LAKESHORE REGIONAL ENTITY

ATTACHMENT 1

Meeting Agenda

SUD OVERSIGHT POLICY BOARD

Wednesday, June 10, 2026 5:00 PM

Board Room - Community Mental Health of Ottawa County

12265 James Street, Holland, MI 49424

1. Call to Order: Chair

2. Roll Call/Introductions: Chair

3. Public Comment: Chair

4. Conflict of Interest: Chair

5. Review/Approval of Agenda-Chair *(Attachment 1)*
   Suggested Motion: To approve the June 10, 2026, LRE Oversight Policy Board meeting agenda as presented.

6. Review/Approval of Minutes-Chair *(Attachment 2)*
   Suggested Motion: To approve the March 11, 2026, LRE Oversight Policy Board meeting minutes as presented.

7. Old Business

8. New Business/Action
   a. Finance Report - Maxine Coleman
      i. Statement of Activities *(Attachment 3)*
      ii. PA2 Fund Balance Report *(Attachment.4)*

   b. Request for Additional PA2 funds – HealthWest – *(Attachment 5)*
      Suggested Motion: To approve the request from HealthWest for an additional allocation of $27,000 in PA2 funds.

   c. FY26 Budget Amendment #2 *(Attachment 6)*
      Suggestion Motion: To approve Amendment #2 to the allocation of FY26 PA2 funds for the LRE SUD Budget as presented and to advise and recommend that the LRE Board approve the amended FY26 non-PA2 fund budgets for SUD services as presented.

9. Prevention/Treatment Updates
   a. Prevention – Stephanie VanDerKooi
      i. Providing Opportunities for Individuals In Need of Treatment & Support (POINTS) Act – *(Attachment 7)*

ii. Keep MI Kids Tobacco Free Alliance *(Attachment 8)*
iii. Problem Gambling Advocacy Day

b. Treatment – Amanda Tarantowski
   i. SUD State Audit Results
   ii. ASAM Conference
   iii. Dear Colleague Letter *(Attachment 9)*
   iv. FY26 Q2 Treatment Evaluation Update *(Attachment 10)*

10. State/Regional Updates – Stephanie VanDerKooi
    a. Legislative Update *(Attachment 11)*
    b. National Prescription Drug Abuse Summit *(Attachment 12)*
    c. Change in the Availability of Buprenorphine Provider Lists *(Attachment 13)*
    d. 3-Year SUD Strategic Plan

11. Round Table
    a. Opiate Settlement Updates *(Attachment 14)*

12. Next Meeting
    September 16, 2026 – 4:00 PM

ATTACHMENT 2

Meeting Minutes (proposed)

SUD OVERSIGHT POLICY BOARD

Wednesday, March 11, 2026 4:00 PM

Board Room - Community Mental Health of Ottawa County

12265 James Street, Holland, MI 49424

CALL TO ORDER:

Ms. Patrick Sweeney, LRE OPB Chair, called the March 11, 2026, LRE Oversight Policy Board meeting to order at 4:00 PM.

ROLL CALL/INTRODUCTIONS:

Mr. Sweeney welcomed new members Erin Gillmet and Nancy Morales to the Oversight Policy Board.

MEMBER	P	A		MEMBER	P	A
Zee Bankhead	x			Richard Kanten	x	
Shelly Cole-Mickens		x		Nancy Morales	x	
Jessica Cook	x			David Parnin	x	
Mark DeYoung	x			Sarah Sobel		x
Dawn Fuller		x		James Storey		x
Erin Gillmet	x			Joe Stone	x	
Jordan Jorritsma		x		Patrick Sweeney	x	
Rebecca Lange	x			Robert Walker	x	
Horace Lattimore	x					

PUBLIC COMMENT

No public comment

CONFLICT OF INTEREST

No conflict of interest declared.

REVIEW/APPROVAL OF AGENDA - Chair

LRE OPB 26-01 Motion: To approve the March 11, 2026, LRE Oversight Policy Board meeting agenda as presented.

Moved by: Cook Support: Walker

MOTION CARRIED

REVIEW/APPROVAL OF MINUTES-Chair

LRE OPB 26-02 Motion: To approve the December 10, 2025, LRE Oversight Policy Board meeting minutes as presented.

Moved by: Parnin Support: Cook

MOTION CARRIED

OLD BUSINESS

LRE Bylaws Amendments

LRE OPB 26-03 Motion: To approve amendments to the Lakeshore Regional Entity Oversight Policy Board Bylaws as presented

Moved by: Walker Support: Kante

MOTION CARRIED

Ms. VanDerKooi reviewed the proposed changes. Mr. DeYoung noted that the next meeting conflicts with a Board Association Conference and may need to change the meeting. Mr. Walker suggested that the bylaws be sent to each county administrator noting the changes and attendance requirements.

NEW BUSINESS/ACTION

Nomination and Selection of Officers - – Patrick Sweeney *(Attachment 4)*

LRE OPB 26-04 Motion: To continue with the current slate of officers: Patrick Sweeney, Chair; Rebecca Lange, Vice Chair; and Sarah Soble, Secretary for an additional one-year term.

Moved by: Walker Support: Stone

MOTION CARRIED

Finance Report - Maxine Coleman

i. Statement of Activities
Ms. Coleman reviewed the report of activities through January 31, 2026. Block grant expenditures are currently near budgeted percentage; Block Grant revenue is slightly under projections due to timing of distributions after billing (only one quarter of funding has been received to date). No areas of concern noted.

PA2 Revenue is under expectations as there has not yet been distributed for 1st quarter (funds were allocated elsewhere). Payment for second quarter is expected in May and there are no concerns at this time. PA2 Expenditures are at about 25 percent and are being covered by reserve funding.

Medicaid and Healthy Michigan revenue is within targeted budget.

ii. PA2 Fund Balance Report – presented for information. Fund balances continue to increase, but the growth rate has slowed as some counties are accessing reserve funds. FY25 is not yet audited.

Community Mental Health of Ottawa County Reserve PA2 Request for Special Projects

LRE OPB 26-05 Motion: To approve the request from Community Mental Health of Ottawa County for Reserve FY26 PA2 funds in the amount of $172,000 for Community Based Treatment program to provide SUD outpatient services including screening, assessment, treatment, case management, and recovery coaching.

Moved by: Parnin Support: Morales

MOTION CARRIED

Joel Ebbers, CMHOC SUD Director, reviewed the request for additional funding to continue a grant that was recently terminated by MDHHS Diversion Council. The grant ended at the end of February. Funds will be allocated to continue to provide services in the jail. Sustainability will be achieved by moving most services to CCBHC.

PREVENTION/TREATMENT UPDATES

Prevention – Amy Embury

MDHHS has issued a grant opportunity ($3.7 million) to be funded through the Opiate Settlement funds for prevention services. LRE has decided that they would not apply for these funds given the limitations around geographic areas. Additionally, other service providers within and outside the region will be applying for these funds.

FY25 Summary of Activities – the annual review of activities in the region. Ms. Embury focused on specific areas of success in prevention activities across the region. A regional awareness campaign focusing on Smoking Cessation has been implemented.

Treatment – Stephanie VanDerKooi

- ASAM IV Implementation – ASAM is used to determine clinical diagnosis and level of care for providers. The state has required that the newest version be implemented, but there are significant issues for providers such as licensing requirements, contracts updating needs, and meeting training requirements.

- FY25 Treatment Evaluation
  Stephanie provided a brief overview of the report.

STATE/REGIONAL UPDATES – Stephanie VanDerKooi

MDHHS PIHP System Rebid - In 2025, MDHHS issued an RFP for PIHP services with the intention to redesign the system. Several regions filed suit against the department, citing legal inconsistencies with the mental health code. The court found that there were issues that were not in keeping with the law, which resulted in MDHHS recalling the RFP. It is not clear what the state's intentions are moving forward. Updates will be provided as they become available.

Legislative Update – presented for information. Stephanie focused on specific legislative activity that might be of interest to the members.

