NATIONAL DRUG CONTROL STRATEGY

Performance Reporting System Report

APRIL 2012

THE WHITE HOUSE
WASHINGTON

Chapter 1: Performance Reporting System Overview

The National Drug Control Strategy (*Strategy*) is a guide for the Nation in controlling the use and consequences of the illicit use of drugs. The Performance Reporting System (PRS) is a performance monitoring and assessment mechanism for gauging the effectiveness of this *Strategy*. It serves to foster interagency responsibility to the American taxpayer for drug control policies, programs, and budget.[1]

The PRS is designed to appraise the performance of the large and complex *interagency* Federal effort set forth in the *Strategy, as* required by ONDCP's 2006 Reauthorization Act.[2] Section 202 of the Act requires ONDCP to track and report on progress as reflected in performance measures and targets established for each goal and objective in the *Strategy* (see Addendum A for more detail about the Reauthorization Act as it pertains to the PRS).[3] The PRS will monitor key performance measures to inform ONDCP whether drug control programs are performing as expected. The PRS is essential because it acts as a signal to indicate where the *Strategy* is on track, and when and where further attention, assessment, evaluation, and problem-solving are needed. Using the PRS, ONDCP will be able to adjust the *Strategy's* policy and program actions accordingly to achieve the FY 2015 Goals.

A full glossary of acronyms, abbreviations, and performance terms mentioned in this report is located in Addendum B.

The Strategy's Goals and Objectives for 2015

The 2010 Strategy's Goals and Impact Targets

The *Strategy* establishes two overarching Goals to reduce drug use and its consequences by 2015, as shown in Table 1-1. The table also includes, for each Goal, performance targets that reflect the desired impact of drug control programs and policies guided by the *Strategy*.

The Strategy, including its two Goals, was developed through an extensive consultation process with Federal, State, local, and tribal partners, and addresses the Nation's call for a balanced policy of prevention, treatment, enforcement, and international cooperation. The Strategy also reflects the close and strong collaboration between ONDCP and its Federal drug control agency partners to undertake evidence-based programs, policies, and practices to achieve desired performance outcomes by 2015.

---

1.   The PRS in accordance with the Government Performance and Results Modernization Act of 2010 which requires cross-agency goals, focuses on the joint performance of agencies with the common mission of reducing drug use and its consequences.

2. The Office of National Drug Control Policy Reauthorization Act of 2006 (Public Law 109-469), referenced as the Reauthorization in this report.

3.   A performance "measure" represents the specific characteristic or aspect of the program (or policy) that is used to gauge performance. For example, a measure for "drug use" might be the percent of the population that used drugs in the past 30 days. A performance "target" shows the desired level of performance to be achieved during a specified fiscal year for that measure. See Addendum B for a listing of terms, acronyms, and abbreviations used in this report.

Table 1-1

The 2010 National Drug Control Strategy's Impact Targets to be attained by 2015

Goal 1: Curtail illicit drug consumption in America

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

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

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

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

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

   2a: Reduce drug-induced deaths by 15%

   2b: Reduce drug-related morbidity by 15%

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

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

Note: For all goals and measures, 2009 data are used as the baseline in accordance with the 2011 Strategy although in some cases, 2009 data are not yet available.

In accordance with the Reauthorization (P.L. 109-469), the *Strategy* aims to achieve two Goals as follows: Goal 1 focuses on reducing U.S. demand for drugs on two fronts: drug use among youth and young adults as well as reducing chronic drug use by users classified as "abusers of drugs" or "addicted." Goal 2 focuses on increasing public health and public safety by improving the health of the American public through setting meaningful targets to reduce mortality and morbidity associated with the disease of addiction. This Goal also targets other serious consequences such as drugged driving in order to improve public safety.

Both Goals are strongly supported by activities to reduce access to and the availability of drugs through domestic and international activities. Efforts to reduce the supply of illicit drugs and to enforce the laws of the United States have decreased crime, increased the protection of U.S. borders, disrupted trafficking networks, and curtailed international and domestic production of drugs.

The Strategy's Objectives

The Strategy constitutes a balanced approach to reducing drug use as well as its consequences, based on the perspective that abuse and addiction are serious public health problems. It articulates seven strategic Objectives (Table 1-2) for the two Goals presented above. Substantive guidance for each Objective is provided In the Strategy's Chapters. The PRS incorporates the two Goals and seven Objectives and identifies performance measures and targets for each Objective. The Objectives articulate a broad range of efforts. Objectives 1 and 2 emphasize preventing the onset of drug use and intervening to stop use once initiated. Objective 3 focuses on the integration of treatment into mainstream health care and

Table 1-2
***Strategy* Objectives**

1. Strengthen Efforts to Prevent Drug Use in Communities

2. Seek Early Intervention Opportunities in Health Care

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

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

5. Disrupt Domestic Drug Trafficking and Production

6. Strengthen International Partnerships and Reduce the Availability of Foreign-Produced Drugs in the United States

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

expanding support for recovery services. Objective 4 articulates the need to address the nexus between public health and public safety and supports approaches to break the cycle of drug use and crime. Objective 5 addresses drug trafficking and production and supports efforts to reduce the availability of drugs in the United States. Objective 6 emphasizes the importance of strengthening international partnerships and reducing the supply of foreign-produced or cultivated drugs before they enter the United States. Objective 7 is distinct in that it seeks to generate new and improved sources of information about the drug market (supply and demand) so as to improve policies, programs, and practices.

In order to gauge progress toward each Objective, the PRS includes performance measures with targets to be achieved by 2015. Detailed information about these measures and their sources of information are presented in Chapter 3.[4] A summary listing of the performance measures and targets can be found in Addendum C.

Performance Monitoring

The Performance Measurement System

The PRS is one element of a broader performance measurement system. The key elements of this system are set forth in ONDCP's Reauthorization which calls for a performance measurement system that includes (i) a monitoring system that indicates whether the Federal drug control community is on track to meet the FY 2015 Goals and Objectives of the Strategy; (ii) evaluation of the contributions of demand and supply programs with corrective actions when targets are not met; (iii) alignment of agency budgets and contributions to the Strategy, indicating the contributions of agencies and their budget resources; and (iv) assessment of the adequacy of data sources and instruments. This broader performance measurement system (represented in Figure 1-1) addresses these requirements as follows:

---

4. The PRS focuses on the interagency performance measures and targets. Information regarding specific Federal drug control initiatives that support these Objectives is presented in the *National Drug Control Strategy, FY 2012 Budget Summary.*

- **Monitoring:** The PRS is a monitoring system that assesses interagency progress toward achieving the Goals and Objectives of the *Strategy*. It provides early warning about progress through ongoing comparisons of targets against actual achievements for each measure. The PRS will, therefore, identify targets that are being met and those that are not - from among the seven impact targets (that show progress towards the Goals) and the twenty-six targets that reflect progress towards each Objective.

  The Strategy outlines various actions necessary to achieve the two overarching goals of reducing drug use and its consequences. The implementation of these actions by the interagency is monitored by ONDCP's Delivery Unit that works with ONDCP Components to coordinate and track progress.

- **Assessment and Evaluation:** The PRS is complemented by assessments and evaluations. When a target is not achieved, the PRS will serve as a trigger for an interagency assessment of potential causes and options for improvement. In collaboration with the Steering Committee[5] and relevant Federal drug control agencies, ONDCP will initiate an in-depth diagnostic review to identify causal factors contributing to the problem. If the cause of the problem is not evident, a more in-depth assessment and/or evaluation may be undertaken.

  Such joint assessments and evaluations will be in the form of in-depth, interagency-focused studies that seek to isolate obstacles to progress and recommend improvements. Since evaluations are expensive and time-consuming, the PRS will act as a filter mechanism to ensure scarce evaluation resources are directed to the most pressing problem areas.

- **Resources and Agency Performance:** The *National Drug Control Strategy, Budget Summary* focuses on the alignment of agency resources with agency contributions. It also examines agency performance in terms of its contributions to the *Strategy*.

- **Data Assessment:** The *National Drug Control Strategy Data Supplement* (*Data Supplement*) reports up-to-date information on the availability and prevalence of illegal drugs. It also reports on the criminal, health, and social consequences of the illicit use of drugs, as well as the adequacy of existing data systems. The Data Supplement summarizes sources of data used to gauge the national drug problem, some of which are used as data sources in the PRS.

Implementing the Performance Reporting System

The PRS will collect and report on data for each performance measure including the data source, and the agency that reports the data. This information will be used to inform budget formulation and resource allocation, *Strategy* implementation, policymaking, planning, and provide information on progress toward the *Strategy's* Goals and Objectives. ONDCP will release the PRS report each year to coincide with the release of the *Strategy*.

---

5. The Steering Committee, consisting of senior agency officials familiar with drug control policies and programs, was established to advise the Director of ONDCP on the design and implementation of the PRS.

