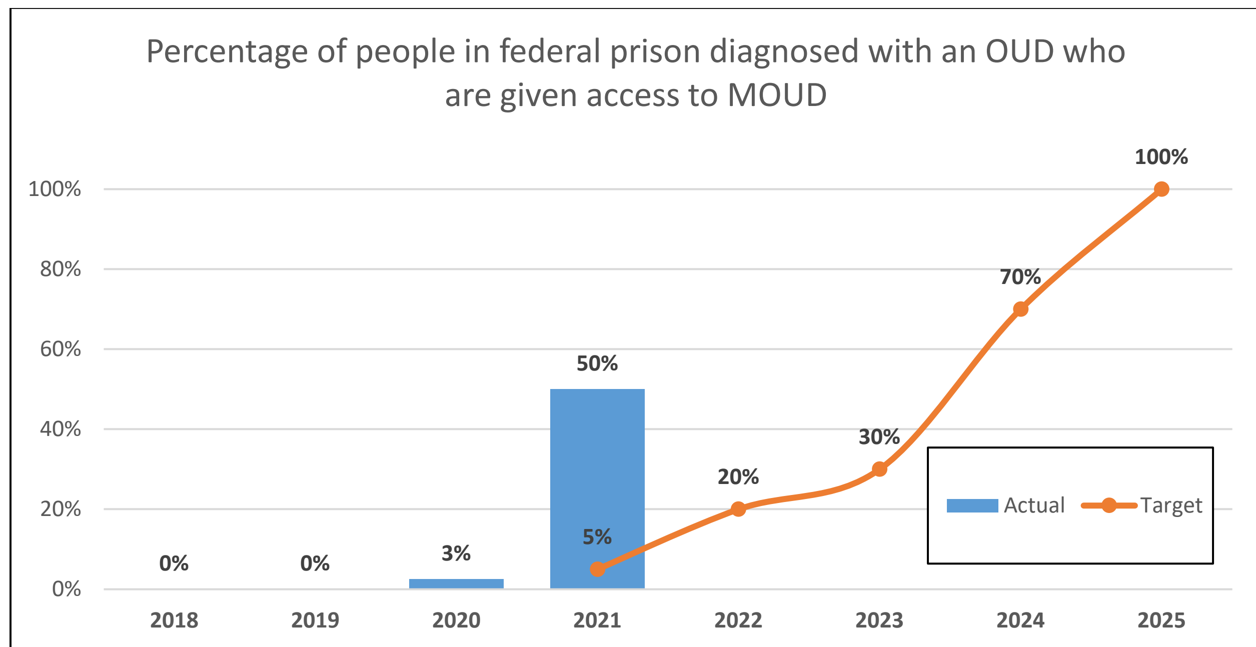
Key to achieving this objective will be cooperation and problem solving among DOJ and HHS. ONDCP is engaged regularly with DOJ's Office of Justice Programs (OJP), the National Institute of Corrections (NIC), and NIDA to ensure movement in the State prisons and local jails, as well as pursuing legislative opportunities to support expansion of MOUD directly to local jails. OJP's RSAT program funding, SAMHSA SOR grants, and some opioid settlement funds all serve as an impetus for the projected growth of inmates given MOUD in United States prisons and jails.

There are three measures for this objective—one measuring the federal response, a second measuring programs in State prisons, and a third measuring progress in local jails. The federal data is derived from BOP's internal data collections regarding patient care, which includes data collection for MOUD. The narrower representation of state prison facilities with program data that are funded by the OJP RSAT State Prisoners Program come from the RSAT grantees, which includes programs offering MOUD. MOUD program data for local jails comes a survey of jails derived from NIC's Jails Compendium. Surveys are also funded by both NIC and NIDA's Justice Community Innovation Network (funded through the NIH's Helping to End Addiction Long-term® (HEAL) Initiative), which is comprised of a group of researchers conducting research in local jails. In 2020, the federal percentage of inmates who received MOUD was 2.6

percent; the percentage of state programs offering MOUD was 50 percent; and the local jail facilities percentage was 29 percent.

There are a number of challenges to achieving this objective, including those that pose administrative burdens on practitioners. Repeal of the Data 2000 waiver (also known as the X-waiver) through the 2022 Omnibus Appropriations Bill eliminated the requirement that medical providers obtain a separate registration to treat opioid use disorders with buprenorphine outside of a certified Opioid Treatment Program (OTP). BOP initially developed and began implementing an OTP/Hub and Spoke Model to be able to provide access to MOUD for all eligible individuals without relying on local community resources (e.g., opioid treatment programs, x-waivered prescribers). Under BOP's model, the seven Federal Medical Centers serve as hubs. All BOP institutions not designated as a hub are assigned to a hub and operate as spokes. This model allows more individuals in confined settings access to care without having to potentially travel hundreds of miles. This approach reduces the burden on safety and security staff who would have to facilitate transport and safety for patients and the general public.

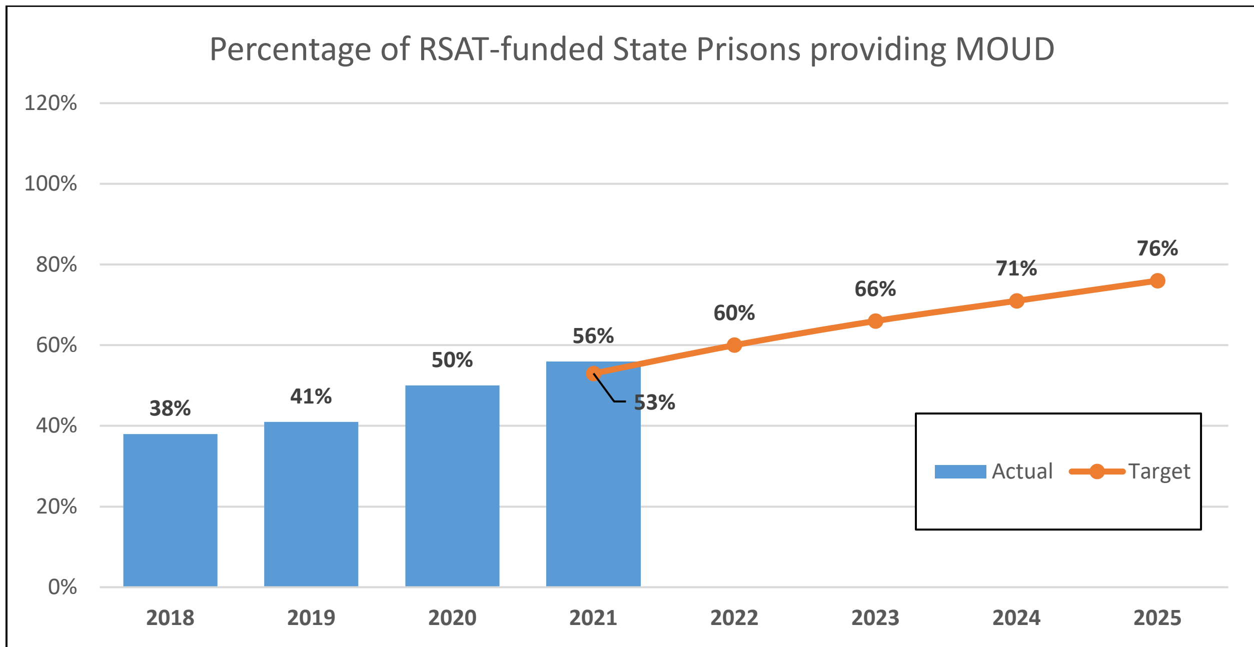
Additional challenges include the ability to extend telehealth flexibilities for prescribing buprenorphine without an in-person exam, and funding availability for state and local expansion, coupled with workforce shortages. Jail administrators and sheriffs report insufficient funding to conduct MOUD Programs; available funding does not reach local jails directly, and is typically subsumed by larger jails. OJP's Comprehensive Opioid, Stimulant, and Substance Abuse Program grants support MOUD as a category of funding, and some RSAT funding goes to jails.