- SB 462 – 465 requiring retailers to obtain a license for tobacco products. No updates since December 16, 2025.
- SB 463 & 466 focusing on penalties for retailers
- Gambling legislation has not moved through the system
- HB 5134 & 5135 focusing on eliminating billboards for marijuana and related products. Bills were introduced in October and there has been no movement.

ROUND TABLE

Opiate Settlement Updates

Rebecca reported that Mason County has held one meeting and will continue to meet monthly.

NEXT MEETING

The CMHA Board Association Summer Conference conflicts with this meeting schedule. Several members may be unavailable to attend. The meeting will be rescheduled to start at 5:00 PM

June 10, 2026 – 5:00 PM - CMHOC Board Room

ADJOURN

LRE OPB 26-06 Motion: To adjourn the March 11, 2026, LRE Oversight Policy Board meeting.
Moved by: Stone Support: Cook
MOTION CARRIED

Mr. Sweeney adjourned the March 11, 2026, LRE Oversight Policy Board meeting at 5:08 pm.

ATTACHMENT 3

Lakeshore Regional Entity
Substance Use Disorders
FY26 Block Grant Expenditures

Block Grant	Year Ending 9/30/2026 FY26 Budget Amendment 1	Year To Date 4/30/2026 FY26 Budget to Date	Actual	Budget to Actual Variance
Operating Revenues				
SUD Block Grant (includes SDA)	7,189,879	4,194,096	2,966,613	1,227,483
SUD Block Grant SOR	2,100,000	1,225,000	816,568	408,432
SUD Block Grant Gambling	250,000	145,833	42,360	103,473
Healing & Recovery Comm Engagagement Infrastr.	458,098	267,224	231,424	35,800
Alcohol Use Disorder Tx	215,590	125,761	141,676	(15,915)
Total Operating Revenues	10,213,567	5,957,914	4,198,641	1,759,273
Expenditures - Treatment				
LRE Direct & Regional Administration - Treatment (incl TBD)	678,492	395,787	160,316	235,471
LRE Direct & Administration - SOR	312,471	182,275	141,155	41,120
LRE Administration - Hlng & Rec Comm Enga Infrastr.	101,950	59,471	150,907	(91,436)
Treatment Payments to Members				
OnPoint (Allegan Co CMH) - Treatment	466,000	271,833	103,808	168,026
OnPoint (Allegan Co CMH) - SOR	175,135	102,162	25,085	77,077
OnPoint (Allegan Co CMH) - Hlng & Rec Comm Enga Infrastr.	82,987	48,409	60,288	(11,879)
OnPoint (Allegan Co CMH) - Alcohol Use Disorder Tx	14,661	8,552	0	8,552
Healthwest - Treatment	930,610	542,856	633,294	(90,438)
Healthwest - SOR	780,000	455,000	307,095	147,905
Healthwest - Hlng & Rec Comm Enga Infrastr.	142,500	83,125	23,428	59,697
Healthwest - Alcohol Use Disorder Tx	27,156	15,841	27,156	(11,315)
Network180 - Treatment	2,455,982	1,432,656	1,028,043	404,613
Network 180 - SOR	535,139	312,164	339,771	(27,607)
Network180 - Hlng & Rec Comm Enga Infrastr.	10,543	6,150	337	5,814
Network 180 - Alcohol Use Disorder Tx	104,350	60,871	104,036	(43,165)
CMH of Ottawa County - Treatment	791,000	461,417	352,279	109,137
CMH of Ottawa County - Hlng & Rec Comm Enga Infrastr.	114,594	66,847	18,810	48,037
CMH of Ottawa County - Alcohol Use Disorder Tx	47,432	27,669	4,028	23,640
West Michigan CMH - Treatment	397,000	231,583	169,830	61,754
West Michigan CMH - SOR	114,703	66,910	53,806	13,104
West Michigan CMH - Hlng & Rec Comm Enga Infrastr.	5,524	3,222	5,524	(2,302)
West Michigan CMH - Alcohol Use Disorder Tx	21,991	12,828	21,085	(8,257)

Expenditures - Prevention				
LRE Direct & Regional Administration - Prevention	257,317	150,102	157,146	(7,044)
LRE Direct & Regional Administration - SOR	17,052	9,947	9,901	46
LRE Direct Administration - Gambling	126,000	73,500	61,891	11,609
Expenditures - Prevention - continued				
OnPoint (Allegan Co CMH) - Prevention	111,163	64,845	111,046	(46,201)
OnPoint (Allegan Co CMH) - SOR	50,000	29,167	33,113	(3,946)
Arbor Circle / Pathways - Prevention	280,000	163,333	160,027	3,306
Arbor Circle / Pathways - SOR	35,500	20,708	11,827	8,881
Arbor Circle / Pathways - Gambling	44,000	25,667	16,919	8,747
District 10 Health Department - Prevention	66,566	38,830	48,914	(10,084)
District 10 Health Department - SOR	47,500	27,708	28,102	(394)
District 10 Health Department - Gambling	38,000	22,167	14,989	7,178
Healthwest - Prevention	127,531	74,393	52,684	21,709
Healthwest - Gambling	42,000	24,500	15,352	9,148
Healthwest - SOR	32,500	18,958	15,780	3,178
Kent County Health Department - Prevention	246,000	143,500	207,162	(63,662)
Mercy Health - Prevention	44,000	25,667	33,800	(8,133)
Network 180 - Prevention	175,000	102,083	85,357	16,727
Ottawa County Health Department - Prevention	88,218	51,461	51,387	73
Wedgwood Christian Services - Prevention	75,000	43,750	56,191	(12,441)
Total Expenditures	10,213,567	5,957,914	4,901,667	1,056,247
Total Change in Net Assets	**0**	**0**	**(703,025)**	**703,025**

As of 6/1/26

Lakeshore Regional Entity
Substance Use Disorders
FY26 PA2 Expenditures

PA2	Year Ending 9/30/2026 FY26 Budget Amendment 1	Year To Date 4/30/2026 FY26 Budget to Date	Actual	Budget to Actual Variance
Operating Revenues				
PA2 Liquor Tax - Current FY	4,349,961	2,537,477	1,226,674	1,310,803
PA2 Liquor Tax - Reserves	816,587	476,342	0	476,342
Total Operating Revenues	5,166,548	3,013,819	1,226,674	1,787,145
Expenditures - Prevention				
OnPoint (Allegan Co CMH) - Prevention	143,680	83,813	32,389	51,424
Arbor Circle / Pathways - Prevention	371,609	216,772	137,774	78,998
District 10 Health Department - Prevention	133,310	77,764	75,460	2,304
Healthwest	90,395	52,730	33,609	19,121
Kent County Health Department - Prevention	251,393	146,646	179,728	(33,082)
Mercy Health - Prevention	13,507	7,879	11,891	(4,012)
Network 180 - Prevention	131,077	76,462	39,287	37,174
Community Mental Health of Ottawa County	38,265	22,321	25,175	(2,854)
Ottawa County Health Department - Prevention	61,890	36,103	10,342	25,760
Wedgwood Christian Services - Prevention	92,585	54,008	18,041	35,967
Expenditures - Treatment				
Treatment Payments to Members				
OnPoint (Allegan Co CMH)	209,707	122,329	0	122,329
Healthwest	381,976	222,819	122,772	100,047
Network180	2,262,619	1,319,861	1,046,771	273,090
CMH of Ottawa County	818,489	477,452	277,584	199,868
West Michigan CMH	166,046	96,860	0	96,860
Total Expenditures	5,166,548	3,013,819	2,010,824	1,002,996
Total Change in Net Assets	**0**	**0**	**(784,149)**	**784,149**

As of 6/1/26

Lakeshore Regional Entity
Substance Use Disorders
FY26 Medicaid Treatment Expenditures