Performance Measurement System			
Context	**Process**	**Questions Answered**	**Mechanism**
Interagency	Implementation	Are Strategy actions on track?	Delivery Unit
	Performance Monitoring	Are we on track to meet the FY 2015 goals and objectives?	PRS
	Assessment & Evaluation (planned)	• Why are we not meeting targets? • What corrective actions can/should be taken?	Interagency Assessment & Evaluation (at ONDCP direction)
Agency	Assessment of Agency Contribution	• What are agencies contributing? • Using what budgetary resources?	• Budget Summary • Budget-Performance Certification Process
	Assessment of Agency Performance System	Does IG attest to the agency management assertions regarding validity, adequacy, of agency performance system?	Performance Summary Report
Interagency	Adequacy of Data Systems	Are available data adequate for policy & evaluation	Data Supplement

Assessing Performance

The lack of nationally representative data has limited ONDCP's ability to assess demand and supply efforts. ONDCP recognizes this limitation and has placed great emphasis on improving information systems to advance understanding of the nature and extent of the drug problem, as well as provide better data for performance assessment. For performance monitoring, specialized types of data are required. Not all data are useable. Data must be collected and available on a regular schedule and also be representative of what is being measured. For the PRS measures, the data should ideally be collected annually and be representative of national trends. Other types of data, such as those from single research studies, intermittent surveys, and ongoing data collections representative of specific geographic areas, are useful in an auxiliary capacity to fully interpret interagency performance.

The PRS development process resulted in the selection of measures that were supported by the best data available. In cases where optimal measures were not useable because of the lack of data, proxy measures were used. While there are limitations to using proxy measures (such as data not always reflecting the universe), they represent an invaluable option given the inadequacy of available data. Future analyses will augment PRS measure-related data with ancillary data to corroborate and set the context for interpreting findings. ONDCP will continue to improve measures as better data sets become available, as reflected in Objective 7 of the *Strategy*.

Diagnosing the specific cause(s) of performance shortcomings can be challenging. In-depth assessments and evaluations of underlying logic models and causal factors will be used to identify issues that result in gaps between targets and actual accomplishments. These may include:

- Errors in the logic model linking program actions to desired results. The logic structure may not include key internal and external factors, some of which may also not be controllable, associated with the objective. Also, the logic model may be based on assumptions and traditional practices not supported by research;

- Insufficient commitment from partners—Federal, State local, and Tribal agencies; non-governmental and private organizations; and international entities—working towards the same objective. Such failures could indicate a need for robust performance partnerships that reflect the relative contribution of each partner;

- Failure to accomplish relevant Action Items identified in the Strategy as necessary for achieving the Objective and its targets;

- Inadequate program administration;

- Inadequate data to fully understand the issue;

- Failure to obtain the resources sufficient to impact the problem; and

- Unrealistic performance targets.

Chapter 2: The Performance Reporting System Development Process

Overview of the PRS Interagency Development Process

The Performance Reporting System (PRS) was developed through an extensive interagency process that brought together subject matter experts, policy and program analysts, researchers, statisticians, and leadership from Federal drug control agencies. While not directly involved in the PRS process, State and local agencies, as well as non-governmental and commercial organizations contribute through their own policies and programs, to achieving the Goals of the *National Drug Control Strategy (Strategy)*. The PRS System will therefore be indirectly monitoring the efforts of non-Federal entities as it tracks progress towards the national *Strategy's* Goals and Objectives.

Using the *Strategy's* overarching two Goals as a foundation, the PRS design process focused on developing appropriate performance measures and targets for each of the seven Objectives (Chapters) in the *Strategy*. A two-tiered process was undertaken. The first step instituted a senior-level Steering Committee[6] with the authority to speak for agencies. The second step established five Working Groups to undertake the complex processes involved in identifying performance measures and targets. The roles of Steering Committee and Working Groups are described in further detail below.

The PRS Steering Committee*: The interagency process instituted a Steering Committee comprised of senior agency officials familiar with drug control issues, policies, and programs. This Committee's principal roles are to advise the Director of ONDCP on the design and implementation of the PRS, serve as primary liaisons with their agencies, bring individual agency concerns to the table for discussion, and review recommendations from the Working Groups.

During the development phase of the PRS, the Steering Committee met twice. The first meeting focused on initiating the PRS process, including the selection of experts for each Working Group. The second meeting occurred after the Working Groups identified draft measures and targets. The Committee reviewed the material, provided feedback, and developed recommendations for review and consideration by the ONDCP Director. This Committee will continue to be involved in the implementation of the PRS and in assessments and evaluations that result from its findings.

The Five PRS Working Groups: Five Working Groups were formed to address the seven Objectives of the Strategy, grouped around common themes. The Working Groups included agency subject matter experts, policy and program analysts, statisticians, researchers, line managers, and other drug program and data experts knowledgeable about drug control programs, policies, and research. Representatives from the following Federal agencies participated in Working Group activities: the Departments of Defense, Education, Health and Human Services, Homeland Security, Interior, Justice, Labor, Transportation, Treasury, State, Veterans Affairs, and the Small Business Administration.

---

6. A full listing of the Steering Committee members is provided in Addendum E.

A summary of the Objectives covered by the Working Groups is presented in Table 2-1 (below). Working Group 1 addressed the first two Objectives focusing on prevention and early intervention. Working Group 2 focused on the third and fourth Objectives, dealing with treatment and recovery and breaking the cycle of drug use and crime. Working Group 3 addressed domestic drug trafficking and production while Working Group 4 concentrated on foreign drug production and international partnerships. Working Group 5 focused on improving drug data information systems. ONDCP subject matter experts served as Working Group chairs.

Table 2-1: The Seven Objectives Covered by the Five Working Groups

PRS Working Group	*Strategy* Objective(s)
Working Group 1	**Objective 1:** Strengthen Efforts to Prevent Drug Use in Communities **Objective 2:** Seek Early Intervention Opportunities in Health Care
Working Group 2	**Objective 3:** Integrate Treatment for Substance Use Disorders into Health Care, and Expand Support for Recovery **Objective 4:** Break the Cycle of Drug Use, Crime, Delinquency, and Incarceration
Working Group 3	**Objective 5:** Disrupt Domestic Drug Trafficking and Production
Working Group 4	**Objective 6:** Strengthen International Partnerships and Reduce the Availability of Foreign-Produced Drugs in the United States
Working Group 5	**Objective 7:** Improve Information Systems for Analysis, Assessment, and Local Management

Working Group Meetings

Each Working Group held meetings to develop and refine targets and measures for the Objectives. The Working Group process (detailed in Addendum D) included the following steps:

- Brainstorming about candidate measures for the assigned Objective;

- Identifying available data sources;

- Evaluating data sources;

- Assessing, ranking, and selecting measures; and

- Identifying targets based on trend lines for each selected measure.

The Working Groups drew upon the most current research and data available to select performance measures and targets for each Objective. Research findings helped to identify optimal performance measures for each Objective. In some cases, however, data limitations precluded the use of ideal measures. In such cases, Working Groups opted to select a suite of measures to best reflect performance.

Each Working Group used common criteria in selecting performance measures. These criteria were used to ensure consistency in the selection of measures across Objectives. These criteria required that performance measures should be:

- Quantifiable;

- Clear in meaning to both analysts and lay readers;

- A valid indicator for the Objective—that is, a plausible indication of success in achieving the Objective;

- Supported by a data source that is representative of the event/concept being measured (that is, data based on nationally representative samples in preference to data collected unsystematically or narrowly focused on a particular region or subpopulation); and

- Reflect an outcome or an intermediate outcome.[7]

Additionally, each performance measure should:

- Reflect the contributions of more than one agency. Since the *Strategy* is meant to reflect inter-agency drug control efforts, the measures should reflect the collective work of contributing agencies in achieving each Objective;

- Allow documentation of small changes. Measures with baselines that are very low or very high will make it more difficult to document change. Also, if the pre-baseline trend is almost a straight line, it may be hard to document change unless some new factor is anticipated that is likely to affect change (e.g. new interdiction technology);

- Have data sources that are as unbiased, continuous, and likely to have funding until FY 2015, the target year;

- Be unambiguous—(e.g. price and purity are ambiguous measures since they are affected by demand elasticity); and

- Be complementary—that is, represent different aspects of success in achieving the Objective.

In recognition of the limitations imposed by insufficient data, the Working Groups recommended that PRS reports include discussion of appropriate auxiliary data when assessing target achievement. The presentation of the context of performance will enable a more complete interpretation of results. For instance, the measures on prescription drug abuse are augmented by information on the extent to which early intervention opportunities in the health care system are available. Similarly, since there

---

7. An intermediate outcome occurs between outputs (services or products delivered) and outcomes (that reflect the purposes of the program or policy). An intermediate outcome is an event or result occurring from actions undertaken by entities other than the agencies responsible for the joint outcome <u>and</u> that are strongly likely to lead to the achievement of desired outcomes.

are no national data on substance abuse recidivism rates for offenders, future PRS reports will include discussion of State and/or local recidivism data that are available, until a national rate becomes available.