Source: Bureau of Prisons

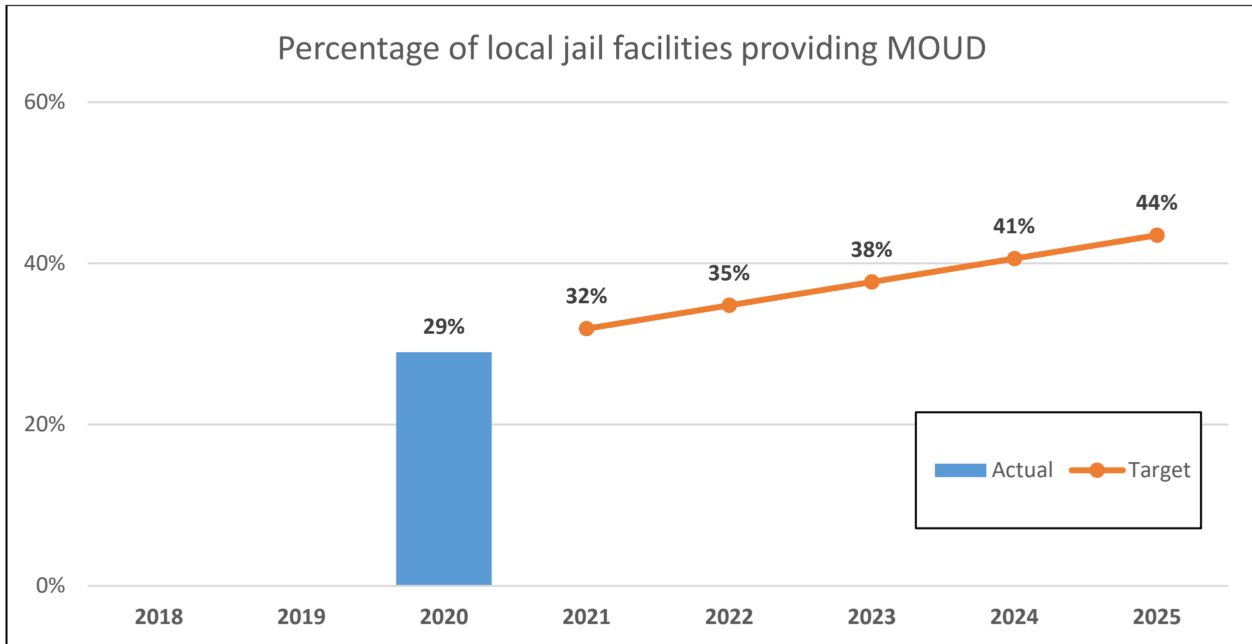
In 2021, the percentage of BOP inmates diagnosed with an opioid use disorder who are given access to MOUD was 50 percent; the target was five percent, meaning the 2021 actual is 900 percent ahead of the target. Extensive collaboration between DEA, SAMHSA, and BOP expedited the expansion of the OTP/NTP hub and spoke model across BOP institutions. BOP is well on the way to full implementation of this novel model of OTP/NTPs that was ramped up in CY2021 given the collaboration and cross agency work. Given the infrastructure is now in place,

pending the additional positions forthcoming, BOP continues recruitment and hiring efforts focused on health care providers integral to the delivery of MOUD medications within the BOP.



Source: Residential Substance Abuse Treatment Program Grantee Data.

The percentage of RSAT funded prison-based programs operational in FY 2021 that provided MAT is 56 percent; the target was 53 percent, meaning the 2021 actual is six percent ahead of the target. RSAT continued to champion the expansion of MOUD as an essential component of successful reentry for inmates with alcohol and opioid use disorders. Jails and prisons with model best practice MAT programs have been showcased through national webinars, onsite training sessions, and a national meeting of prison, jail, and juvenile correctional practitioners.



Source: Survey of jails derived from National Institute of Corrections' Jails Compendium. 2018 and 2019 data not available.

MAT/MOUD program data for local jails comes from the National Institute of Correction's Jails Compendium, developed in collaboration with NIDA's Justice Community Innovation Network (funded by the NIH HEAL Initiative), which is comprised of a group of researchers conducting research in local jails. In 2020, the data was based on preliminary findings from a survey whose findings were published in the Journal of General Internal Medicine. While there is no equivalent comparison survey for 2021, there is a new survey in the field which will provide 2022 data that will likely provide a more comprehensive picture of provision of MOUD in Jails. Therefore, data is not yet available in order to assess progress; ONDCP will release an amended *PRS* once the data is available.

Goal 7. The supply of illicit substances into the United States is reduced.

The majority of the illicit drugs consumed in the United States are produced in foreign countries and smuggled into the United States.[63] Reducing the supply of illicit drugs and their precursor chemicals to the United States will make acquiring these substances in American communities more challenging, riskier, and more expensive, and as a result, would limit their overall availability. The continued increase in overdose deaths highlights the need to continually evaluate supply reduction efforts for efficiency and effectiveness. Additionally, the ability of Transnational Criminal Organizations (TCOs) to successfully adapt to law enforcement and regulatory pressure in order to maintain their illicit drug trafficking activities emphasizes the need to reduce the supply of illicit substances into the United States.

A number of federal agencies across the interagency (including the Departments of State, Justice, Defense, Homeland Security, Transportation, the Treasury, the Interior, the U.S. Postal Service, and the intelligence community) work together to limit this supply. ONDCP maintains continual daily contact with these interagency stakeholders to coordinate supply reduction efforts through a variety of working groups and regular policy and strategy discussions. Specific concerns are continuously addressed in order to achieve these goals and objectives. In addition, ONDCP works with its international partners, such as the United Nations' Office on Drugs and Crime (UNODC), and partner nations of the United States, including Canada, Mexico, Colombia, China, and India, through a wide variety of regular interchanges.

These partners serve a number of roles. United States federal law enforcement agencies disrupt supply chains, seize illicit substances coming into the country, and provide data on trends and emerging threats. The Department of State (with United States Embassies) provides funding and/or technical assistance to improve dialogue and information sharing with and build the capacity of partner nations. These partner nations collaborate to share data and information on drug trends, best practices, and work on collaborative efforts to reduce the supply of illicit drugs. Finally, the United States intelligence community provides data and analysis on foreign drug trafficking and manufacturing to inform United States policy.

Objective 1: The number of targets identified in counternarcotics Executive Orders and related asset freezes and seizures made by law enforcement is increased by 365 percent by 2025.

TCOs are driven by economics. As long as illicit drugs continue to be economically beneficial, TCOs will manufacture and traffic them to the consumers willing to purchase them, even at great risk to the consumers' own safety and health.

Disrupting illicit financial activities serves two purposes. First, to disrupt the flow of financial benefits to individuals directly and indirectly involved in the illicit drug industry, reducing the incentive to engage in drug trafficking by eroding its profitability; and second, to deny drug producers and traffickers the operating capital they need to sustain their illicit activities.