Year To Date Through 4/30/26

CATEGORY	CMHSP Medicaid YTD Totals	LRE Admin Med YTD Totals	LRE Medicaid Budget Totals	LRE % of Budget Spent
Total Expenditures for Treatment Services	$ 2,950,986.52	$ -	$ 7,205,920	40.95%
Women's Specialty Services	$ 445,336.47	$ -	$ 711,715	62.57%
Other Specialty Services - (incl SUD Health Homes)	$ -	$ -	$ 54,672	0.00%
Access Management System	$ 220,529.85	$ -	$ 356,327	61.89%
General Administration	$ 102,420.78	$ 181,434.68	$ 598,048	47.46%
GRAND TOTAL OF SA EXPENDITURES	**$ 3,719,273.62**	**$ 181,434.68**	**$ 8,926,682**	**43.70%**
SOURCE OF FUNDS				
Medicaid	$ 3,719,273.62	$ 181,434.68	$ 8,926,682	43.70%
Other: Local	$ -	$ -	$ -	0.00%
Other: Federal	$ -	$ -	$ -	0.00%
Fees	$ -	$ -	$ -	0.00%
TOTAL FUNDING	**$ 3,719,273.62**	**$ 181,434.68**	**$ 8,926,682**	**43.70%**

As of 6/1/26

Lakeshore Regional Entity
Substance Use Disorders
FY26 Healthy MI Plan Treatment Expenditures

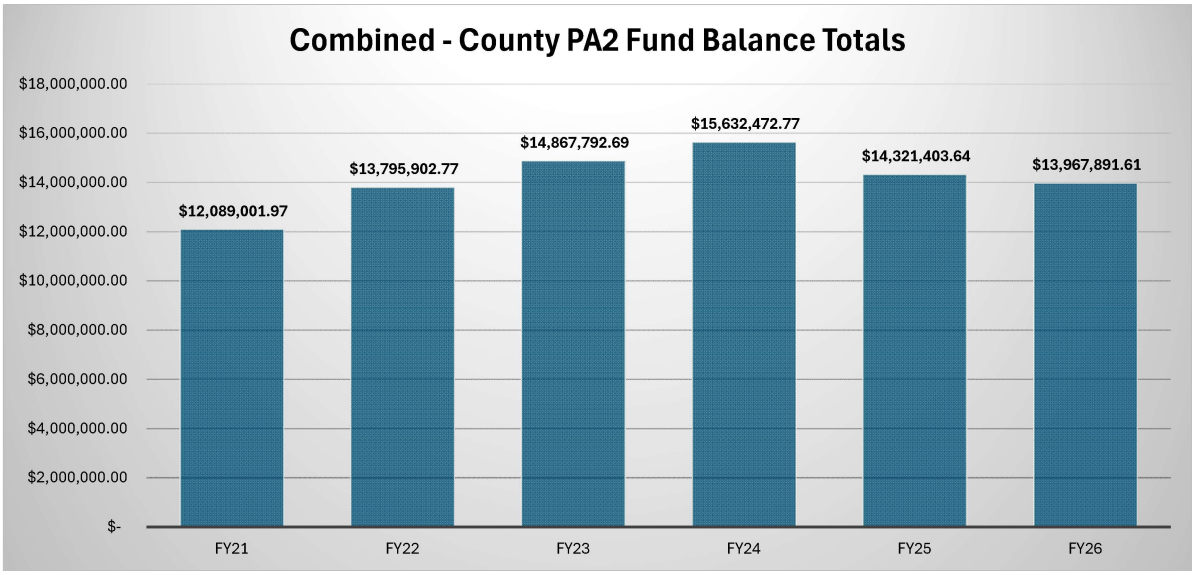
Year To Date Through 4/30/26

CATEGORY	CMHSP HMP YTD Totals	LRE Admin HMP YTD Totals	LRE HMP Budget Totals	LRE % of Budget Spent
Total Expenditures for Treatment Services	$ 6,600,554.93	$ -	$ 12,088,875	54.60%
Women's Specialty Services	$ 264,429.25	$ -	$ 290,835	90.92%
Other Specialty Services	$ -	$ -	$ -	0.00%
Access Management System	$ 405,338.59	$ -	$ 478,913	84.64%
General Administration	$ 112,831.59	$ 278,294.67	$ 833,560	46.92%
GRAND TOTAL OF SA EXPENDITURES	**$ 7,383,154.35**	**$ 278,294.67**	**$ 13,692,183**	**55.95%**
SOURCE OF FUNDS				
Healthy MI Plan	$ 7,383,154.35	$ 278,294.67	$ 13,692,183	55.95%
Other: Local	$ -	$ -	$ -	0.00%
Other: Federal	$ -	$ -	$ -	0.00%
Fees	$ -	$ -	$ -	0.00%
TOTAL FUNDING	**$ 7,383,154.35**	**$ 278,294.67**	**$ 13,692,183**	**55.95%**

As of 6/1/26

ATTACHMENT 4

Lakeshore Regional Entity
PA2 Fund Summary Report
FY 2021 - FY 2026



0	FY21	FY22	FY23	FY24	FY25	FY26
County Fund Bal Total	$ 10,389,595.83	$ 12,089,001.97	$ 13,795,902.77	$ 14,897,646.80	$ 15,632,472.77	$ 14,702,306.54
Increase	$ 1,699,406.14	$ 1,706,900.80	$ 1,071,889.92	$ 734,825.97	$ (1,311,069.13)	$ (734,414.93)
End of Year Balance	$ 12,089,001.97	$ 13,795,902.77	$ 14,867,792.69	$ 15,632,472.77	$ 14,321,403.64	$ 13,967,891.61
% Change	0	14.1%	7.8%	4.9%	-8.4%	-5.0%

FY2018

On 2/6/2019 LRE requested $ 5,315,565.70

Use of Reserve Funds - To address the FY2018 Medicaid and Healthy Michigan regional budget deficit. Each County's PA2 reserve funds shall only be applied against that county's Medicaid/Healthy Michigan operating deficit.

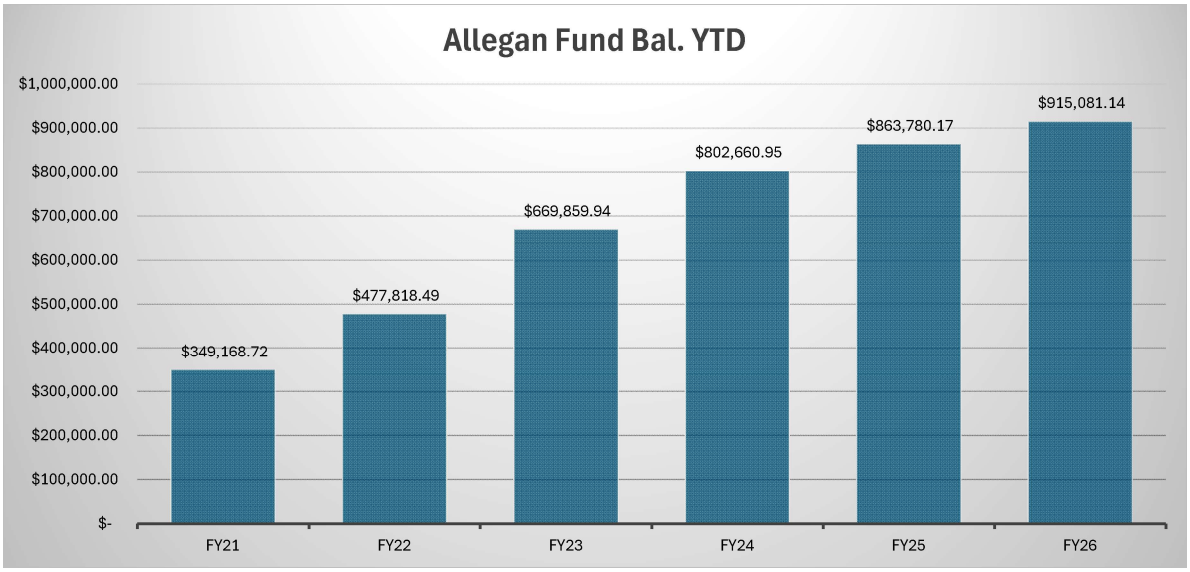
Per 10/3/2018 OPB Meeting Minutes

PA2 Reserve Funding Program Grants Update *– A policy and application for providers to apply for reserve PA2 funds for special projects was developed early in 2019. The process was completed over the summer, with applications being submitted and reviewed. Unfortunately, due to the regional deficit, these project expenditures are not possible at this time. If, after final regional budget numbers allow for these grants, the applications will be presented to the OPB to discuss possible grants.*