The process delineated above was captured through templates that reflected each stage in the discussion with candidate measures, available data sources, existing time-series data, Working Group assessments about the reliability and validity of each measure and its data, and additional concerns about the measures under consideration. Once each group felt confident that it had fully discussed the range of possible measures, it ranked each measure on a scale of 1-3:

Ranking 1—The measure and data meet most of the criteria listed above. For example, the measure is a valid interagency outcome measure and there are adequate data collected on a regular basis that would allow detection of small changes.

Ranking 2—The measure and/or data do not meet key elements of the criteria listed above. For example, the measure is an interagency outcome measure but the data are not collected routinely. Or, data are representative and reported annually but the measure would not sufficiently reflect the achievement of the Objective.

Ranking 3—Both the measure and the data have significant deficiencies with respect to the criteria identified above. For example, the measure does not reflect achieving the Objective and the data are not collected routinely.

The Working Groups thereafter refined the higher-ranked measures and arrived at consensus on the best measures to include in the PRS. Each Working Group also used historical data for trend analysis to identify FY 2015 targets for each of the final measures. These targets signal interagency success in reducing the Nation's drug problem by 2015. In setting such targets, the most recently available baseline data for each performance measure was employed.

Each year, ONDCP will collect data for the impact targets of the two *Strategy* Goals and the 26 performance targets established for the *Strategy's* Objectives. The next chapter of this report presents the performance measures and targets recommended by the interagency Steering Committee and approved by the ONDCP Director. Addendum C presents details, including trend lines for measures for which data are currently available.

Chapter 3: PRS Measures and Targets for Strategy Objectives

The National Drug Control Strategy (*Strategy*) represents a comprehensive and balanced approach to reducing drug abuse and its damaging consequences. The measures and targets developed for each of the Strategy Objectives employed the most recent data available and constitute an important tool to measure interagency progress. Each measure—with its baseline, FY 2015 target, and data source—is described in detail in this chapter; baseline values and 2015 targets are provided in Addendum C.

The PRS Objectives harmonize with the *Strategy's* Chapters and include the following:

Objective 1   Strengthen Efforts to Prevent Drug Use in Our Communities

Objective 2   Seek Early Intervention Opportunities in Health Care

Objective 3   Integrate Treatment for Substance Use Disorders into Health Care, and Expand Support for Recovery

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

Objective 5   Disrupt Domestic Drug Trafficking and Production

Objective 6   Strengthen International Partnerships and Reduce the Availability of Foreign-Produced Drugs in the United States

Objective 7   Improve Information Systems for Analysis, Assessment, and Local Management

What follows is a description of the performance measures and targets selected for monitoring progress towards each of the seven Objectives.

Objective 1—Strengthen Efforts to Prevent Drug Use in Our Communities

Preventing drug use before it begins is a central component of a comprehensive drug control effort to protect individuals from the dangerous consequences of drug use and builds safe and healthy communities. Progress in substance abuse prevention is monitored through the *Strategy's* overarching impact measures focusing on drug use prevalence and a suite of Objective level measures focusing on perception of risk and average age of initiation. Table 3-1 outlines the measures and targets that were selected to assess the progress of this Objective.

Table 3-1 Objective 1 Measures, Baselines, Targets, Data Sources, and Reporting Agencies

Measure	Baseline	2015 Target	Data Source	Reporting Agency[8]
Percent of respondents, ages 12–17, who perceive a great risk in smoking marijuana once or twice a week	49.3% (2009)	51.2%	National Survey on Drug Use and Health (NSDUH)	SAMHSA
Percent of respondents, ages 12–17, who perceive a great risk in consumption of one or more packs of cigarettes per day	65.8% (2009)	68.0%	NSDUH	SAMHSA
Percent of respondents, ages 12–17, who perceive a great risk in consuming four or five drinks once or twice a week	39.9% (2009)	41.4%	NSDUH	SAMHSA
Average age of initiation for all illicit drugs	17.6 (2009)	19.5	NSDUH	SAMHSA
Average age of initiation for alcohol use	16.9 (2009)	21.0[10]	NSDUH	SAMHSA
Average age of initiation for tobacco use	17.5 (2009)	18.0	NSDUH	SAMHSA

Analysis of Measures

The measures and targets selected for Objective 1 fall into two categories: (i) risk perception and (ii) average age of initiation. Data for all six of the selected measures are collected by SAMHSA through their National Survey on Drug Use and Health (NSDUH) on an annual basis which reports prior calendar year results each September.

---

8. The Reporting Agency is the agency responsible for ensuring that the data are collected and reported to ONDCP. However, multiple agencies contribute to achieving the Strategy's Goals and Objectives through programs, policies, etc.

9. Substance Abuse and Mental Health Services Administration, Department of Health and Human Services

10. Age 21 is the end goal we are seeking; while it will be a challenge to achieve this by 2015, we do not want to lose sight of this intent.

Risk Perception Measures:

- Percent of respondents who perceive a great risk in smoking marijuana once or twice a week

- Percent of respondents who perceive a great risk in consumption of one or more packs of cigarettes per day

- Percent of respondents who perceive a great risk in consuming four or five drinks once or twice a week

These three measures were selected because of the research-based link between attitudes and drug use. Research has shown a strong relationship between youth attitudes and use; as the perception of risk and social disapproval decreases, drug use among youth increases.[11] Additionally, effective prevention initiatives are those that are comprehensive, include messages directed at youth regarding the potential harms of drug use, target environmental factors, and fully engage communities. Hence, changes in perception are a good measure of whether such prevention messaging and programming is having the desired effect on attitudes and use. Attitudes about marijuana, tobacco, and alcohol use were therefore chosen as strong proxy measures for all drug use and as a measure of the overall effectiveness of prevention efforts.

Targets for the risk perception measure were established based on historical NSDUH data. The NSDUH provides annual data on a range of populations and drugs of abuse. Young people's negative attitudes regarding the perception of risk about drugs, including marijuana, have been softening since 2005: the 2015 target aims to return to reverse this trend. In comparison, perceptions of risk for tobacco use have been increasing over time. Attitudes against cigarettes have strengthened each year since 2004: the 2015 target seeks to increase the percentage to 68 percent from a 2009 high of 65.8 percent. Similarly, perceptions about the risk of consuming five or more drinks of alcohol, once or twice a week, have been increasing since 2004. The 2015 goal looks to increase the percentage from a 2009 level of 39.9 percent to 41.4 percent.

Average Age of Initiation Measures:

- Average Age of Initiation for All Illicit Drugs

- Average Age of Initiation for Alcohol Use

- Average Age of Initiation for Tobacco Use

The age at which a user starts using illicit substances for the first time is a significant indicator of future drug use and abuse. The older the individuals are when they use a substance for the first time, the less likely they are to develop a long-term substance use disorder. Additionally, delaying the age of initiation is a sound indicator of the effectiveness of prevention initiatives that aim to reduce youth drug use. The age of initiation data is based on NSDUH respondents who reported using an illicit drug for the first time within the past 12 months. For alcohol and tobacco, the targets were identified in the context of the legal age for use for both substances.

---

11. Age 21 is the end goal we are seeking; while it will be a challenge to achieve this by 2015, we do not want to lose sight of this intent.

Objective 2—Seek Early Intervention Opportunities in Health Care

Health care professionals are logical providers of interventions given their role in early detection of substance abuse. Attention to the warning signs of drug abuse can help reduce the damaging consequences of abuse, including prescription drug abuse. Early interventions are an effective way to address early signs of substance abuse before they become well-established, chronic conditions.

Table 3-2 outlines the measures and targets that were selected to assess the progress of this Objective.

Table 3-2 Objective 2 Measures, Baselines, Targets, Data Sources, and Reporting Agencies

Measure	Baseline (Year)	2015 Target	Data Source	Reporting Agency
Percent of Federally Qualified Health Center grantees providing SBIRT services	10% (2009)	15%	Uniform Data System	HRSA
Percent of respondents in the past year using prescription-type drugs non-medically, age 12 - 17	7.7% (2009)	6.5%	National Survey on Drug Use and Health (NSDUH)	SAMHSA
Percent of respondents in the past year using prescription-type drugs non-medically, age 18 - 25	15% (2009)	12.8%	NSDUH	SAMHSA
Percent of respondents in the past year using prescription-type drugs non-medically, age 26+	4.7% (2009)	4.0%	NSDUH	SAMHSA

SBIRT - Screening, Brief Intervention, and Referral to Treatment

Analysis of Measures

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

Screening and brief intervention approaches are an effective way for the health care system to intervene with individuals at risk for problem behaviors. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those at risk of developing these disorders. Primary care centers, hospital emergency

rooms, trauma centers, and community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

The Health Resources and Services Administration (HRSA), through its Federally Qualified Health Center (FQHC) grantees, provides services to people in traditionally underserved areas and collects data on the types of services its grantees provide. HRSA is committed to expanding screening for substance abuse in their health centers. The target represents an increase of 50 percent by 2015 and reflects the commitment to significantly increase the SBIRT program. While HRSA only collects data on its grantees and does not survey all health centers, the grantees surveyed provide services to nearly 20 million people. The HRSA measure is a sound proxy for the expansion of screening services, given the absence of data on the aggregate performance of all health care providers and facilities.