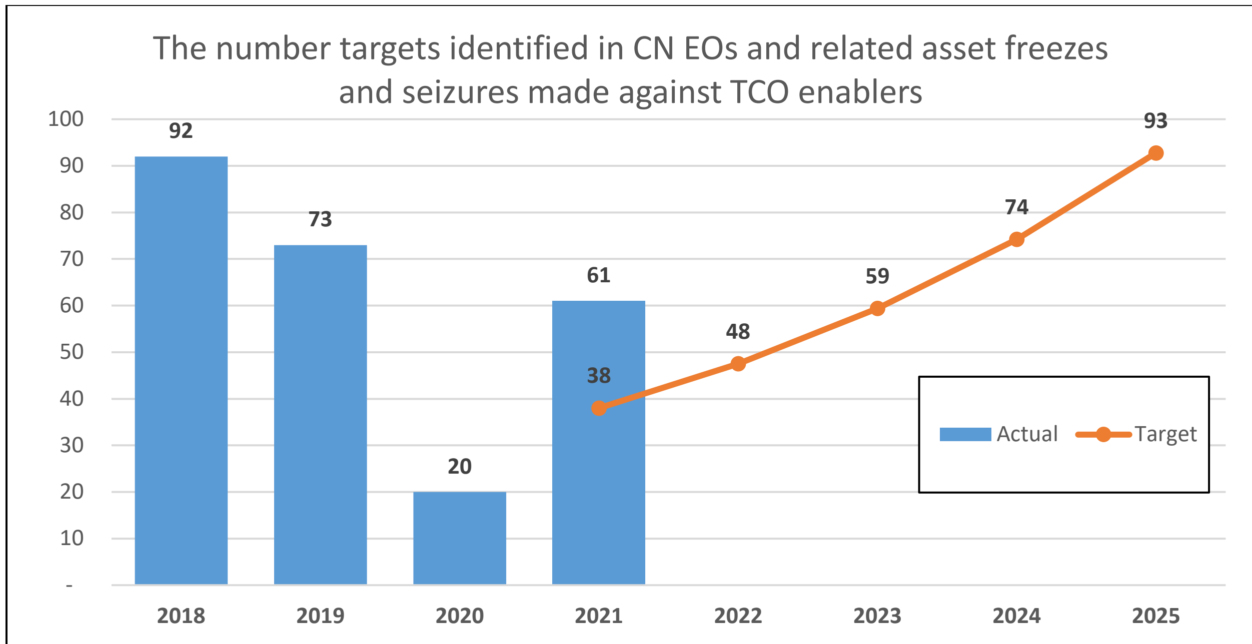
[63] Finklea, Kristin. Illicit Drug Flows and Seizures in the United States: What Do We [Not] Know?. Congressional Research Service. July 3, 2019. https://sgp.fas.org/crs/misc/R45812.pdf

The Office of Foreign Assets Control (OFAC) of the Department of the Treasury administers and enforces economic and trade sanctions based on United States foreign policy and national security goals against targeted foreign countries and regimes, terrorists, international narcotics traffickers, those engaged in activities related to the proliferation of weapons of mass destruction, and other threats to the national security, foreign policy or economy of the United States.

OFAC administers multiple sanctions programs, including programs that can target TCOs that traffic drugs and their enablers. On October 21, 1995, the President issued Executive (EO) 12978, "*Blocking Assets and Prohibiting Transactions with Significant Narcotics Traffickers*," to deal with the unusual and extraordinary posed by narcotics traffickers centered in Colombia. On March 5, 1997 OFAC issued the Narcotics Trafficking Sanctions Regulations (31 CFR Part 536) which implemented EO 12978. On December 3, 1999, the Foreign Narcotics Designation Act (The *Kingpin Act*) was signed, to apply economic and other financial sanctions to significant foreign narcotics traffickers and their organizations worldwide. On July 5, 2000, OFAC issued the Foreign Narcotics Kingpin Sanctions Regulations (31 CFR Part 598) which implemented the Kingpin Act.

ONDCP will work with relevant departments and agencies through existing coordination mechanisms, including the Interdiction Committee, and well as new coordinating mechanisms, such as the United States Council on Transnational Organized Crime (USCTOC), to address whole-of-government efforts against TCOs engaged in the manufacture and trafficking of illicit drugs and their illicit finance enablers. Additionally, ONDCP, working with the interagency, will support OFAC by identifying the Administration's highest priority issues, so that OFAC can continue to develop the most relevant targets under EO 14059, entitled *Imposing Sanctions on Foreign Persons Involved in the Global Illicit Drug Trade*, consistent with the Department of the Treasury's 2021 Sanctions Review.

The objective seeks to increase the number of individuals and entities targeted as TCO enablers through sanctions by 365 percent by 2025. EO 14059 was signed on December 15, 2021 and builds on Treasury's previous narcotics-related sanctions authorities. 2021 data will include sanctions under the Kingpin Act and under E.O. 14059, while 2018-2020 data only includes sanctions under the Kingpin Act. The OFAC List of Specially Designated Nationals and Blocked Persons ("SDN List") will be used as the definitive sources of data for assessing progress toward this objective. The interagency plays a role in providing relevant targeting information to OFAC to further develop into sanction actions, and the effectiveness of these actions requires a whole-of-government effort.



Source: OFAC

In 2021, the number of individuals and entities targeted for activity tied to drug trafficking through sanctions was 61; the target was 38, meaning the 2021 actual is 60 percent ahead of the target. In 2021, sanctions pursuant to E.O. 14059 accounted for 41 percent of the counternarcotics sanctions for the calendar year. Of the 25 new sanctions under E.O. 14059, 17 were individuals and entities previously designated.

Objective 2: The number of defendants convicted in active OCDETF investigations that incorporate FinCEN data is increased by 14 percent by 2025.

Pursuing illicit finance disrupts the working capital that TCOs need to operate. Because the majority of TCOs are poly-crime, attacking their illicit finances has the potential to disrupt all of their illegal activities and will be more effective at exposing previously unknown associates and enablers and could further aid in dismantling these organizations.

Treasury's Financial Crimes Enforcement Network (FinCEN) administers the Bank Secrecy Act (BSA), our nation's comprehensive anti-money laundering statute. The BSA requires financial institutions, including depository institutions, and other industries vulnerable to money laundering to take a number of precautions against financial crime. This includes filing and reporting certain data about financial transactions, including cash transactions over $10,000 and suspicious transactions; those data provide a wealth of potentially useful information to agencies whose mission is to detect and prevent money laundering, other financial crimes, and terrorism.