PA2 Fund Balance by FY

	FY21	FY22	FY23	FY24	FY25	FY26
County						
Allegan County	$ 253,059.12	$ 349,168.72	$ 477,818.49	$ 669,859.94	$ 802,660.95	$ 863,780.17
Kent County	$ 5,812,785.29	$ 7,002,883.63	$ 7,982,606.15	$ 8,103,054.08	$ 7,917,532.01	$ 6,691,501.92
Lake County	$ 193,476.10	$ 218,272.41	$ 243,561.11	$ 274,877.05	$ 304,138.06	$ 304,650.16
Mason County	$ 519,997.72	$ 584,441.99	$ 614,093.94	$ 700,862.34	$ 797,419.12	$ 819,391.03
Muskegon County	$ 768,648.01	$ 821,638.47	$ 1,173,531.19	$ 1,407,222.75	$ 1,623,214.13	$ 1,618,195.11
Oceana County	$ 240,583.42	$ 271,305.03	$ 313,183.27	$ 375,776.34	$ 405,617.24	$ 421,736.27
Ottawa County	$ 2,601,046.17	$ 2,841,291.72	$ 2,991,108.62	$ 3,365,994.30	$ 3,781,891.26	$ 3,983,051.88
	$ 10,389,595.83	$ 12,089,001.97	$ 13,795,902.77	$ 14,897,646.80	$ 15,632,472.77	$ 14,702,306.54

As of 4/30/26



Allegan County	FY21	FY22	FY23	FY24	FY25	FY26
Beginning Fund Balance	$ 253,059.12	$ 349,168.72	$ 477,818.49	$ 669,859.94	$ 802,660.95	$ 863,780.17
Revenues	$ 186,148.60	$ 188,688.77	$ 282,080.45	$ 301,240.13	$ 293,802.19	$ 83,689.95
Expenses	$ 90,039.00	$ 60,039.00	$ 90,039.00	$ 168,439.12	$ 232,682.97	$ 32,388.98
FY Total	$ 349,168.72	$ 477,818.49	$ 669,859.94	$ 802,660.95	$ 863,780.17	$ 915,081.14
% Change	38%	37%	40%	20%	8%	6%

FY2025

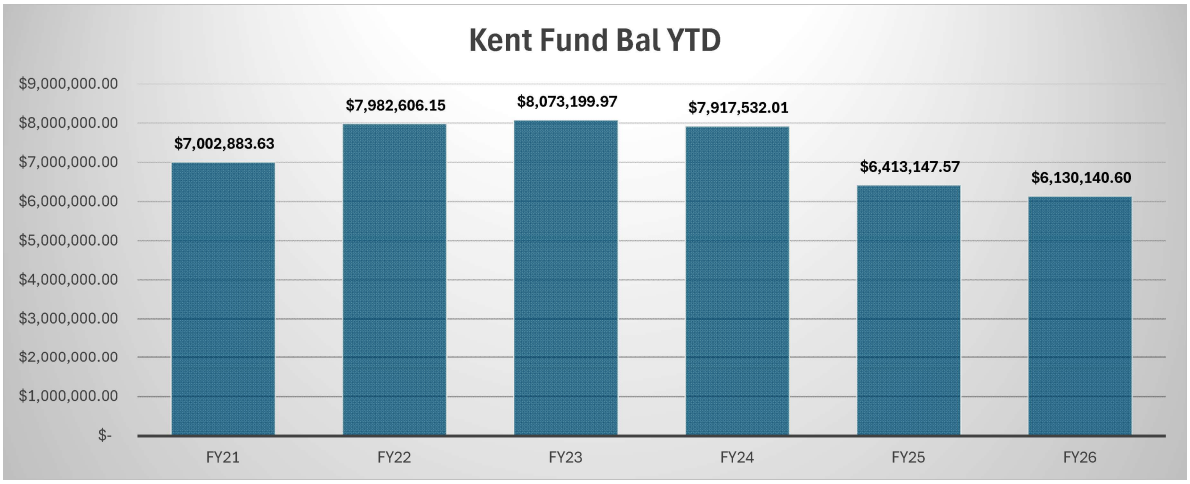
On 9-4-2024 OnPoint requested up to $100,000

Special Project - To fund local drug courts in FY25.

FY2026

On 12-10-2025 OnPoint requested $115,000

Special Project - To fund local drug courts planned for the 57th District Court and the 48th Judicial Circuit Court.



Kent County	FY21	FY22	FY23	FY24	FY25	FY26
Beginning Fund Balance	$ 5,812,785.29	$ 7,002,883.63	$ 7,982,606.15	$ 8,103,054.08	$ 7,917,532.01	$ 6,691,501.92
Revenues	$ 1,837,707.72	$ 1,826,393.32	$ 2,781,259.25	$ 2,829,011.02	$ 2,692,847.13	$ 744,666.88
Expenses	$ 647,609.38	$ 846,670.80	$ 2,690,665.43	$ 3,014,533.09	$ 4,197,231.57	$ 1,306,028.20
FY Total	$ 7,002,883.63	$ 7,982,606.15	$ 8,073,199.97	$ 7,917,532.01	$ 6,413,147.57	$ 6,130,140.60
% Change	20%	14%	1%	-2%	-19%	-8%

FY2023

On 9-6-2023 N180 requested up to $1,400,000

Use of Reserve Funds - To fund two programs (Family Engagement Team and Recovery Management) at Network180 for FY2023 expenditures.

FY2024

On 1-8-2025 N180 requested $1,256,139.47

Use of Reserve Funds - To offset budget shortfalls for FY 2024.

FY2025

On 1-8-2025 N180 requested $294,060

Special Project - For 100 in 100 initiative targeting homelessness. Funding four (4) Housing Stabilization Case Managers (CM) employed through Mel Trotter Ministries and Degage Ministries to assist rehoused individuals in maintaining housing, meet health and wellness goals including access to SUD services and supports, and secure and maintain financial security.

On 3-12-2025 N180 requested $1,879,569

Use of Reserve Funds - To fund two programs (Family Engagement Team and Recovery Management) at Network180 for FY2025 expenditures.

On 4-16-2025 Wedgwood Christian Services requested $8,300

Use of Reserve Funds - Continue to provide SUD prevention services through the Project Success program at Burton Middle School due to ARPA funding cuts.

FY2026

On 9-17-2025 Kent County Health Department requested $105,772

Use of Reserve Funds - To support 1.188 FTE Salary/Fringe (3 staff), mileage, printing & class materials, evaluation, and office expenses due to FY26 PA2 budget cut.

On 9-17-2025 Wedgwood requested $37,970

Use of Reserve Funds - To support .55 FTE Salary/Fringe (2 staff), conference/training, Supplies, and office expenses due to FY26 PA2 budget cut.