Percent of respondents in the past year using prescription-type drugs non-medically

Non-medical use of prescription drugs is a rapidly increasing problem spanning multiple generations. This Objective is focused on curbing non-medical use of prescription drugs; hence three of the measures for this Objective focus on reducing this growing problem. Measures for three separate age cohorts were chosen to reflect progress in multiple age groups by 2015.

- Non-medical Use of Prescription Drugs Ages 12-17

- Non-medical Use of Prescription Drugs Ages 18-25

- Non-medical Use of Prescription Drugs Ages 26 and Over

NSDUH collects data on non-medical use of prescription drugs for each of the three cohorts. Prescription drug use continues to be a serious problem. The 2015 targets identified for the above measures—6.5 percent, 12.8 percent, and 4.0 percent, respectively - represent reductions of approximately 15 percent for each age group. NSDUH data is based on self-reported household survey data. It does not reflect individuals in the criminal justice system or in other institutions, or individuals who are homeless. As in any self-reported data there is the potential in NSDUH for over or under reporting specific behaviors.

Objective 3—Integrate Treatment for Substance Use Disorders into Health Care, and Expand Support for Recovery

There are many barriers to receiving clinically appropriate substance abuse treatment, such as a lack of access to suitable clinical care, facilities, and insurance coverage. Additionally, coordination between primary medical care and treatment facilities is often poor. Objective 3 reflects the *Strategy's* direction in shifting substance abuse treatment away from an episodic treatment care model to one grounded in primary health care that recognizes addiction is a chronic disorder associated with relapse where outcomes are greatly improved with augmentation by recovery support services.

Table 3-3 outlines the measures and targets that were selected to assess the progress of this Objective.

Table 3-3 Objective 3 Measures, Baselines, Targets, Data Sources, and Reporting Agencies

Measure	2010 Baseline	2015 Target	Data Source	Reporting Agency
Percent of treatment plans completed	45.1% (2007)	50.0 %	Treatment Episode Data Set - Discharge	SAMHSA
Percent of Health Center grantees providing substance abuse counseling and treatment services	23.0% (2009)	23.0%	Uniform Data System	HRSA
Percent of treatment facilities offering at least 4 of the standard spectrum of recovery services (child care, transportation assistance, employment assistance, housing assistance, discharge planning, and after-care counseling)	35.5% (2008)	39.0%	National Survey of Substance Abuse Treatment Services	SAMHSA

Analysis of Measures

Percent of treatment plans completed

Objective 3 addresses the improvement of current treatment services. In the absence of nationwide data on treatment effectiveness, a proxy measure on the percent of those completing treatment was adopted. This choice reflects the research correlating the completion of appropriate treatment with reductions in use and consequences. Multi-year data tracking clinical outcomes for individuals receiving treatment would have been ideal for this measure but those data are not available.

Data for this measure are drawn from SAMHSA's Treatment Episode Data Set on Discharges (TEDS-D). This data set covers areas such as treatment completion, length of stay in treatment, substance abuse

characteristics, and client demographics. All States report TEDS-D data, but the data reported are based on state administrative systems and their varying reporting methods. Data are collected regularly and published annually.

Only two data points—for 2006 and 2007—were available to set the 2015 target. TEDS-D data are available for three years prior to 2006. However, fewer states reported data during these years which skews the data and prevents comparison to subsequent years. Between 2006 and 2007, there was a slight decrease in the percentage of treatment plans completed, from 47.1 percent to 45.1 percent. With 45.1 percent as a baseline, it is expected that treatment completion will improve to 50 percent by 2015 as a result of the *Strategy's* action plans related to improving the quality of substance abuse treatment services. This target represents a 10.8 percent increase over the baseline.

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

This measure focuses on a primary component of the Objective. Since data for all health care services in the United States are not available, data on HRSA's Federally Qualified Health Center grantees and the 20 million individuals they serve, support this proxy measure for assessing the extent of substance abuse counseling and treatment services provided in primary care settings. An increase in the number of health center facilities offering these services is an indicator that substance abuse services are more integrated and expansive. Data for this measure are drawn from HRSA's Uniform Data System (UDS) and are collected annually from HRSA grantees.

Percent of treatment facilities offering at least 4 of the standard spectrum of recovery services

Recovery from substance dependence is a lifelong process and research has documented that treatment success is greatly improved by programs that facilitate recovery. In recent years, some Federally-funded recovery services have resulted in favorable outcomes. For instance, programs such as Access to Recovery (ATR, now in its third cohort of grantees) have shown improvements in employment, family and living conditions, and reduced involvement with the criminal justice system.

Based on the data available through SAMHSA's National Survey of Substance Abuse Treatment Services (N-SSATS), it was determined that the following services be included as the measure's definition of the standard spectrum of recovery services: discharge planning, after-care counseling, child care, transportation assistance, employment assistance, and housing assistance. An increase in the percentage of substance abuse treatment facilities that provide at least four of these services will serve to indicate recovery support services are expanding. N-SSATS is an annual survey that collects data from all facilities that provide substance abuse treatment services—both public and private—in the United States. This measure does not include all the recovery support services offered by facilities. Therefore, actual expansion of services may be underestimated.

The goal is that, by 2015, 39 percent of all facilities will provide at least four of the six services defined by the standard spectrum, a 10 percent increase over the 2008 baseline of 35.5 percent. Since 2004, the percentage of facilities providing at least four of these services has remained fairly constant. A 10 percent increase is reasonable given the recent focus on recovery support services and the documented success of grant programs such as ATR.

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

At the end of 2008, there were over 7.3 million adult men and women under the supervision of America's criminal justice system. Recent studies have examined the amount of illicit drug use and dependence among this special population. In 2004, 53 percent of state prisoners and 45 percent of Federal prisoners met the criteria for drug dependence or abuse.[12]

Individuals commit crimes while under the influence of drugs, commit crimes to obtain drugs or money to purchase drugs, and commit crimes that are drug offenses, such as possession and trafficking. Many of these drug-related crimes stem from underlying, treatable, illicit drug dependence or abuse. The criminal justice system can play a substantial role in reducing drug use and its consequences.

Table 3-4 Objective 4 Measures, Baselines, Targets, Data Sources, and Reporting Agencies

Measure	2010 Baseline	2015 Target	Data Source	Reporting Agency
Percent of residential facilities in the Juvenile Justice System offering substance abuse treatment	85.0% (2006)	90.0%	OJJDP – Juvenile Residential Facility Census	DOJ/OJJDP
Percent of treatment plans completed by those referred by the Criminal Justice System	46.8% (2007)	49.1%	Treatment Episode Data Set – Discharge	SAMHSA/CBHSQ

Analysis of Measures

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

This measure focuses on treatment that is available to youth in the Juvenile Justice system and the importance of breaking the cycle of drugs and crime in this population at an early stage. The data are provided by the Office of Juvenile Justice and Delinquency Prevention's Juvenile Residential Facility Census (JRFC). The JRFC reviews a variety of information on facility operations and services, including substance abuse treatment. The rationale for using this proxy measure is that as more facilities offer treatment, more juveniles have access to treatment. In 2002, 86 percent of all residential juvenile facilities offered substance abuse treatment services. This survey was conducted most recently in 2006 when the percentage dropped to 85 percent, which is the baseline for this measure. The target for 2015 is for 90 percent of surveyed residential juvenile justice facilities to offer substance abuse treatment. This target represents a 5 percent increase over the 2006 baseline. Actual achievement in 2015 will be estimated, based on the 2014 data, since this census is conducted every two years.

---

12. Bureau of Justice Statistics Special Report: Drug Use and Dependence, State and Federal Prisoners, 2004. Revised January 19, 2007.

Percent of treatment plans completed by those referred by the Criminal Justice System

Increased completion of treatment plans is correlated with improved treatment outcomes; according to the research, it is also a predictor of reduced drug use.[13] The Treatment Episode Data Set on Discharges (TEDS-D) collects data annually, but data are reported two years subsequent to collection. In 2007, the baseline year, the most recent year for which data are available, 46.8 percent of all criminal justice referrals completed treatment, representing a slight decrease from the previous year (47.7 percent in 2006). A 2015 target of 49.1 percent was selected, representing a 5 percent increase over the baseline.

Probation and Parole Related Measures

The PRS identified two additional measures that are valid and meaningful indicators of progress towards achieving Objective 4: (i) Of those on probation, percent that have used drugs in the past 30 days; and (ii) Of those on parole/supervised release, percent that have used drugs in the past 30 days. While data exist for these two measures, they are not ideal for performance monitoring since sample sizes are too small to allow confidence that estimated changes are statistically significant. The PRS will nonetheless monitor these data for possible trends.