On January 1, 2021, Congress enacted the FY2021 National Defense Authorization Act, which included significant reforms to the United States anti-money laundering (AML) regime by way of the Anti-Money Laundering Act of 2020 (AML Act) and, within the AML Act, the Corporate Transparency Act (CTA). The AML Act seeks to strengthen, modernize, and streamline the existing AML regime by promoting innovation, regulatory reform, and industry engagement

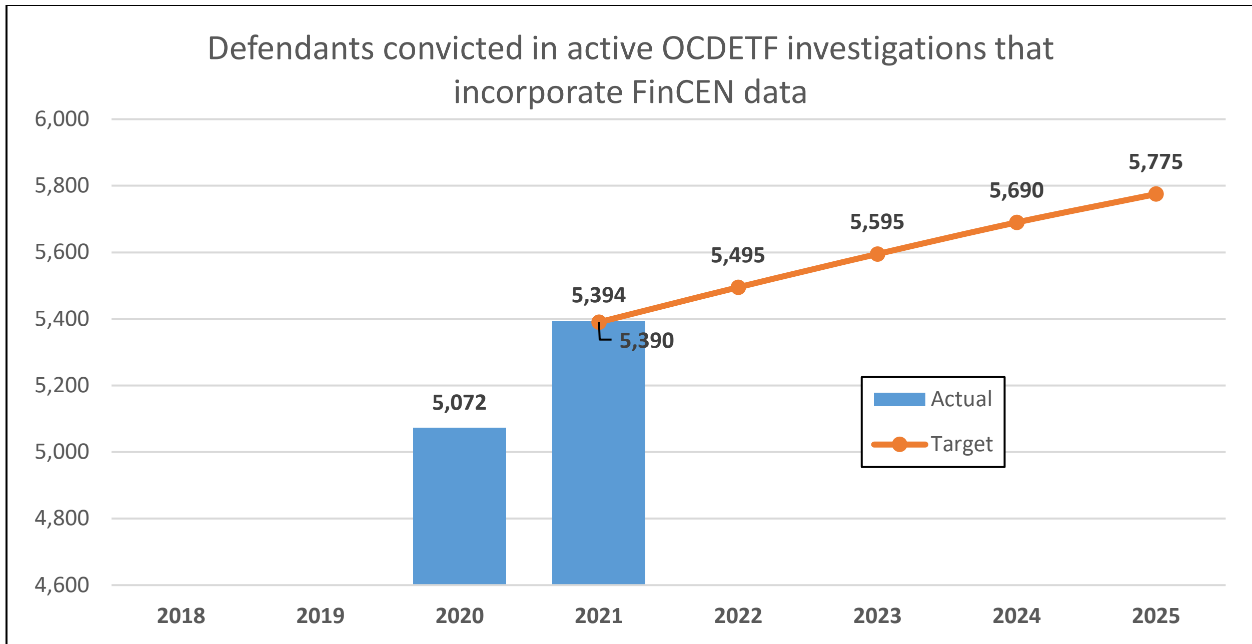
through forums, such as the BSA Advisory Group (BSAAG) and FinCEN Exchange. The AML Act also calls for FinCEN to work closely with its regulatory, national security, and law enforcement partners to identify risks and priorities and provide valuable feedback to industry partners.

The CTA establishes uniform beneficial ownership information reporting requirements for certain types of corporations, limited liability companies, and other similar entities formed or registered to do business in the United States. The CTA authorizes FinCEN to collect that information and share it with authorized government authorities and financial institutions, subject to effective safeguards and controls. Certain provisions of the AML Act provide for new coordinating mechanisms. FinCEN published AML/countering the financing of terrorism (CFT) priorities in June of 2021 to assist regulated institutions in their efforts to meet their obligations under laws and regulations designed to address money laundering and terrorist financing: two of those AML/CFT priorities are combating transnational criminal organization activity and drug trafficking organization activity.[64]

ONDCP will continue to work with relevant departments and agencies through existing coordination mechanisms, including the Interdiction Committee, and well as new coordinating mechanisms, such as USCTOC, to address whole-of-government efforts against TCOs engaged in the manufacture and trafficking of illicit drugs and their illicit finance enablers. Additionally, ONDCP, working with the interagency, will continue supporting the full use of the President's EO 14059, *Imposing Sanctions on Foreign Persons Involved in the Global Illicit Drug Trade.* The objective seeks to increase the number of defendants convicted in active Organized Crime Drug Enforcement Taskforce (OCDETF) investigations that incorporate FinCEN/SAR data by 14 percent by 2025.

OCDETF's management information system (MIS) will be used as the definitive source of data for assessing progress toward this objective. ONDCP obtains access to FinCEN data through interagency coordination. A now resolved MIS data collection and reporting issue prevented MIS from reporting OCDETF investigations incorporating BSA data prior to 2020. While the issue has been resolved, MIS is a living database, and establishing a baseline for 2018-2019 was not possible when the *PRS* was first published in 2022. As a result, only the 2020 baseline is available.

[64] Anti-Money Laundering and Countering the Financing of Terrorism National Priorities. June 30, 2021. https://www.fincen.gov/sites/default/files/shared/AML_CFT%20Priorities%20(June%2030%2C%202021).pdf



Source: OCDETF MIS

In 2021, the number of defendants convicted in active OCDETF investigations that incorporate FinCEN/BSA data was 5,394, meaning the 2021 actual is just (0.1 percent) ahead of the target. Given the data available at this time, there is a reasonable expectation that the 2025 target will be met.

Objective 3: The percentage of active priority OCDETF investigations linked to the Sinaloa or Jalisco New Generation (CJNG) cartels, or their enablers (such as illicit financiers) is increased by 25 percent by 2025.

The Sinaloa and the CJNG cartels are broadly acknowledged as the two criminal organizations most responsible for the majority of flow of illicit drug flow into the United States, especially synthetic drugs.[65] Since 88 percent of OCDETF investigations result in disruption and dismantlement,[66] focusing investigative efforts on these two organizations is the most effective way to disrupt and dismantle their operations and immediately reduce the supply of illicit drugs trafficked into the United States and reduce the number of overdose deaths. This objective aims to address the drug trafficking threat posed by these TCOs, identified over the past decade in DEA's annual *National Drug Threat Assessment* as the primary drug trafficking threat to the United States.

USCTOC developed an overall strategy to confront Sinaloa and CJNG, and the parts of the interagency with relevant supply reduction responsibilities can support this strategy by operationalizing those portions of the strategy pertaining to interdiction and to links between interdictions and investigations to help achieve this objective. Additionally, the two EOs, *Establishing the United States Council on Transnational Organized Crime* and *Imposing*

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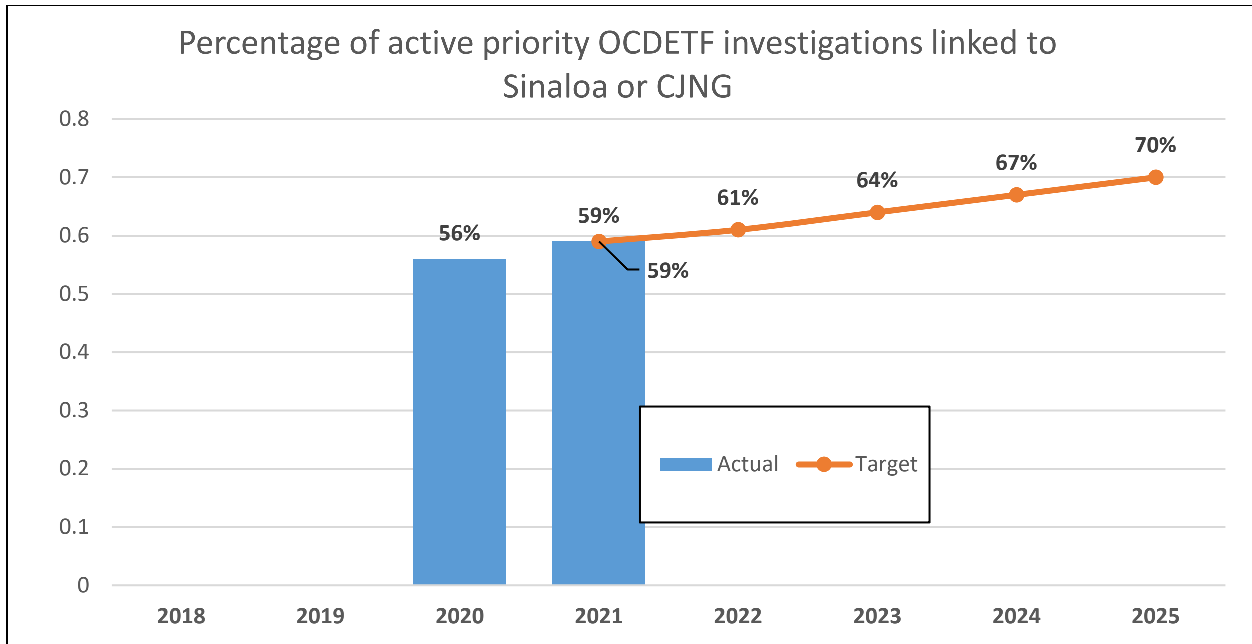
[65] DOJ DEA. *2020 National Drug Threat Assessment*. March 2021; https://www.dea.gov/sites/default/files/2021-02/DIR-008-21%202020%20National%20Drug%20Threat%20Assessment_WEB.pdf
[66] DOJ OCDETF. (2022). *FY2021 Interagency Crime and Drug Enforcement Congressional Submission.* https://www.justice.gov/doj/page/file/1246751/download.