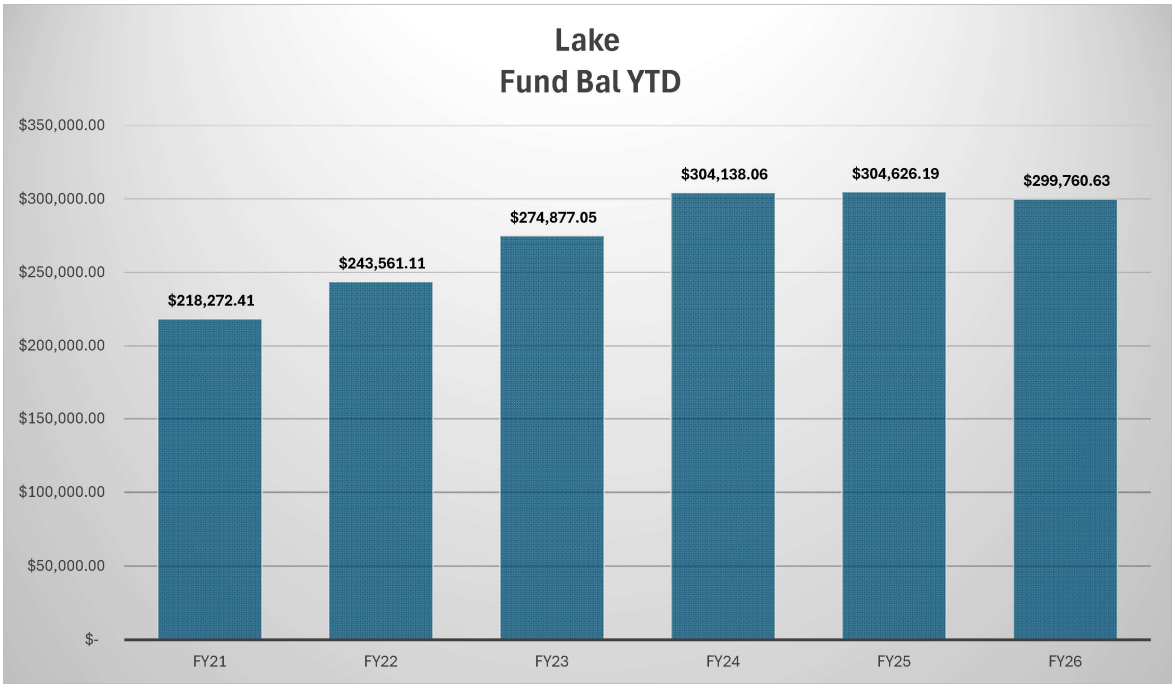
FY2026

On 12-10-2025 N180 requested $461,770

Special Project - For 100 in 100 initiative targeting homelessness. Funding Housing Stabilization Program through Mel Trotter Ministries and Degage Ministries to providie individualized housing stabilization case management, built through strong relationships, to individuals who have experienced chronic homelessness, which means they have been unhoused for at least one year and have a diagnosed disability.

On 12-10-2025 N180 requested $100,000

Special Project - For Real Clean individual and family treatment program aimed at engaging youth and their families to support recovery and sobriety.



Lake County	FY21	FY22	FY23	FY24	FY25	FY26
Beginning Fund Balance	$ 193,476.10	$ 218,272.41	$ 243,561.11	$ 274,877.05	$ 304,138.06	$ 304,650.16
Revenues	$ 26,183.31	$ 25,288.70	$ 31,315.94	$ 33,612.01	$ 31,648.99	$ 8,652.47
Expenses	$ 1,387.00	$ -	$ -	$ 4,351.00	$ 31,160.86	$ 13,542.00
FY Total	$ 218,272.41	$ 243,561.11	$ 274,877.05	$ 304,138.06	$ 304,626.19	$ 299,760.63
% Change	13%	12%	13%	11%	0%	-2%

FY2025

On 7-30-2025 West Michigan CMH requested $6,036

Special Project - To cover projected shortfalls in Department of Justice for SUD jail bases services grant that will exceed available funding in SUD Block Grant and SOR grants.

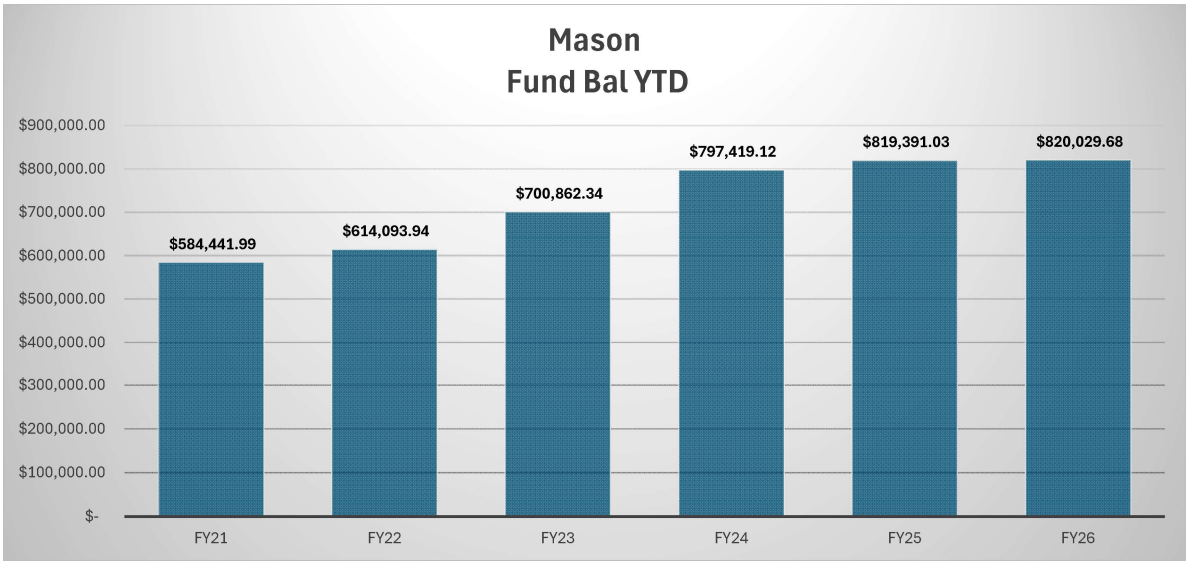
FY2026

On 9-17-2025 District Health Department #10 requested $18,000

Use of Reserve Funds - To support .105 FTE Salary/Fringe (2 staff), Travel, Supplies, office expenses, printing materials due to FY26 PA2 budget cut.

On 9-17-2025 West Michigan CMH requested $6,953

Use of Reserve Funds - To offset budget shortfalls in SUD Block Grant for FY 2026.



Mason County	FY21	FY22	FY23	FY24	FY25	FY26
Beginning Fund Balance	$ 519,997.72	$ 584,441.99	$ 614,093.94	$ 700,862.34	$ 797,419.12	$ 819,391.03
Revenues	$ 78,252.27	$ 78,065.95	$ 116,724.08	$ 125,849.78	$ 97,161.27	$ 26,612.65
Expenses	$ 13,808.00	$ 48,414.00	$ 29,955.68	$ 29,293.00	$ 75,189.36	$ 25,974.00
FY Total	$ 584,441.99	$ 614,093.94	$ 700,862.34	$ 797,419.12	$ 819,391.03	$ 820,029.68
% Change	12%	5%	14%	14%	3%	0%

FY2025

On 7-30-2025 West Michigan CMH requested $2,088

Special Project - To cover projected shortfalls in Department of Justice for SUD jail bases services grant that will exceed available funding in SUD Block Grant and SOR grants.