---

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

Objective 5—Disrupt Domestic Drug Trafficking and Production

While prevention, intervention, and treatment initiatives address reducing the demand for drugs, a comprehensive drug strategy must also include efforts to reduce the availability of drugs. Well-established Drug Trafficking Organizations (DTOs) exist within U.S. borders, threatening the public safety and well-being of citizens. Objective 5 focuses on limiting access to illicit drugs by targeting organizations that distribute illicit drugs and by targeting the cultivation and production of illicit drugs.

Table 3-5 outlines the measures and targets that were selected to assess the progress of this Objective.

Table 3-5 Objective 5 Measures, Baselines, Targets, Data Sources, and Reporting Agencies

Measure	Baseline	2015 Target	Data Source	Reporting Agency
Number of domestic CPOT-linked organizations disrupted or dismantled	299 (2009)	380	Priority Target Activity and Resource Reporting System (PTARRS)	DEA
Number of RPOT-linked organizations disrupted or dismantled	119 (2009)	90	DOJ database on RPOT-linked organizations	OCDETF
Number of meth lab incidents	9,723 (2009)	7,293 (25% Reduction)	EPIC	DEA

CPOT—Consolidated Priority Organization Targets
RPOT—Regional Priority Organization Targets

Analysis of Measures

Number of domestic CPOT-linked organizations disrupted or dismantled

The measure, Number of domestic CPOT-linked organizations disrupted or dismantled, is used to assess domestic enforcement efforts. The Department of Justice's CPOT List comprises a select group of DTOs that represent the greatest threat to the United States. DOJ's Priority Target Activity and Resource Reporting System (PTARRS) documents the majority of data concerning the number of CPOT-linked organizations, as collected by the Drug Enforcement Administration (DEA) and the Organized Crime Drug Enforcement Task Forces (OCDETF).

DEA, OCDETF, FBI, Department of Homeland Security (DHS), and the High Intensity Drug Trafficking Area (HIDTA) Program all focus on disrupting and dismantling DTOs linked to the CPOT list and each agency documents its achievements in its own data systems. Since these data systems use varying definitions and methodologies, the Working Group selected DEA's PTARRS as a proxy data source representing the interagency focus in this area.

Number of RPOT-linked organizations disrupted or dismantled

Similar to CPOT-linked organizations, Regional Priority Organization Targets (RPOTs) are drug trafficking organizations that are primarily responsible for a specific region's drug threat. The RPOT list enables

the OCDETF regions to focus enforcement efforts on specific targets, and they encourage and facilitate coordination of related critical investigations.[14]

The primary data source for the number of RPOT-linked organizations disrupted or dismantled is the OCDETF database to which OCDETF regions report data concerning disruptions or dismantlements. The number of organizations that law enforcement identifies fluctuates each year, greatly influencing the number of disruptions and dismantlements. In alignment with DOJ's Strategic Plan, the 2015 target has been set at 90 RPOT-linked organizations disrupted or dismantled with a 2009 baseline of 119. This target is reflective of the current circumstance where, beginning in FY 2011, OCDETF reduced the number of possible RPOTs from 200 to 150. The reason for this reduction is to ensure that the OCDETF regions are identifying and targeting the major drug traffickers operating throughout the region so that the limited resources available are used to disrupt and dismantle the most significant drug trafficking organizations in the region. Therefore, the estimated targets for the number of RPOT-linked organizations disrupted or dismantled from FY 2011 through FY 2015 show a slight downward trend because of the reduced number of RPOTs identified.

Number of meth lab incidents

Methamphetamine (meth) abuse represents one of the most troubling and damaging drug threats. Federal and state laws regulate or prohibit the sale of pseudoephedrine, a key ingredient used in the production of meth. Meth lab incident data are collected by the El Paso Intelligence Center (EPIC) and reported by ONDCP. The data do not reflect merely the number of labs seized but also information regarding dumpsites, chemicals, glass, and other relevant equipment used in the production of meth. This distinction is important since the data reflect not only illegal activity, but also any adaptations in production. Methamphetamine laboratory incident numbers decreased from approximately 15,335 in 2005 to 6,296 by 2007. This decline was a significant accomplishment, largely a result of State and Federal (via the Combating Methamphetamine Epidemic Act of 2005 or CMEA) retail purchase limits for products containing pseudoephedrine. However, by 2008, lab incident numbers began to increase again, and in 2010, approximately 11,681 incidents were reported. Lab incidents increased as lab operators learned how to circumvent the CMEA and State laws. The post CMEA increase in lab incidents is directly related to "smurfing"[15]pseudoephedrine/ephedrine at the retail level. The vast majority of these labs discovered over the last several years were operated by local user/distributors with no organizational ties, and there have also been several multi-kilogram labs with ties to Mexican organized criminal groups who have "smurfed" large quantities of pseudoephedrine in order to produce significant amounts of methamphetamine for regional or national distribution.

An aggressive target was set—a 25 percent decrease from the 2009 level—while recommending that the PRS assessment of progress consider auxiliary data on meth use and consequences when assessing progress. For example, if it is found that methamphetamine labs are decreasing domestically, and auxiliary data indicate both methamphetamine use rates and emergency department visits are decreasing, then it would reinforce a potential conclusion that a reduction in domestic labs was not an anomaly and may be impacting use.

---

14. Definition source: Department of Justice Fact Sheet

15. To circumvent laws that limit the amount of pseudoephedrine containing products that can be sold to any one customer, methamphetamine manufacturers adopted an approach to evade these controls by making purchases in several different store—a practice known as "smurfing."

Objective 6—Strengthen International Partnerships and Reduce the Availability of Foreign-Produced Drugs in the United States

Disrupting and dismantling the violent criminal enterprises that transit drugs into the United States both reduces the supply of drugs and fulfills U.S. responsibility to foreign nations to respect and support the rule of law.

Objective 6 concentrates on international efforts to curb the amount of drugs that ultimately enter the United States and assisting Nations in addressing their own drug problems. Objective 6 focuses comprehensively on international partnerships, the rule of law, and disruption of international Drug Trafficking Organizations (DTOs). Furthermore, the renewed emphasis on supporting source countries in their supply reduction efforts, seeks to substantially reduce the flow of foreign produced drugs into the United States while stabilizing foreign partnerships.

Table 3-6 outlines the measures and targets that were selected to assess the progress of this Objective.

Table 3-6 Objective 6 Measures, Baselines, Targets, Data Sources, and Reporting Agencies

Measure	Baseline	2015 Target	Data Source	Reporting Agency
Percent of selected countries on the Majors list* that increased their commitment to supply reduction **	TBD in CY 2012	Pending Baseline Determination	Special Survey by Department of State	Department of State
Percent of selected countries on the Majors list* that increased their commitment to demand reduction **	TBD in CY 2012	Pending Baseline Determination	Special Survey by Department of State	Department of State
Percent of Majors list countries showing progress since 2009 in reducing either cultivation or drug production potential	Baseline year of 2009	100%	Department of State	Department of State
Number of international CPOT-linked organizations disrupted or dismantled	65 (2009)	60	Priority Target Activity and Resource Reporting System (PTARRS)	DEA

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

As these measures are new additional time is needed for the development and testing of the methodology, and analyzing the data for consistency and accuracy.

Analysis of Measures

Percent of selected countries on the Majors list that increased their commitment to supply reduction efforts, and, Percent of selected countries on the Majors list that increased their commitment to demand reduction efforts

Increased commitment by a Majors list country is an indicator of its intent to curb the flow of illegal drugs into the United States and address substance abuse domestically. "Major" countries are countries that are classified as major drug transit or drug producing countries for the purpose of the Foreign Assistance Act of 1961 (FAA). ONDCP will work with the State Department's Bureau of International Law Enforcement to develop procedures for the first year that will establish a baseline and eventually a FY 2015 target based on a selected list of countries from the Majors list for which these data are available, specifically Afghanistan, Bolivia, Colombia, Guatemala, Mexico, Pakistan, Peru and the Dominican Republic. The information collected will track historical support over time within a country for both supply and demand efforts.

The definitions for support of supply and demand efforts are as follows:

- Supply Reduction. International partner support, including financial resources, for drug crop eradication, drug interdiction, judicial and law enforcement programs and institutional strengthening focused on drug trafficking.

- Demand Reduction. International partner support , including financial resources, for drug prevention programs, to include: media, education programs in the public schools, testing, community organization, family focused programs, and training to recognize drug abuse in schools and the workplace, professional training, research and development, drug abuse treatment programs and facilities, and alternatives to incarceration such as drug courts.

Percent of Majors list countries showing progress in reducing either cultivation or drug production potential

Reducing the cultivation or drug production potential of a Majors list country represents a success of international efforts to reduce the flow of illicit drugs. "Majors list" countries are those that meet specific State Department criteria for illicit drug production or transit of illicit drugs. Currently the following countries are classified as major drug-transit or drug-producing countries for purposes of the FAA: Afghanistan, the Bahamas, Bolivia, Brazil, Burma, Colombia, the Dominican Republic, Ecuador, Guatemala, Haiti, India, Jamaica, Laos, Mexico, Nigeria, Pakistan, Panama, Paraguay, Peru, and Venezuela. The Majors list countries for which 2009 data exist that can be used to track this measure include: Afghanistan, Burma, Laos, Mexico, Bolivia, Colombia, and Peru. For these countries, the cultivation or production of opium poppy, heroin, coca, and marijuana will be estimated.