Sanctions on Foreign Persons Involved in the Global Illicit Drug Trade are being leveraged in pursuit of this objective. ONDCP works to optimize existing agency and interagency investigation coordination and information sharing mechanisms. This includes information sharing and collaboration between the intelligence community and law enforcement, interdictors and investigators, and federal-State-local-Tribal entities. ONDCP also serves as a center for policy review, performance assessment, and budget oversight for agencies engaged in disrupting and dismantling drug trafficking organizations and their enablers.

The OCDETF MIS serves as the definitive source for this objective. MIS is a live database, which limits the ability to reconstruct historical statistics. A historical baseline prior to 2020 does not exist, because MIS data for the purpose of this objective had not been archived prior to 2020. The objective seeks to increase the percentage of active priority OCDETF investigations linked to the Sinaloa or CJNG cartels or their enablers by 25 percent by 2025.

An active priority investigation is one that pursues the highest priority OCDETF targets. An organization is considered linked to Sinaloa or CJNG if credible evidence exists (i.e., from corroborated confidential source information, phone tolls, Title III intercepts, drug ledgers, financial records, or other similar investigative means) of a nexus between the primary investigative target and a Sinaloa or CJNG target, verified associate, or component of the organization. A disruption occurs when the normal and effective operation of the organization has been significantly curtailed. Evidence of "disruption" may be seen, for example, in changes in price/purity of the drug or changes in methods of operation; increases in fees paid to couriers or transporters; movement of the organization to a neighboring district; and/or a reduction in availability of a drug on the streets, even if only temporarily. A drug seizure, the execution of a search warrant or another enforcement activity, by itself, does not constitute a "disruption" unless the action truly results in the alteration of the organization's operations or membership. Finally, a dismantlement occurs when the identified organization's leadership, financial base, and drug supply network have been destroyed to the extent that the organization is incapable of operating and/or reconstituting itself.

A combination of factors may pose challenges to achieving this objective. Resource challenges and court closures due to the COVID-19 pandemic are the most pressing concerns because they can limit the number of agents, attorneys, and support staff available to initiate and conduct investigations and enforcement operations. Similarly, travel restrictions impede the ability to travel for investigative purposes and court closures reduce the ability to adjudicate cases. To mitigate these effects, senior-level attention and advocacy will be required to obtain necessary resources and to set and maintain institutional priorities directed at achieving this objective.



Source: OCDETF MIS

In 2021, the percentage of active priority OCDETF investigations linked to the Sinaloa or CJNG cartels or their enablers was 59 percent, meaning the 2021 actual was exactly on target. Given the data available at this time, there is a reasonable expectation that the 2025 target will be met.

Objective 4: Potential production of cocaine is decreased by 10 percent, and heroin is decreased by 30 percent by 2025.

A key factor in reducing the supply of illicit drugs into the United States is to prevent the cultivation and production of plant-based drugs, such as cocaine and heroin.

Cocaine

The United States and Colombian governments partner annually in a Counternarcotics Working Group and a High-Level Dialogue. These meetings are the culmination of ongoing conversations between a range of representatives across each government to continually assess the effectiveness of ongoing programs to ensure the needs of rural communities are being met while implementing programs to reduce coca cultivation and potential pure cocaine production.

In October 2021, the United States and Colombian governments agreed to implement a new bilateral counternarcotics strategy based upon three pillars: rural security and development, environmental protection, and supply reduction. In April 2022, the United States and Colombian governments agreed upon eight metrics intended to gauge the effectiveness of the strategy to strengthen peace, security, and development in rural Colombia. Implementation of the holistic approach continues while the interagency works to refine the strategy with the Petro Administration.

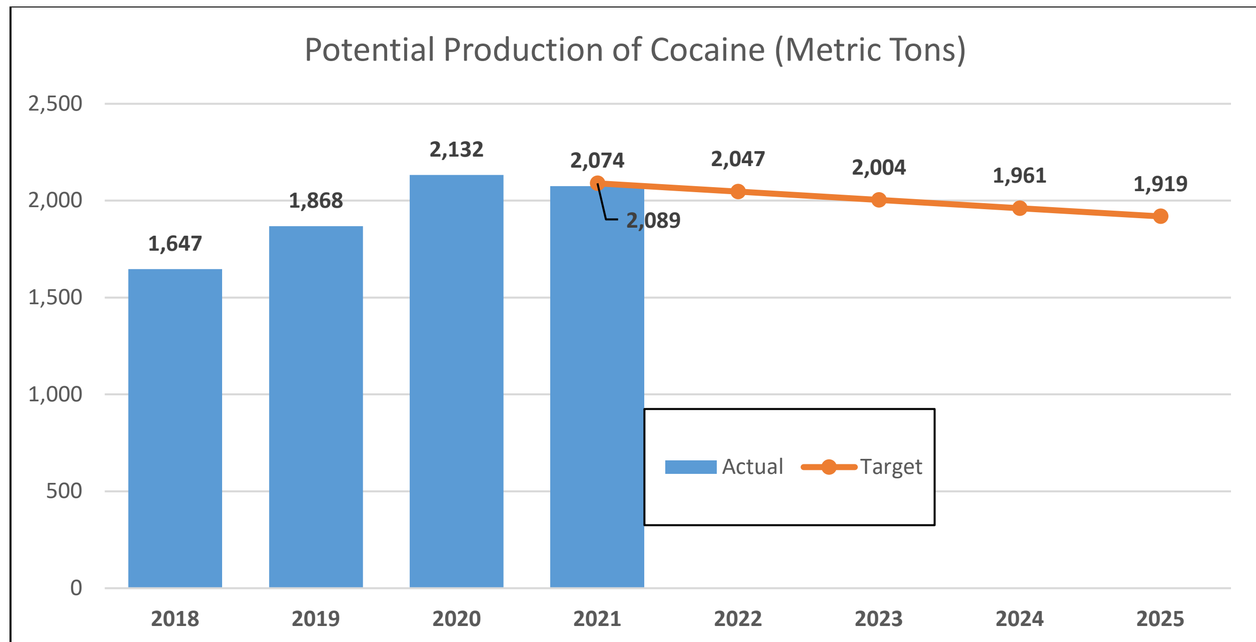
ONDCP leads the Peru counter-narcotics small group, comprised of United States agencies, to coordinate interagency efforts on reducing coca cultivation in Peru, with a special emphasis on alternative development. ONDCP also engages with Peru's Commission for Development and

Life without Drugs (DEVIDA), which handles the full spectrum of drug issues in Peru—including public health, eradication, and alternative development.