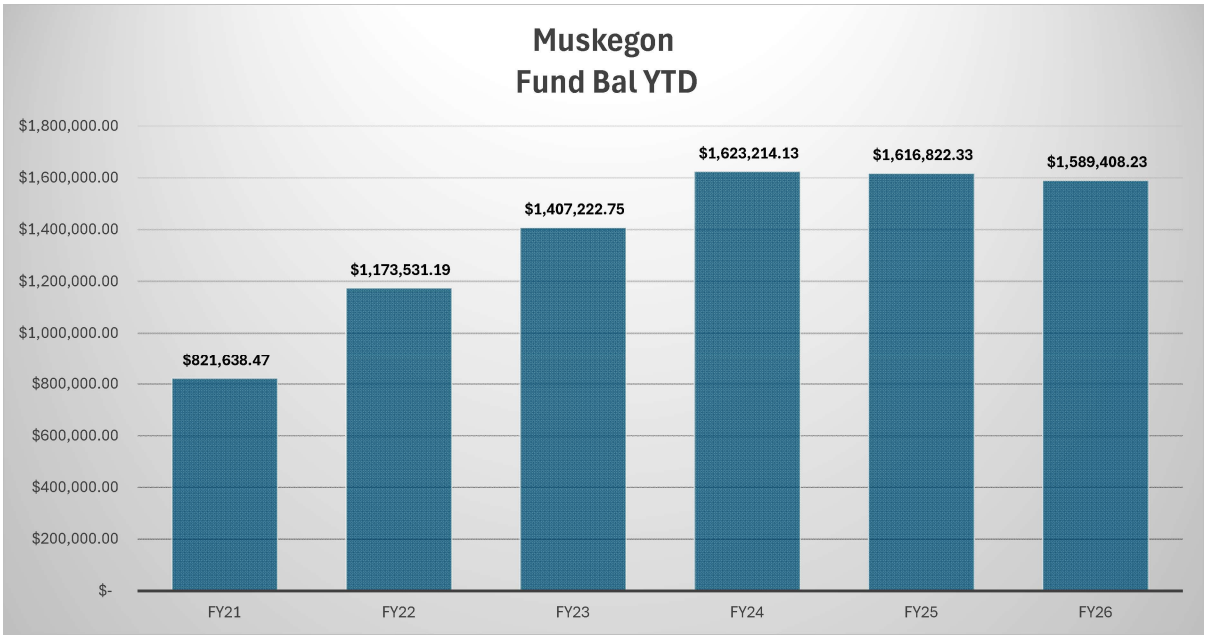
FY2026

On 9-17-2025 District Health Department #10 requested $45,000

Use of Reserve Funds - To support .25 FTE Salary/Fringe (2 staff), Travel, Supplies, office expenses, and printing materials due to FY26 PA2 budget cut.

On 9-17-2025 West Michigan CMH requested $17,344

Use of Reserve Funds - To offset budget shortfalls in SUD Block Grant for FY 2026.



Muskegon County	FY21	FY22	FY23	FY24	FY25	FY26
Beginning Fund Balance	$ 768,648.01	$ 821,638.47	$ 1,173,531.19	$ 1,407,222.75	$ 1,623,214.13	$ 1,618,195.11
Revenues	$ 436,285.19	$ 436,332.91	$ 499,788.81	$ 512,428.93	$ 495,143.63	$ 139,485.49
Expenses	$ 383,294.73	$ 84,440.19	$ 266,097.25	$ 296,437.55	$ 501,535.43	$ 168,272.37
FY Total	$ 821,638.47	$ 1,173,531.19	$ 1,407,222.75	$ 1,623,214.13	$ 1,616,822.33	$ 1,589,408.23
% Change	7%	43%	20%	15%	0%	-2%

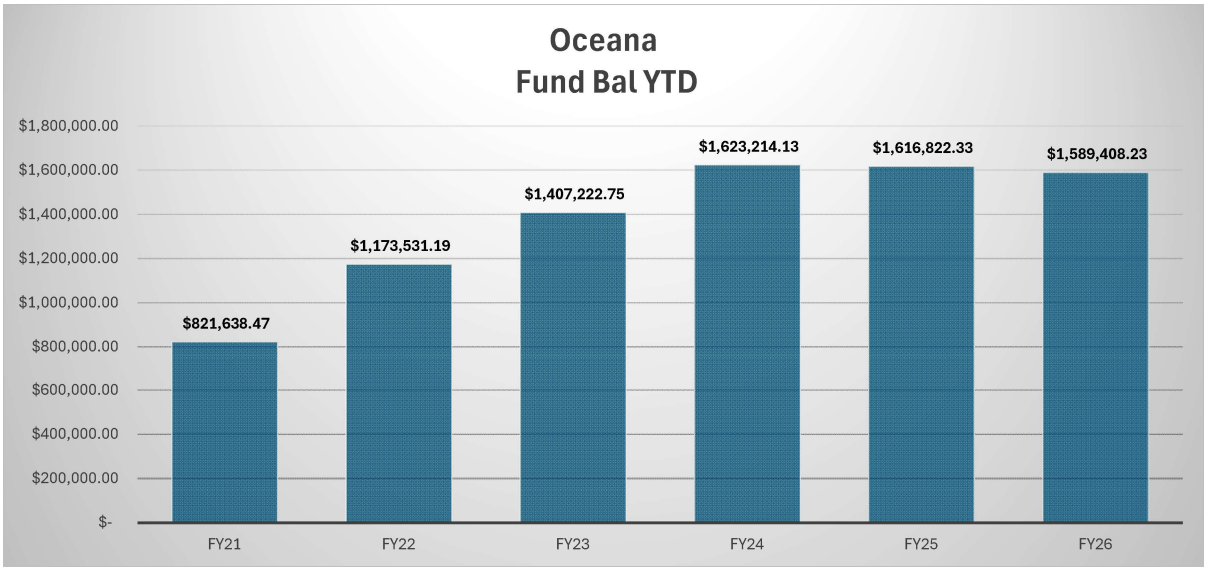
FY2025

On 3-12-2025 Healthwest requested $80,470

Use of Reserve Funds - To fund FOC Recovery Management Team, support CCAR Trainings in Muskegon, support staffing for Fresh Coast Alliance in assisting individuals with accessing SUD and Recovery Supports within the community due to funding duts in other areas.

On 4-16-2025 Healthwest requested $76,000

Use of Reserve Funds - Staffing, administrative and organizational support for Life Align due to ARPA funding cuts.



Oceana County	FY21	FY22	FY23	FY24	FY25	FY26
Beginning Fund Balance	$ 240,583.42	$ 271,305.03	$ 313,183.27	$ 375,776.34	$ 405,617.24	$ 421,736.27
Revenues	$ 40,869.61	$ 41,878.24	$ 62,593.07	$ 56,898.90	$ 53,802.76	$ 14,951.67
Expenses	$ 10,148.00	$ -	$ -	$ 27,058.00	$ 46,824.10	$ 35,944.00
FY Total	$ 271,305.03	$ 313,183.27	$ 375,776.34	$ 405,617.24	$ 412,595.90	$ 400,743.94
% Change	13%	15%	20%	8%	2%	-5%

FY2025

On 7-30-2025 West Michigan CMH requested $18,205

Special Project - To cover projected shortfalls in Department of Justice for SUD jail bases services grant that will exceed available funding in SUD Block Grant and SOR grants.

FY2026

On 9-17-2025 District Health Department #10 requested $30,000

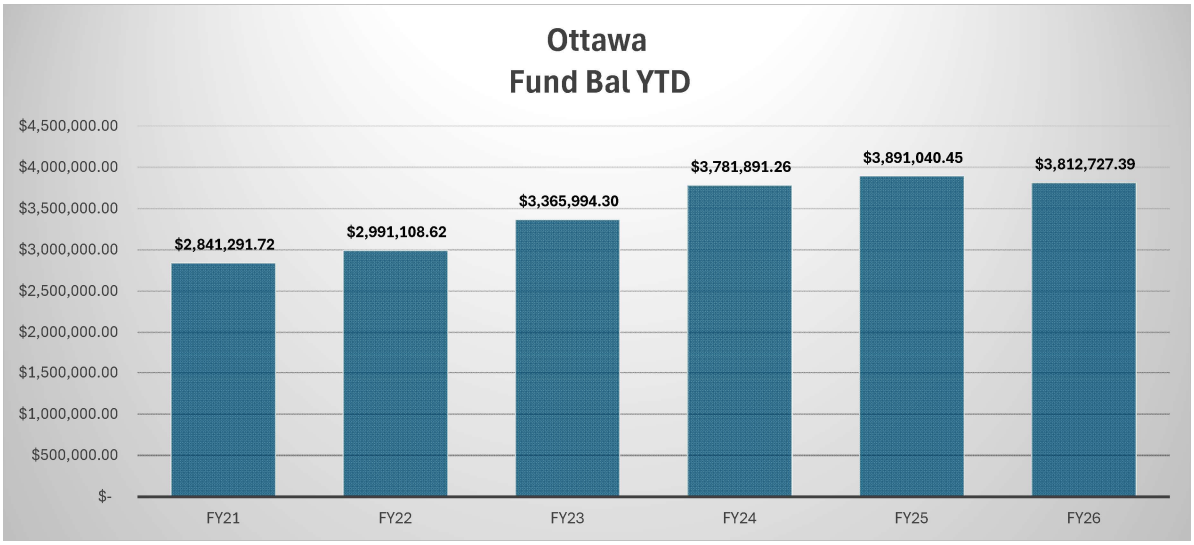
Use of Reserve Funds - To support .2 FTE Salary/Fringe (2 staff), Travel, Supplies, office expenses, printing materials due to FY26 PA2 budget cut.