The baseline that will be used is 2009 and the target is 100 percent, meaning, between 2009 and 2015, all of the selected seven Majors list countries should show progress in reducing drug cultivation or production.

Number of CPOT-linked international organizations disrupted or dismantled

The Department of Justice's Consolidated Priority Organization Targets (CPOTs) are the most significant international drug trafficking and money laundering organizations and those primarily responsible for the Nation's drug supply.[16] Disrupting and dismantling CPOT-linked international organizations has great impact on the Nation's illicit drug supply and the flow of foreign-produced drugs into the United States.

DEA, OCDETF, FBI, DHS, and the HIDTA program all focus on disrupting and dismantling priority drug trafficking organizations linked to DOJ's CPOT list and each agency documents its achievements in its own database. Since these databases use varying definitions and methodologies, the Working Group selected DEA's Priority Target Activity and Resource Reporting System (PTARRS) as a proxy data source representing the interagency focus in this area.

---

16. Definition source: Department of Justice Performance and Accountability Report

Objective 7—Improve Information Systems for Analysis, Assessment, and Local Management

Using data for evidence-based decision making is the cornerstone of a strategic approach to both supply and demand reduction efforts. Currently, there are over 70 drug-related data systems that are used to inform policy and decision making. The primary systems identified by the *Strategy* include:

- National Survey on Drug Use and Health
- Monitoring the Future
- Drug Abuse Warning Network
- National Forensic Laboratory Information System
- National Seizure System
- Drug and Alcohol Services Information System
- System to Retrieve Information on Drug Evidence
- Youth Risk Behavior System
- Behavioral Risk Factor Surveillance System
- Vital Statistics Multiple Cause Mortality Data
- Uniform Crime Reports

Objective 7 addresses existing data deficiencies for the purpose of informing drug-related policy, decision making, and performance monitoring. Improvements in data systems will contribute to more effective programs, policies, initiatives, and performance monitoring, thereby contributing indirectly to the Strategy's Goals and Objectives.

Table 3-7 outlines the measures and targets that were selected to assess the progress of this Objective.

Table 3-7 Objective 7 Measures, Baselines, Targets, Data Sources, and Reporting Agencies

Measure	2010 Baseline	2015 Target	Data Source	Reporting Agency
Increase timeliness (year-end to date-of-release) of select Federal data sets above their baseline by 10%				
Treatment Episode Data Set(TEDS)[17]	15 months	13 months	SAMHSA	SAMHSA
Increase the utilization (number of annual web hits, or number of documents refer- encing the source) of select Federal data sets by 10% from the baseline				
Substance Abuse and Mental Health Data Archive (SAMHDA)	200,000 web hits per year	300,000 web hits per year	SAMHDA	SAMHSA
National Survey of Drug Use and Health (NSDUH) (Journal articles referencing NSDUH)	37 per year	50 per year	SAMHSA	SAMHSA
Increase Federal data sets that establish feedback mecha- nisms to measure usefulness (surveys, focus groups, etc.)				
SAMHSA Funded Data Sets[18]	0	1	CBHSQ/ SAMHSA	SAMHSA

Analysis of Measures

Federal data sets that increase timeliness of data by 10 percent

The timeliness of federal data sets was identified as an area for improvement. Improved timeliness and reduced lag times between an event and reporting it, allows policy and decision makers to more quickly address new and emerging threats. The faster data is reported after it is collected, the more actionable and relevant it becomes. The Drug Abuse Warning Network and Treatment Episode Data Sets reports were identified as important data sources and good candidates for improv- ing lag times between collection and reporting. Given year-to-year variation in reporting times, targets for this measure were developed based on historical 3-year moving average of timeliness.

---

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

18. SAMHSA is sponsoring a conference for the users of SAMHSA's data sets; conference will generate recommendations for implementation.

Federal data sets that increase utilization of data by 10 percent

The rate of utilization of Federal data sets is a clear indication of the relevance, utility, and importance of the data that is being reported. Improved data sets can better inform policy, program development and management. Two key sources of data are the Substance Abuse and Mental Health Data Archive (SAMHDA) and the National Survey of Drug Use and Health (NSDUH). SAMHDA promotes the access and use of the nation's preeminent substance abuse and mental health research data by assuring accurate public use data files and documentation. The NSDUH is a key source of data on drug use in the United States.

The baseline for SAMHDA web hits per year is based on current SAMHSA information and sets a target of 300,000 web hits per year by 2015. The baseline for NSDUH was based on current information SAMHSA and sets a 2015 target of 50 journal articles/year referencing NSDUH data.

Percent of National Drug Control Strategy data actions implemented

In order to reduce data gaps, the Strategy outlines a series of actions to help attain Objective 7. These are:

- Sustain and Enhance Existing Federal Data Systems
- Collect further data on drugged driving
- Enhance the Drug Abuse Warning Network emergency department data system
- Improve the National Survey on Drug Use and Health
- Sustain Support for the Drug and Alcohol Services Information System
- Better Assess Price and Purity of Illicit Drugs on the Street
- Strengthen Drug Information Systems Focused on Arrestees and Incarcerated Individuals
- Develop and Implement Measures of Drug Consumption
- Transition Drug Seizure Tracking to the National Seizure System
- Enhance the Various Data that Inform Common Understanding of Global Illicit Drug Markets
- In Coordination with International Partners, Improve Capacity for More Accurately, Rapidly and Transparently Estimating the Cultivation and Yield of Marijuana, Opium, and Coca in the World
- Develop a Community Early Warning and Monitoring System that Tracks Substance Use and Problem Indicators at the Local Level

ONDCP will report on the success of the interagency efforts on these actions. The current baseline is zero percent and the 2015 target is 100 percent completion.

Federal data sets that establish feedback mechanisms to measure usefulness

Changes in Federal data sets must be based on the program and policy needs of Federal, State and local stakeholders. Establishing feedback mechanisms will ensure that Federal data sets are meeting the needs of the individuals and organizations who use them. SAMHSA is convening a conference for the users of SAMHSA-supported data sets; these data sets represent a significant Federal investment in understanding drug use and its consequences and treatment patterns in the United States. SAMHSA's conference is intended to generate recommendations, including those for improving the usefulness of the data sets.

Addendum A: ONDCP's Statutory Requirement to Develop and Implement a Performance Reporting System

Section 202 of The National Drug Control Policy Reauthorization Act of 2006, provides:

(c) Performance Measurement System.—Not later than February 1 of each year, the Director shall submit to Congress as part of the National Drug Control Strategy, a description of a national drug control performance measurement system, that:

1. Develops 2-year and 5-year performance measures and targets for each National Drug Control Strategy goal and objective established for reducing drug use, availability, and the consequences of drug use;

2. Describes the sources of information and data that will be used for each performance measure incorporated into the performance measurement system;

3. Identifies major programs and activities of the National Drug Control Program agencies that support the goals and annual objectives of the National Drug Control Strategy;

4. Evaluates the contribution of demand reduction and supply reduction activities as defined in section 702 implemented by each National Drug Control Program agency in support of the National Drug Control Strategy;

5. Monitors Consistency between the drug-related goals and objectives of the National Drug Control Program agencies and ensures that each agency's goals and budgets support and are fully consistent with the National Drug Control strategy and;

6. Coordinates the development and implementation of national drug control data collection and reporting systems to support policy formulation and performance measurement, including an assessment of:

    A. The quality of current drug use measurement instruments and techniques to measure supply reduction and demand reduction activities;

    B. The adequacy of the coverage of existing national drug use measurement instruments and techniques to measure the illicit drug user population, and groups that are at risk for illicit drug use;

    C. The adequacy of the coverage of existing national treatment outcome monitoring systems to measure the effectiveness of drug abuse treatment in reducing illicit drug use and criminal behavior during and after the completion of substance abuse treatment, and ;

    D. The actions the Director shall take to correct any deficiencies and limitations identified pursuant to subparagraphs (A) and (B) of this subsection

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

Acronyms

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

ATR   Access to Recovery, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, U.S. Department of Health and Human Services

CBHSQ   Center for Behavioral Health Statistics and Quality, SAMHSA

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

CPOT   The Consolidated Organization Priority (CPOT) List identifies the most significant international drug trafficking and money laundering organizations and those primarily responsible for the nation's drug supply.

CPOT-linked   An organization is considered linked to a CPOT if credible evidence exists (i.e., from corroborated confidential source information, phone tolls, Title III intercepts, drug ledgers, financial records or other similar investigative means) of a nexus between the primary investigative target and a CPOT target, verified associate, or component of the CPOT organization.