The UNODC assesses potential coca cultivation and production. Additionally, the United States publishes annual estimates of coca cultivation and potential pure cocaine production for Colombia, Peru, and Bolivia. The Colombian and Peruvian governments remain committed to reducing coca cultivation and potential pure cocaine production, though current conditions in both of these countries present considerable challenges.

The United States' 2021 Colombian coca cultivation and pure cocaine production potential estimates released in June 2022 revealed both cultivation and production decreased slightly from the record highs experienced in 2020. The United States is working with the Petro Administration to refine the holistic approach where necessary, while encouraging the Colombian government to make gradual changes to the country's counternarcotics efforts to reduce the likelihood of increased coca cultivation.

After two years of minimal eradication efforts, Peru has exceeded its goal of 18,000 hectares in 2022. The United States government is supporting Peru's counternarcotics efforts by helping to bring security, state services, and alternative livelihoods to the people of the region, while emphasizing the importance of addressing coca cultivation in the highest-yield areas of the country. In Bolivia, United States government agencies that are traditionally engaged in counterdrug activities do not currently have a presence. The United States is monitoring the situation in Bolivia for potential opportunities to engage in efforts to reduce coca cultivation and cocaine production. In 2021, the most recent year in which data were collected, Colombia was the world's top cocaine producer, with 972 metric tons (MT) of potential pure cocaine production, followed by Peru at 785 MT, and Bolivia at 317 MT. The objective seeks to reduce potential cocaine production in each country by 4 percent of the 2020 value in 2022 and by 10 percent in 2025.



Source: United States Government estimates measuring potential cocaine production for the Republic of Colombia, the Republic of Peru, and the Plurinational State of Bolivia

In 2021, the potential cocaine production was 2,074 MT, meaning the 2021 actual was nearly one percent ahead of target. Given the data available at this time, there is a reasonable expectation that the 2025 target will be met.

Heroin

The Government of Mexico and United States interagency participate in robust dialogue throughout the year to assess and continually improve efforts to reduce heroin production in Mexico. These conversations occur through myriad staff and principal level bilateral exchanges and monthly working groups such as the Heroin-Fentanyl Working Group (HFWG).

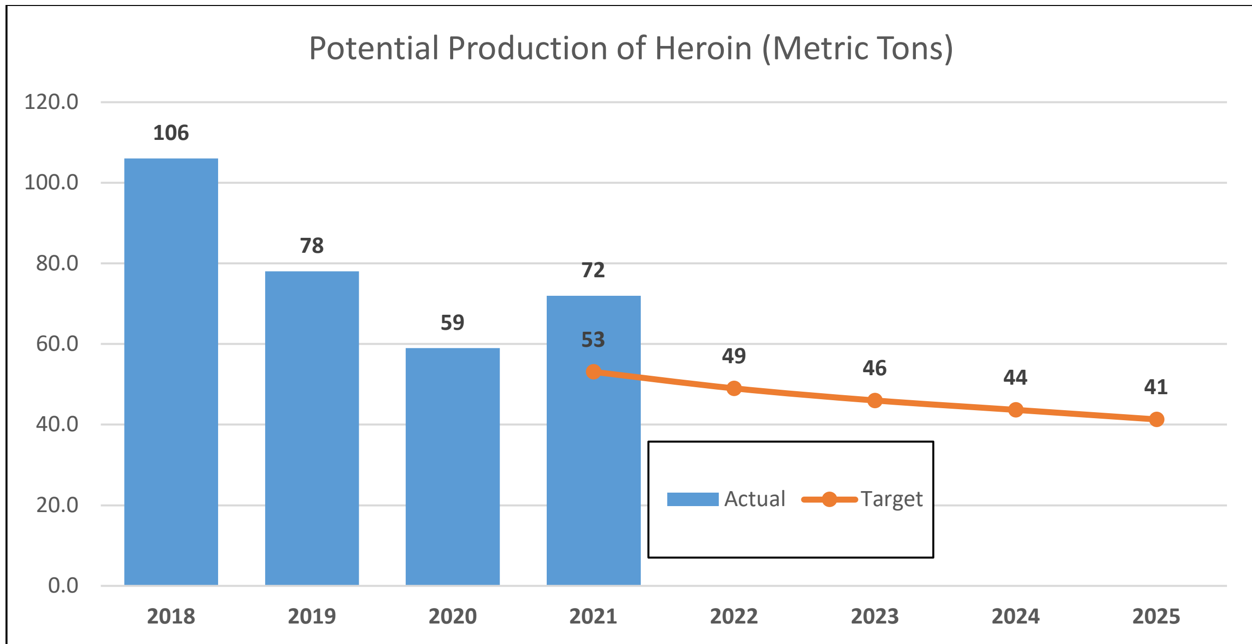
ONDCP coordinates the HFWG every month with United States Embassy Mexico City and key stakeholders. This monthly forum has become the most effective tool for synchronizing policy formulation and implementation between Mission Mexico and ONDCP. The HFWG has enabled the United States government to speak with one voice and maintain critical security relationships with our Mexican partners. The HFWG has facilitated close coordination on efforts to develop accurate Mexican heroin yield estimates, improve the Mexican government's poppy eradication efforts, support investigations of fentanyl and methamphetamine seizures, track ongoing clandestine lab training, and reinforce interdiction efforts. ONDCP engages with Mexico government representatives both in Mexico City and at the Mexican Embassy in Washington, D.C. to discuss efforts to reduce heroin production in Mexico.

The United States publishes estimates on Mexico's annual poppy cultivation and potential heroin production. The Government of Mexico and UNODC publish an annual opium poppy cultivation study (MEX-K54 program) on the UNODC website. It includes one-year estimates of the area under poppy cultivation, opium yield, potential production of dry opium gum, and the morphine concentration in opium gum. In addition, the report includes information provided by the Mexican Government on the eradication of poppy fields, destruction of clandestine laboratories used for heroin production, and seizures of opium gum products.

As part of ongoing efforts to reduce the supply of illicit drugs, in October 2021 the United States and Mexico announced the United States-Mexico Bicentennial Framework for Security, Public Health, and Safe Communities that established a comprehensive, long-term approach for binational actions to enhance the safety and security of both countries. Under this framework, the United States and Mexico pledged to stand together to:

- Protect our people by investing in public health and public safety as related to the impacts of drug use, supporting safe communities, and reducing homicides and high-impact crimes.
- Prevent transborder crime by securing modes of travel and commerce, reducing arms trafficking, targeting illicit supply chains, and reducing human trafficking and smuggling.
- Pursue criminal networks by disrupting financiers and strengthening security and justice sectors.

Each goal is an integral part of the holistic approach needed to effectively address drug related issues on both sides of the border. In 2020, estimated poppy cultivation and potential heroin production reached their lowest totals since 2014. The objective seeks a 30 percent reduction by 2025. Continuing to strengthen our current relationships with our partners is key to maintaining the Mexican government's current commitment and help reduce the likelihood of potential future challenges.