On 9-17-2025 Arbor Circle requested $68,965

Use of Reserve Funds - To support Salary/Fringe (1 staff), professional development, office expenses and supplies due to FY26 PA2 budget cut.

On 9-17-2025 West Michigan CMH requested $16,014

Use of Reserve Funds - To offset budget shortfalls in SUD Block Grant for FY 2026.



Ottawa County	FY21	FY22	FY23	FY24	FY25	FY26
Beginning Fund Balance	$ 2,601,046.17	$ 2,841,291.72	$ 2,991,108.62	$ 3,365,994.30	$ 3,781,891.26	$ 3,983,051.88
Revenues	$ 556,289.18	$ 550,970.99	$ 855,641.40	$ 921,217.48	$ 801,772.98	$ 258,349.81
Expenses	$ 316,043.63	$ 401,154.09	$ 480,755.72	$ 505,320.52	$ 692,623.79	$ 428,674.30
FY Total	$ 2,841,291.72	$ 2,991,108.62	$ 3,365,994.30	$ 3,781,891.26	$ 3,891,040.45	$ 3,812,727.39
% Change	9%	5%	13%	12%	3%	-4%

FY2024

On 9-6-2023 CMHOC requested $60,000

Special Project - To fund Recovery Coach Support Services to the Homeless Population in FY2024.

FY2025

On 9-4-2024 CMHOC requested $61,147

Special Project - To fund the expansion of SoBar Recovery Community Center in FY25.

On 9-4-2024 CMHOC requested $60,000

Special Project - To fund Recovery Coach Support Services to the Homeless Population in FY2025 (Continuation of 2024 project)

On 1-8-2025 CMHOC requested $16,382

Special Project - Funding for a portion of a prevention specialist position to conduct prevention related activities to decrease stigma, prevent prescription drug misuse, and promote overdose prevention. Funding will also support Ottawa County's Recovery Fest celebration

On 4-16-2025 CMHOC requested $60,000

Use of Reserve Funds - To continue SoBar Recovery Community Center's operations due to ARPA funding cuts.

FY2026

On 9-17-2025 CMHOC requested $200,000

Special Project - To continue funding for the Prevention and Stigma Reduction program at SoBar Recovery Community Center in FY26.

On 9-17-2025 CMHOC requested $60,000

Special Project - To continue funding Recovery Coach Supportive Services to work with Community Action House's homeless outreach team in FY26.

On 9-17-2025 Arbor Circle requested $180,569

Use of Reserve Funds - To support 1.65 FTE Salary/Fringe (3 staff), youth conference, coalition supplies, Safe Prom, Reducing Alcohol focus, Evaluation, and office expenses due to FY26 PA2 budget cut.

On 9-17-2025 Ottawa Public Health requested $30,000

Use of Reserve Funds - To support printing costs to promote initiatives, office supplies, operating supplies to support SUD initiatives, programming and community outreach due to FY26 PA2 budget cut.

On 3-11-2026 CMHOC requested $172,000

Special Project - To fund the Community Based Treatment program in providing SUD outpatient services including screening, assessment, treatment, case management, and recovery coaching.

ATTACHMENT 5

HealthWest
Muskegon's Behavioral Wellness Connection

March 12, 2026

Lakeshore Regional Entity
c/o Amanda Tarantowski
5000 Hakes Dr, Suite 500
Norton Shores, MI 49441

Dear Ms. Tarantowski:

I am writing to request a budget increase for Fiscal Year 2026 for PA2. HealthWest is requesting an increase of **$27,000**, bringing our total FY26 PA2 budget to **$408,975.71**.

HealthWest is currently operating under a no-cost extension with the Department of State Police for the Comprehensive Opioid, Stimulant, and Substance Abuse Site-based Program (COSSAP). The State was delayed in confirming the amount of available carryover and supplemental funding; however, this information was received in early February. Based on current projections, HealthWest expects to fully expend the remaining COSSAP funds by **March 1, 2026**.

This funding shortfall directly impacts on several staff positions and services. HealthWest has taken steps to eliminate, reallocate, or otherwise fund all affected projects with the exception of one position. The Law Enforcement Coordinator/CIT Coordinator position is currently funded at **50% by PA2** and **50% by COSSAP**. We are able to shift **20%** of this position to the Bureau of Justice (BJA) Crisis Response and Intervention Training grant; however, we are unable to identify funding for the remaining **30%**.

HealthWest is therefore requesting an increase to our FY26 PA2 allocation to allow us to continue funding the Law Enforcement Coordinator/CIT Coordinator position throughout the remainder of the fiscal year.

Please feel free to contact me if additional detailed information is needed. I can be reached at 231-215-2211. Thank you for your consideration.

Respectfully,
Brandy Carlson

Brandy Carlson
HealthWest Chief Financial Officer

Lakeshore Regional Entity
Oversight Policy Board

ATTACHMENT 6

ACTION REQUEST

SUBJECT: FY2026 LRE SUD Budget Amendment 2

* Approval of PA2 Funds
* Advice and Recommendation to LRE

MEETING DATE: June 10, 2026
PREPARED BY: Stacia Chick, LRE Chief Financial Officer

RECOMMENDED MOTION:

The Oversight Policy Board:

(a) Approves the allocation of PA2 funds for the
(b) Advises and recommends that the LRE Board approve the non-PA2 fund budgets for SUD services as summarized below.

PROPOSED TO GO TO THE BOARD ON JUNE 24, 2026

SUMMARY OF REQUEST/INFORMATION:

* Public Act 500 of 2012 requires each PIHP region to establish an Oversight Policy Board with certain roles and responsibilities related to substance abuse services.
* The Lakeshore Regional Entity Oversight Policy Board is the Oversight Policy Board for Region 3 PIHP.
* Among other functions, the Oversight Policy Board is responsible for approving budgets which contain local funds and to advise and recommend budgets containing non-local funds to the LRE board for services within the region.

STAFF: Stacia Chick, LRE Chief Financial Officer **DATE:** June 3, 2026

FY2026 LRE SUD Budget Amendment 2 Summary:

PREVENTION (direct by LRE)	PA2	Block Grant	SOR	SUD Health Homes	Alcohol Use Disorder Tx	Hlng & Rec Comm Enga Infrastr.	Gambling	Medicaid	Healthy Michigan	Total
Allegan County	$ 155,169	$ 111,163	$ 50,000	$ -	$ -	$ -	$ -	$ -		$ 316,332
Kent County	$ 576,810	$ 601,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,177,810
Lake County	$ 24,953	$ 11,497	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 36,450
Mason County	$ 62,343	$ 28,631	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 90,974
Oceana County	$ 46,014	$ 26,438	$ 47,500	$ -	$ -	$ -	$ 38,000	$ -	$ -	$ 157,952
Muskegon County	$ 103,902	$ 171,531	$ 32,500	$ -	$ -	$ -	$ 42,000	$ -	$ -	$ 349,933
Ottawa County	$ 370,009	$ 263,218	$ 35,500	$ -	$ -	$ -	$ 44,000	$ -	$ -	$ 712,727
LRE Regional Projects	$ -	$ 63,000	$ -	$ -	$ -	$ -	$ 38,000	$ -	$ -	$ 101,000
LRE Staffing	$ -	$ 194,317	$ 17,052	$ -	$ -	$ -	$ 88,000	$ -	$ -	$ 299,369
Unallocated	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
PREVENTION TOTAL	$ 1,339,200	$ 1,470,795	$ 182,552	$ -	$ -	$ -	$ 250,000	$ -	$ -	$ 3,242,547