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

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

DHS   U.S. Department of Homeland Security

DOD   U.S. Department of Defense

DOI   U.S. Department of Interior

DOJ   U.S. Department of Justice

DOL   U.S. Department of Labor

DOS   U.S. Department of State

DOT   U.S. Department of Transportation

DTO   drug trafficking organization; complex organization with a highly defined command-and-control structure that produces, transports, and/or distributes large quantities of one or more illicit drugs.

DVA   U.S. Department of Veterans Affairs

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

FAA   Foreign Assistance Act of 1961

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

HHS   U.S. Department of Health and Human Services

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

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

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

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

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

NSDUH National Household Survey on Drug Use and Health Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

OCDETF Organized Crime Drug Enforcement Task Forces, U.S. Department of Justice

OJJDP Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice

ONDCP Office of National Drug Control Policy, Executive Office of the President, The White House

PTARRS DOJ's Priority Target Activity and Resource Reporting System; reports the majority of data concerning the number of CPOT-linked organizations collected by the Department of Justice's Drug Enforcement Administration (DEA) and the Organized Crime Drug Enforcement Task Forces (OCDETF).

RPOT The Regional Priority Organization Target (RPOT) Lists identify those significant regional drug trafficking and money laundering organizations that are primarily responsible for regional drug threats.

RPOT-linked The RPOT Lists consist of those organizations having a significant impact on the drug supply within the designated OCDETF Regions. OCDETF participants apply the same standards for establishing a "link" to a RPOT as they use to establish a credible link to a CPOT.

SAMHSA Substance Abuse and Mental Health Services Admistration, U.S. Department of Health and Human Services

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

SBA Small Business Administration

TEDS-A Treatment Episode Data Set on Admissions, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

TEDS-D Treatment Episode Data Set on Discharges, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

UDS Uniform Data System, Health Resources and Services Administration, U.S. Department of Health and Human Services

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

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

Abbreviations

Majors list—countries that are classified as major drug transit or drug producing countries for the purpose of the Foreign Assistance Act of 1961; Currently the following countries meet State Department criteria for illicit drug production or transit: Afghanistan, the Bahamas, Bolivia, Brazil, Burma, Colombia, the Dominican Republic, Ecuador, Guatemala, Haiti, India, Jamaica, Laos, Mexico, Nigeria, Pakistan, Panama, Paraguay, Peru, and Venezuela.

PRS Steering Committee—comprised of senior agency officials familiar with drug control issues, policies, and programs. This Committee's primary roles are to advise the Director of ONDCP on the design and implementation of the PRS, serve as primary liaisons with their agencies, bring individual agency concerns to the table for discussion, and to review the recommendations of the Working Groups.

The Strategy—2010 National Drug Control Strategy—guide for the nation in controlling the use and consequences of the illicit use of drugs.

PRS Working Groups—representatives from the Federal drug control agencies whose purpose was to address the seven Objectives of the Strategy; working groups included agency subject matter experts, policy and program analysts, statisticians, researchers, line managers, and other drug program or data experts knowledgeable of drug control programs, policy, and research. Representatives from the following Federal agencies participated in the Working Group activities: the Departments of Defense, Education, Health and Human Services, Homeland Security, Interior, Justice, Labor, Transportation, Treasury, State, Veterans Affairs, and the Small Business Administration.

Performance Terms

Impact Target—shows the impact of policies, programs, and initiatives.

Intermediate Outcome—result or event occurring from actions taken by entities other than the agencies responsible for the joint outcome <u>and</u> that are likely to lead to the achievement of desired outcomes. These usually occur between outputs (services or products delivered) and outcomes reflecting the purpose of the policy or program.

Performance Measure—represents the specific characteristic or aspect of the program (or policy) that is used to gauge performance. For instance, a measure for "drug use" might be the percent of the population that used drugs in the past 30 days.

Performance Reporting System (PRS)—performance monitoring and assessment mechanism for gauging the effectiveness of the Strategy.

Performance Target—shows the desired level of performance to be achieved during a specified fiscal year for that measure.

Reporting Agency—The Reporting Agency is the agency responsible for ensuring that the data are collected and reported to ONDCP. However, multiple agencies contribute to achieving the Strategy's Goals and Objectives through programs, policies, etc.

Addendum C: Goals, Objectives, Measures, Baselines and FY 2015 Targets

National Drug Control Strategy Goals				
Goals	**Measures**	**Baseline (Year)**	**FY15 Target**	**Data Source**
Strategy Goal 1— Curtail Illicit Drug Consumption in America	Decrease the 30-day prevalence of drug use among 12 - 17 year olds by 15%	10.0 (2009)	8.5	NSDUH
	Decrease the lifetime prevalence of 8th graders who have used drugs, alcohol, or tobacco by 15%	TBD	TBD	MTF
	Decrease the 30-day prevalence of drug use among young adults aged 18 - 25 by 10%	21.2 (2009)	19.1	NSDUH
	Reduce the number of chronic drug users by 15%	TBD	TBD	Data Source TBD
Strategy Goal 2—Improve the Public Health and Public Safety of the American People by Reducing the Consequences of Drug Abuse	Reduce drug-induced death by 15%	12.8 (2009)	10.9	CDC
	Reduce drug-related morbidity by 15%	TBD	TBD	Data Source TBD
	Reduce the prevalence of drugged driving by 10%	4.4 (2009)	4.0	NSDUH

TBD: To be Determined

PRS Objectives				
Objectives	**Measures**	**Baseline (Year)**	**FY15 Target**	**Data Source**
Objective 1— Strengthen Efforts to Prevent Drug Use in Our Communities	Percent of respondents, ages 12 - 17, who perceive a great risk in smoking marijuana once or twice a week	49.3 (2009)	51.2	NSDUH
	Percent of respondents, ages 12 - 17, who perceive a great risk in consumption of one or more packs of cigarettes per day	65.8 (2009)	68.0	NSDUH
	Percent of respondents, ages 12 - 17, who perceive a great risk in four or five drinks once or twice per week	39.9 (2009)	41.4	NSDUH
	Average age of initiation for all illicit drugs	17.6 (2009)	19.5	NSDUH
	Average age of initiation for alcohol use	16.9 (2009)	21.0*	NSDUH
	Average age of initiation for tobacco use	17.5 (2009)	18.0	NSDUH

PRS Objectives				
Objectives	**Measures**	**Baseline (Year)**	**FY15 Target**	**Data Source**
Objective 2—Seek Early Intervention Opportunities in Health Care	Percent of Federally Qualified Health Center grantees providing SBIRT services	10% (2009)	15%	Uniform Data System
	Percent of respondents in the past year using prescription-type drugs non-medically, age 12 - 17	7.7 (2009)	6.5	NSDUH
	Percent of respondents in the past year using prescription-type drugs non-medically, age 18 - 25	15 (2009)	12.8	NSDUH
	Percent of respondents in the past year using prescription-type drugs non-medically, age 26+	4.7 (2009)	4.0	NSDUH

PRS Objectives				
Objectives	**Measures**	**Baseline (Year)**	**FY15 Target**	**Data Source**
Objective 3— Integrate Treatment for Substance Use Disorders into Health Care, and Expand Support for Recovery	Percent of treatment plans completed	45.1 (2007)	50.0	TEDS
	Percent of Health Center grantees providing substance abuse counseling and treatment services	23% (2009)	23%	Uniform Data System
	Percent of treatment facilities offering at least 4 of the standard spectrum of recovery services (child care, transportation assistance, employment assistance, housing assistance, discharge planning, and aftercare counseling)	35.5 (2008)	39	NSSATS
Objective 4— Break the Cycle of Drug Use, Crime, Delinquency, and Incarceration	Percent of residential facilities in the Juvenile Justice System offering substance abuse treatment	85.0 (2006)	90.0	Juvenile Residential Facility Census
	Percent of treatment plans completed by those referred by the Criminal Justice System	46.8 (2007)	49.1	TEDS-D

PRS Objectives				
Objectives	**Measures**	**Baseline (Year)**	**FY15 Target**	**Data Source**
Objective 5—Disrupt Domestic Drug Trafficking and Production	Number of domestic CPOT-linked organizations disrupted or dismantled	299 (2009)	380	PTARRS
	Number of RPOT-linked organizations disrupted or dismantled	119 (2009)	90	DOJ database on RPOT-linked organizations
	Number of meth lab incidents	9,723 (2009)	7,293	
Objective 6—Strengthen International Partnerships and Reduce the Availability of Foreign-Produced Drugs in the United States	Percent of selected countries on the Majors list that increased their commitment by increasing their budgets for supply reduction	TBD in 2012		Dept. of State - Special survey
	Percent of selected countries on the Majors list that increased their commitment by increasing their budgets for demand reduction	TBD in 2012		Dept. of State - Special survey
	Percent of Majors list countries showing progress since 2009 in reducing either cultivation of drug production potential	Baseline of 2009	100	Dept. of State records
	Number of international CPOT-linked organizations disrupted or dismantled	65 (2009)	60	PTARRS

PRS Objectives				
Objectives	**Measures**	**Baseline (Year)**	**FY15 Target**	**Data Source**
Objective 7— Improve Information Systems for Analysis, Assessment, and Local Management	Increase timeliness (year-end to date-of-release) of select Federal data sets above their baseline by 10% - TEDS	15 months	13 months	SAMHSA
	Increase the utilization (number of annual web hits, or number of documents referencing the source) • SAMHDA • NSDUH	 - 200,000 web hits/year - 37/year	 - 300,000 web hits/year - 50/year	 SAMHDA SAMHSA
	Increase Federal data sets that establish feedback mechanisms to measure usefulness (surveys, focus groups, etc.) – SAMHSA-funded data sets	0	1	CBHSQ/SAMHSA

* Age 21 is the end goal we are seeking; while it will be a challenge to achieve this by 2015, we do not want to lose sight of this intent.