Source: United States Government estimate of Mexican Heroin Production

The annual United States Government estimate found that in 2021, poppy cultivation in Mexico increased by 23 percent, from 23,200 hectares in 2020 to 28,600 hectares. In 2021, the potential heroin production was 72 MT, meaning the 2021 actual was 35 percent behind the target of 53 MT. While the 2021 results failed to meet the target, it is important to note the Centers for Disease Control and Prevention's latest provisional data predicted 9,137 overdose deaths involving heroin in 2021, a 32 percent decrease compared to heroin-involved deaths in 2020 (13,437 deaths). Additionally, heroin seizures at the Southwest border in 2021 decreased 30 percent from 2020 levels. Together, the reduction in heroin seizures and heroin-involved drug poisoning deaths indicate decreased availability of heroin in the United States suggesting Mexican heroin is going to other drug markets. Given the data available at this time, significant progress is required to meet the 2025 target.

Objective 5: The number of incident reports for precursor chemicals sourced from China or India reported by North American countries increases by 125 percent by 2025.

As the amount of synthetically produced drugs increases, seizing the precursor chemicals required to synthesize them disrupts the process necessary to produce them and thereby reduces the supply of drugs available to traffic into the United States.

Most synthetic drugs are produced outside the United States with the majority being trafficked from Mexico. For example, precursor chemicals are shipped into Mexico where fentanyl and its analogues are synthesized prior to being trafficked into the United States. As such, collecting precursor seizure data from international partners will be key to measuring the effectiveness of supply reduction efforts. Incidents are voluntarily entered and include seizures, shipments stopped in transit, diversions and diversion attempts, illicit laboratory dismantlement, and seizures of illicit laboratory information.

Determining progress in the collective effort to disrupt the flow of synthetic drug precursor chemicals to drug producers outside the United States is central to the *Strategy*. Although this new objective presents some challenges, ONDCP established a 2020 baseline to measure progress over time. As part of that effort, ONDCP narrowed the scope of the problem and established the clear definition for the substances of interest for this objective:

> A chemical that is a recognized precursor for drug production and is controlled internationally, domestically in one or more North American countries, or is uncontrolled but has been identified by one of the countries as being a chemical of concern that requires increased scrutiny because of its potential for illicit diversion.

Few domestic and international databases exist where this information may be accessed. As this is a new measure, ONDCP continually seeks to refine the data collected and provide the best repeatable longitudinal information in order to most accurately determine trends and impacts of policy decisions.

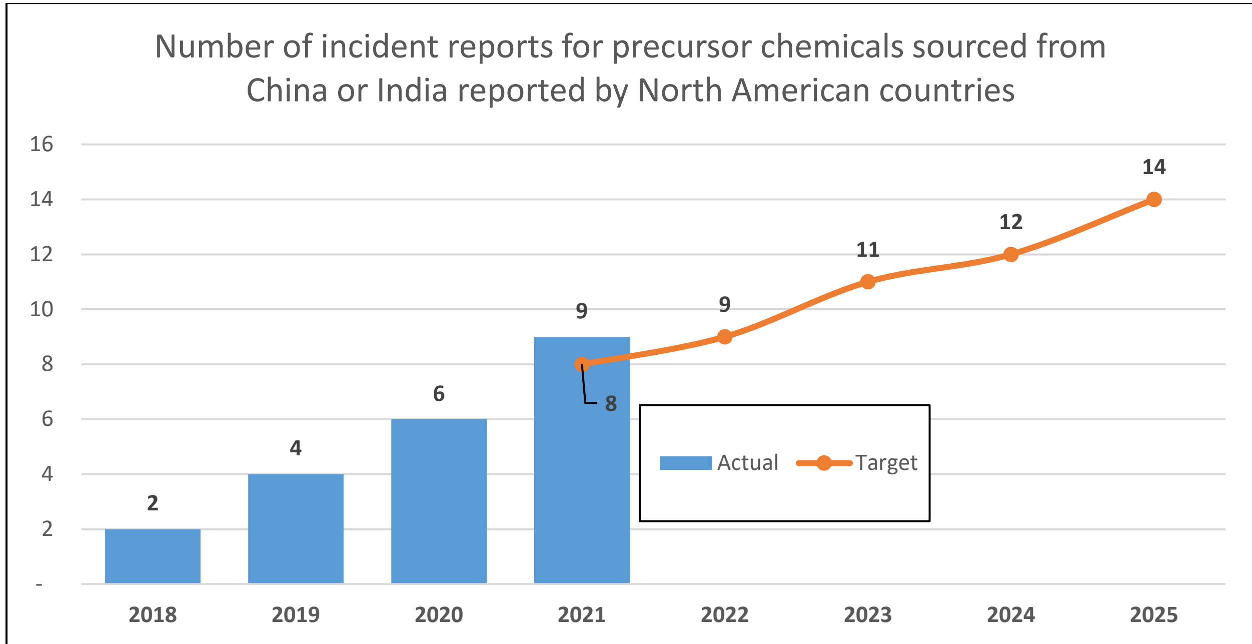
Data is collected via the International Narcotics Board's (INCB's) Precursors Incident Communication System (PICS). PICS is a tool for enhanced information sharing between national authorities on precursor incidents worldwide. The initial pre-defined list of substances reportable through PICS includes all 30 internationally controlled precursors as well as the 52 substances from the Limited International Special Surveillance List (ISSL). Additional substances of international interest and control have also been added by PICS users in partner countries as they have been encountered. While this does not include all chemicals contained within the definition above, it provides an objective baseline from which to start.

According to PICS, in 2020, there were a total of six precursor incident reports in North America for chemicals sourced from China or India. Moving forward, this objective seeks to increase law enforcement's ability to detect precursors from these countries by 125 percent by 2025.

As with many other aspects of drug policy, ONDCP leads efforts across the interagency and internationally to facilitate the collection of the best data available. In the northern hemisphere, ONDCP partners with Mexico and Canada at the North American Drug Dialogue, ONDCP works directly with Canada in the bilateral United States – Canada Action Plan, and ONDCP leads interagency coordination through the Heroin-Fentanyl Working Group with United States Embassy Mexico City. Each of these venues provide opportunities to increase information sharing to help improve the fidelity and repeatability of information collected on the seizure of precursor chemicals.

Drug producers and traffickers continually adapt to law enforcement efforts in intercepting chemicals, a trend that will certainly continue. Attaining success in the seizure of synthetic drug precursors also leads drug trafficking organizations to turn to other precursor chemicals as existing ones become more difficult to acquire or are monitored heavily by law enforcement and customs agencies. Changes in manufacturing processes for illicit narcotics also change which precursor chemicals are being used. All these features of synthetic drug production will make establishing and examining longitudinal trends more difficult. Moreover, different chemicals are needed in different amounts to synthesize drugs, so these differences need to be appropriately normalized to ensure consistency. Measuring success in precursor chemical seizures is not only a function of overall supply but also the priorities and effectiveness of enforcement action and changing drug production patterns. Additionally, since an increasing number of precursor

chemicals have both licit and illicit purposes, incorrectly including licit chemicals could incorrectly bias the data.



Source: International Narcotics Control Board, Precursors Incident Communication System (PICS) Online.

In 2021, the number of incident reports in North America for chemicals sourced from China or India was nine, meaning the 2021 actual was 13 percent ahead of target. Given the data available at this time, there is a reasonable expectation that the 2025 target will be met.