Addendum D: Template & Process for Identifying Outcome Measures

Figure D-1: Template

1st meeting							
How to identify outcome measures for the Objective?* (Facilitator)	What are possible outcome measures?	What data needed? Numerator? Denominator?	Are these data available?	Are these data appropriate for assessing the outcome? **	Are there any additional costs to get the data? How much?	When are data reported? (timeliness)	Candidate outcome measures

* What does success look like? (What are the indicators that show reduction in the problem implied in the Objective?)

** Will we know we are making a difference if we use this measure & data?

NOTE: Homework at the end of each meeting is to (i) review decisions made at previous meeting, and (ii) draft responses for decisions to be made at the next meeting.

2nd meeting						Baseline data: use most recent year available (specify which year)	Data for year 1 before baseline	Year 2 before baseline				
Candidate outcomes from last meeting	Additional considerations	Selected outcome measures	Data sources	Which agency reports?	Agency POC for reporting				...	...	...	Target for year

3rd meeting			
Final WG draft measures & targets	Gaps in data	Data gap recommendations	Select presenter to interagency committee

Process

Identifying performance outcome measures and targets involved collaboration among many participants especially the representatives of organizational units contributing to the achievement of the targets. Based on previous experience, ONDCP developed the template above for working through the various viewpoints of persons with different perspectives on the joint mission, following diverse professional disciplines, and subject to varying institutional and data constraints. It allowed for a systematic assessment of options to arrive at majority, if not consensus, decisions.

It was important to establish an interagency Steering Committee of key senior officials and involve it in setting up working groups grouped by objective (or set of similar objectives). Working group members were expected to contribute expertise in policy, program, research, data, budget, and performance areas. For smooth functioning, working group chairs were trained in using these procedures (template above) before working group meetings commenced.

The working group process took about 3 meetings of two hours each. Especially thorny areas required an additional session. The final selection was then presented to the Steering Committee for review and adoption.

Each working group used the following process (completing its own template spreadsheet) to develop and refine measures and targets for each objective:[19]

- Brainstorming about candidate measures for the assigned objective

- Identifying available data sources

- Evaluating data sources

- Assessing, ranking, and selecting measures

- Identifying targets based on trend lines for each selected measure

Working groups drew on the most current research and data available to make final selections of performance measures and targets for each objective. Research findings often suggested optimal performance measures. However, data limitations often precluded the use of these ideal measures. In such cases, working groups identified proxy measures or developed a suite of measures to reflect various aspects of performance.

The following criteria were useful in selecting among candidate performance measures, enabling consistency across objectives. To assess effectiveness, performance measures should:

- Be quantifiable;

- Be clear in meaning to both analysts and lay readers;

- Be a valid indicator for the objective—that is, a plausible indication of success in achieving the objective[20];

- Be supported by a data set that is representative of the event/concept being measured (that is, data based on nationally representative samples in preference to data collected unsystematically or narrowly focused on a particular region or subpopulation); and

- Be an outcome or an intermediate outcome.[21]

Additionally, each performance measure:

- May reflect the contributions of more than one agency. For interagency missions, the measures should reflect the collective work of contributing agencies in achieving a particular objective;

- Should allow the documentation of small changes. Measures with baselines that are very low or very high will make it more difficult to document change. Also, if the pre-baseline trend is almost a straight line, it may be hard to document change unless some new factor is anticipated that is likely to affect change (e.g. innovations anticipated);

- Have data sources that are as unbiased, continuous, and likely to have funding until FY 2015, the target year;

---

19. This process described earlier in the body of this report is detailed here in order to present a full picture of the interagency process.

20. Psychometric terms such as "validity" should be made user-friendly.

21. An intermediate outcome occurs between outputs (services or products delivered) and outcomes (that reflect the purposes of the program or policy). An intermediate outcome is an event or result occurring from actions undertaken by entities other than the agencies responsible for the joint outcome <u>and</u> that are strongly likely to lead to the achievement of desired outcomes.

- Be unambiguous—(e.g. price and purity are ambiguous measures since they are affected by both the demand reduction and the supply reduction of drugs); and

- Be complementary—that is, represent different aspects of success in achieving the objective.

In recognition of the limitations imposed by insufficient data, working groups recommended that annual reporting include discussion of appropriate auxiliary data when assessing target achievement. A presentation of the context of performance will allow for a more complete interpretation of results. For instance, measures on prescription drug abuse can be augmented by information on the extent to which early intervention opportunities in the health care system are available. Similarly, since there is no national data on recidivism rates, the annual report can include discussion of available State and/or local recidivism data until a national rate becomes available.

The process described above were captured on templates that reflected each stage in the decision process—with candidate measures, available data sources, existing time-series data, working group assessments about the reliability and validity of each measure and its data, and additional concerns about each measure under consideration. The process was expedited by projecting at each meeting an on-line template on a large screen and participant comments and ideas added to the template in real-time. This ensured that everyone's comments were entered, assessed, and decisions made clear to all. Completed templates were sent to each participant after each meeting, enabling the completion of preparatory work for the next meeting. The next meeting started with the final template of the previous meeting.

Once each group was confident that it had fully discussed the range of possible measures, it ranked each measure on a scale of 1-3:

Ranking 1—The measure and data meet most of the criteria listed above. For example, the measure is a valid interagency outcome measure and there are adequate data collected on a regular basis that allows the detection of small changes.

Ranking 2—The measure and/or data do not meet key elements of the criteria listed above. For example, the measure is an interagency outcome measure but the data are not collected routinely. Or, the data are representative and reported annually but the measure does not adequately reflect the achievement of the objective.

Ranking 3—Both the measure and the data have significant deficiencies with respect to the criteria identified above. For example, the measure does not reflect achieving the objective and the data are not reliable or credible.

The highest-ranked measures were thereafter refined and the best ones selected. Historical trends (starting with baseline data) were identified for determining feasible long-term targets for each of the final measures: budget projections were also considered. The final selection was presented to the Steering Committee of senior officials for modification and adoption.

Addendum E: PRS Interagency Steering Committee Members

U.S. Department of Defense

William Wechsler, Deputy Assistant Secretary of Defense (Counternarcotics and Global Threats)

Caryn Hollis, Principal Director (Counternarcotics and Global Threats)

U.S. Department of Education

Kevin Jennings, Assistant Deputy Secretary for Safe and Drug-Free Schools

Norris Dickard, Director, Drug-Violence Prevention—National Programs, Office of Safe and Drug-Free Schools

U.S. Department of Health & Human Services

Richard Frank, Ph. D., Deputy Assistant Secretary, Office of Disability, Aging, and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation (ASPE)

Peter Delany, Director, Office of Applied Studies, (SAMHSA)

U.S. Department of Homeland Security

Kimberly O'Connor, Ph.D., Chief of Staff, Counternarcotics Enforcement,

Bruce Lichtman, Assistant Director of Policy, Counternarcotics Enforcement

U.S. Department of the Interior

John Rolla, Branch Chief, Drug Enforcement

U.S. Department of Justice

Thomas Padden, Deputy Director, Organized Crime Drug Enforcement Task Forces

Jeffrey Sutton, Assistant Director, Justice Management Division

U.S. Department of Labor

Barbara DesMarteau, ETA—Deputy Assistant Secretary

Karen Staha, ETA—Director, Division of Performance Accountability, Office of Performance and Technology, Employment and Training Administration

U.S. Department of State

James A. Walsh, Deputy Executive Director, Bureau of International Narcotics & Law Enforcement

U.S. Department of Transportation

Jim L. Swart, Director Office of Drug & Alcohol Policy & Compliance

Bob Ashby, Deputy Assistant General Counsel

U.S. Department of the Treasury

Stephen Haselton, Director, Treasury Operations Center

Martin Melone, Director Strategic Planning and Performance Management

U.S. Department of Veterans Affairs

Robert L. Jesse, MD, Ph.D., Acting Principal Deputy Under-Secretary for Health

John Paul Allen, Ph. D., Associate Chief Consultant for Addictive Disorders

Small Business Administration

Meaghan K. Burdick, Deputy Chief of Staff and White House Liaison

Antonio Doss, Associate Administrator, Office of Small Business Development Centers