Appendix A: Objectives' data sources, baseline and targets

Obj	Measure	Source	2020 Baseline	2022 Target	2025 Target
1-1	Number of Drug Overdose Deaths	Spencer MR, Miniño AM, Warner M. Drug overdose deaths in the United States, 2001–2021. NCHS Data Brief, no 457. Hyattsville, MD: National Center for Health Statistics. 2022.	91,799	107,725	81,000
1-2A	Percentage of people meeting criteria for cocaine use disorder	Table 5.1B SUD for Specific Substances in Past Year: Among People Aged 12 or Older. Center for Behavioral Health Statistics and Quality. Results from the 2021 NSDUH: Detailed tables. Rockville, MD: SAMHSA	0.5%	0.5%	0.4%
1-2B	Percentage of people meeting criteria for opioid use disorder	Table 5.1B SUD for Specific Substances in Past Year: Among People Aged 12 or Older. Center for Behavioral Health Statistics and Quality. Results from the 2021 NSDUH: Detailed tables. Rockville, MD: SAMHSA	1.0%	0.9%	0.8%

Obj	Measure	Source	2020 Baseline	2022 Target	2025 Target
1-2C	Percentage of people meeting criteria for meth use disorder	Table 5.1B SUD for Specific Substances in Past Year: Among People Aged 12 or Older. Center for Behavioral Health Statistics and Quality. Results from the 2021 NSDUH: Detailed tables. Rockville, MD: SAMHSA	0.6%	0.5%	0.5%
2-1	Past 30-day alcohol use among young people aged 12-17	Table 2.1B Tobacco Product and Alcohol Use in Lifetime, Past Year, and Past Month among Persons Aged 12 or Older, by Age Group: Percentages. SAMHSA, Center for Behavioral Health Statistics and Quality. 2021 NSDUH, Rockville, MD	8.2%	7.9%	7.4%
2-2	Past 30-day use of any vaping among youth aged 12-17	Gentzke AS, Wang TW, Cornelius M, et al. Tobacco Product Use and Associated Factors Among Middle and High School Students — National Youth Tobacco Survey, United States, 2021. MMWR Surveill Summ 2022;71(No. SS-5):1–29.	13.1%	12.3%	11.1%
3-1	Number of counties with high overdose death rates which have at least one SSP	University of Washington; CDC WONDER	130	174	241

Obj	Measure	Source	2020 Baseline	2022 Target	2025 Target
3-2	Percentage of SSPs that offer some type of drug safety checking support service	University of Washington	17.0%	18.7%	21.3%
4-1	Number of treatment admissions for the populations most at risk of overdose death	Table 1.1A. TEDS:2020. Admissions to and Discharges From Publicly Funded Substance Use Treatment. SAMHSA Center for Behavioral Health Statistics and Quality. Rockville, MD	620,487	868,682	1,240,974
4-2	Percent reduction in 2025 forecasted shortfall of behavioral health workforce	HRSA's Health Professions Training Program Dashboard	27%	35%	46%
5-1	Number of states operating a recovery-ready workplace initiative	ONDCP survey of State recovery organizations	8	10	14
5-2	Number of peer-led recovery community organizations	Faces and Voices—List of ARCO Members	155	164	194
5-3	Number of recovery high schools	Association of Recovery Schools	38	44	47
5-4	Number of collegiate recovery programs	Association of Recovery in Higher Education	132	145	165
5-5	Number of certified recovery residences	National Alliance for Recovery Residences/Oxford House	6,882	7,575	8,600
6-1	Number of treatment courts trained and implementing practices to increase equity	National Association of Drug Court Professionals	0%	32%	80%

Obj	Measure	Source	2020 Baseline	2022 Target	2025 Target
6-2A	Percentage of Federal BOP inmates diagnosed with an OUD who are given access to MOUD	Bureau of Prisons	3%	20%	100%
6-2B	Percentage of state prison programs offering MOUD	Residential Substance Abuse Treatment Program Grantee Data	50%	60%	76%
6-2C	Percentage of local jail facilities offering MOUD	Survey of jails derived from National Institute of Corrections' Jails Compendium.	29%	35%	44%
7-1	Number of targets identified in counternarcotics EOs and related asset freezes and seizures made by law enforcement	OFAC	20	48	93
7-2	Number of defendants convicted in active OCDETF investigations that incorporate FinCEN data	OCDETF MIS	5,072	5,495	5,775
7-3	Percentage of active priority OCDETF investigations linked to the Sinaloa or CJNG cartels, or their enablers	OCDETF MIS	56%	61%	70%
7-4A	Potential production of heroin (metric tons)	USG estimates for Mexico	2,132	2,047	1,919
7-4B	Potential production of cocaine (metric tons)	USG estimates for Colombia/Peru/Bolivia	59	49	41
7-5	Number of incident reports for precursor chemicals sourced from China or India reported by North American countries	INCB Precursors Incident Communication System (PICS)	6	9	14

Appendix B: Acronyms

AML	Anti-money laundering
ARCO	Association of Recovery Community Organizations
ASAM	American Society of Addiction Medicine
BSA	Bank Secrecy Act
BSAAG	BSA Advisory Group
CADCA	Community Anti-Drug Coalitions of America
CARA	Comprehensive Addiction and Recovery Act
CDC	Centers for Disease Control and Prevention
CFT	Countering the financing of terrorism
CJNG	Jalisco New Generation
CRP	Collegiate recovery programs
CTA	Corporate Transparency Act
DFC	Drug Free Community
DOJ	Department of Justice
EBT	Evidence-based treatments for addiction
EO	Executive Order
FinCen	Financial Crimes Enforcement Network
FTS	Fentanyl test strips
HFWG	Heroin-Fentanyl Working Group
HRSA	Health Resources and Services Administration
HUD	Department of Housing and Urban Development
IACP	International Association of Chiefs of Police
INCB	International Narcotics Board
ISSL	Limited International Special Surveillance List
LAC	Legal Action Center
MIS	Management information system
MOUD	Medications for Opioid Use Disorder
MT	Metric tons
NAADAC	National Association of Addiction Professionals
NADCP	National Association of Drug Court Professionals
NARR	National Alliance for Recovery Residences
NASADAD	National Association of State Alcohol and Drug Abuse Directors
NASEM	National Academies of Sciences, Engineering, and Medicine
NASEN	North American Syringe Exchange Network
NDCI	National Drug Court Institute
NDCPA	National Drug Control Program agency
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIC	National Institute of Corrections
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
NSA	National Sheriff's Association
NSDUH	National Survey on Drug Use and Health
NYTS	National Youth Tobacco Survey

OCDETF	Organized Crime Drug Enforcement Task Forces
OFAC	Office of Foreign Assets Control
OJP	Office of Justice Programs
ONDCP	Office of National Drug Control Policy
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PAARI	Police Assisted Addiction and Recovery Initiative
PERF	Police Executive Research Forum
PICS	Precursors Incident Communication System
PRS	Performance Review System
PRSS	Peer recovery support services
PTACC	Police, Treatment, and Community Collaborative
PWOD	People who use drugs
RCC	Recovery community center
RCO	Recovery Community Organizations
RSAT	Residential Substance Abuse Treatment
SAMHSA	Substance Abuse and Mental Health Services Administration
SAR	Suspicious Activity Reports
SOR	State Opioid Response
SSAs	Single State Agencies
SSP	Syringe Service Program
SUD	Substance Use Disorder
SUPTRS	Substance Use Prevention, Treatment and Recovery Services
TASC	Treatment Alternatives for Safe Communities
TCO	Transnational Criminal Organization
TEDS	Treatment Episode Data Set
TTA	Training and Technical Assistance
UNODC	United Nations' Office on Drugs and Crime
USCTOC	United States Council on Transnational Organized Crime
VA	Department of Veterans Affairs