TREATMENT (delegated to CMH members)	PA2	Block Grant	SOR	SUD Health Homes	Alcohol Use Disorder Tx	Hlng & Rec Comm Enga Infrastr.	Gambling	Medicaid	Healthy Michigan	Total
Allegan	$ 198,218	$ 466,000	$ 170,370	$ -	$ 14,661	$ 82,987	$ -	$ 703,653	$ 1,014,637	$ 2,650,526
Healthwest	$ 381,976	$ 1,485,411	$ 840,707	$ -	$ 54,598	$ 98,878	$ -	$ 1,729,030	$ 2,512,968	$ 7,103,567
Network 180	$ 2,263,389	$ 2,455,982	$ 535,139	$ -	$ 104,350	$ 953	$ -	$ 4,415,324	$ 7,146,624	$ 16,921,762
Ottawa	$ 818,489	$ 791,514	$ 6,964	$ 22,160	$ 20,000	$ 114,594	$ -	$ 1,149,537	$ 1,938,135	$ 4,861,392
West Michigan (Lake, Mason Oceana)	$ 166,046	$ 408,585	$ 114,703	$ -	$ 21,991	$ 5,524	$ -	$ 594,643	$ 922,478	$ 2,233,971
LRE Staffing & Regional Projects	$ -	$ 311,592	$ 249,565	$ 5,540	$ -	$ 155,162	$ -	$ 309,424	$ 487,314	$ 1,518,597
Unallocated	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TREATMENT TOTAL	$ 3,828,118	$ 5,919,084	$ 1,917,448	$ 27,700	$ 215,600	$ 458,098	$ -	$ 8,901,611	$ 14,022,157	$ 35,289,815

TOTAL PREVENTION & TREATMENT	$ 5,167,318	$ 7,389,879	$ 2,100,000	$ 27,700	$ 215,600	$ 458,098	$ 250,000	$ 8,901,611	$ 14,022,157	$ 38,532,362

Lakeshore Regional Entity
FY 2026 SUD Budget - Amendment #2

Prevention	Amendment 1	Amendment 2	Block Grants	SOR	SUD Health Homes	Alcohol Use Disorder Tx	Hlng & Rec Comm Enga Infrastr.	PA2	Gambling	
Allegan County										
OnPoint (Allegan Co CMH)	304,843	316,332	111,163	50,000	-	-	-	155,169	-	-
Total	304,843	316,332	111,163	50,000	-	-	-	155,169	-	-
Kent County										
Arbor Circle	206,755	206,755	105,000	-	-	-	-	101,755	-	-
Kent County Health Department	497,393	497,393	246,000	-	-	-	-	251,393	-	-
Network 180	306,077	306,077	175,000	-	-	-	-	131,077	-	-
Wedgwood	167,585	167,585	75,000	-	-	-	-	92,585	-	-
Total	1,177,810	1,177,810	601,000	-	-	-	-	576,810	-	-
Lake County										
District Health Department #10	36,450	36,450	11,497	-	-	-	-	24,953	-	-
Total	36,450	36,450	11,497	-	-	-	-	24,953	-	-
Mason County										
District Health Department #10	90,974	90,974	28,631	-	-	-	-	62,343	-	-
Total	90,974	90,974	28,631	-	-	-	-	62,343	-	-
Oceana County										
District Health Department #10	157,952	157,952	26,438	47,500	-	-	-	46,014	38,000	-
Total	157,952	157,952	26,438	47,500	-	-	-	46,014	38,000	-
Muskegon County										
Healthwest	292,426	292,426	127,531	32,500	-	-	-	90,395	42,000	-
Mercy Health	57,507	57,507	44,000	-	-	-	-	13,507	-	-
Total	349,933	349,933	171,531	32,500	-	-	-	103,902	42,000	-
Ottawa County										
Arbor Circle (Ottawa Co)	524,354	524,354	175,000	35,500	-	-	-	269,854	44,000	-
CMH of Ottawa County	38,265	38,265	-	-	-	-	-	38,265	-	-
Ottawa Co. Department of Public Health	150,108	150,108	88,218		-	-	-	61,890	-	-
Total	712,727	712,727	263,218	35,500	-	-	-	370,009	44,000	-
LRE Regional Projects (TalkSooner, Trainings, Conference, Tech. Assistance, Family Meals Month)	101,000	101,000	63,000	-	-	-	-	-	38,000	-
LRE Staffing	299,369	299,369	194,317	17,052	-	-	-	-	88,000	-
Unallocated	-	-	-	-	-	-	-	-	-	-
Total	400,369	400,369	257,317	17,052	-	-	-	-	126,000	-
Overall Prevention Total	3,231,058	3,242,547	1,470,795	182,552	-	-	-	1,339,200	250,000	-

Treatment	Amendment 1	Amendment 2	Block Grants (incl. SDA)	SOR	SUD Health Homes	Alcohol Use Disorder Tx	Hlng & Rec Comm Enga Infrastr.	PA2	Medicaid	Healthy Michigan
OnPoint (Allegan Co CMH)	2,653,281	2,650,526	466,000	170,370	-	14,661	82,987	198,218	703,653	1,014,637
Healthwest	6,397,724	7,103,567	1,485,411	840,707	-	54,598	98,878	381,976	1,729,030	2,512,968
Network 180	16,827,950	16,921,762	2,455,982	535,139	-	104,350	953	2,263,389	4,415,324	7,146,624
CMH of Ottawa County	4,844,076	4,861,392	791,514	6,964	22,160	20,000	114,594	818,489	1,149,537	1,938,135
West Michigan CMH (Lake, Mason Oceana)	2,218,646	2,233,971	408,585	114,703	-	21,991	5,524	166,046	594,643	922,478
LRE Staffing & Regional Projects	1,417,648	1,518,597	311,592	249,565	5,540	-	155,162	-	309,424	487,314
Unallocated	463,268	-	-	-	-	-	-	-	-	-
Overall Treatment Total	34,822,593	35,289,815	5,919,084	1,917,448	27,700	215,600	458,098	3,828,118	8,901,611	14,022,157
SUD Total Prevention + Treatment:	**38,053,651**	**38,532,362**	**7,389,879**	**2,100,000**	**27,700**	**215,600**	**458,098**	**5,167,318**	**9,151,611**	**14,022,157**

The POINTS Act

Providing Opportunities for Individuals In Need of Treatment & Support Act

NCPG
National Council on Problem Gambling

A Federal Response to Gambling Addiction

Nearly 20 million American adults (8%) report experiencing at least one indicator of problematic gambling behavior "many times" in the past year. Gambling disorder is recognized as an addictive disorder in the DSM-5. Yet unlike alcohol or drug addiction, there is no dedicated federal funding for gambling addiction treatment or research, despite estimated annual social costs of $14 billion.

The POINTS Act would reallocate one-third of the existing federal excise tax on sports wagers (0.25% of handle) to support prevention,treatment, and research. The bill would generate an estimated $100 million annually without raising or creating new taxes. Federal sports wagering excise tax revenue exceeded $150 million in FY2024 and is estimated to reach $300 million in FY2025.

REALLOCATES

1/3

of the existing federal excise tax on sports wagers to address gambling addiction.

$100 MILLION

PER YEAR

Estimated annual funding for prevention, screening, intervention, and treatment of problem gambling.

NO NEW TAXES

The bill uses existing federal sports betting tax revenue, no new taxes are created.

What the POINTS Act Does

Recognizes Gambling Addiction in Federal Law

Amends the Public Health Service Act to include gambling addiction alongside other substance use and mental health disorders, consistent with the DSM-5 classification of gambling disorder.

Establishes a Federal Grant Program

Creates a competitive grant program administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) for states, Indian Tribes, and Tribal Organizations.

Prioritizes High-Risk Populations

Directs funding toward populations at elevated risk of gambling harm, including youth, men, veterans, and Native American communities.

Supports Prevention Programs

Funds statewide and community-based initiatives that increase public awareness and educate individuals about the risks of gambling.

Expands Early Intervention

Supports training for healthcare providers and community leaders to implement Screening, Brief Intervention, and Referral to Treatment (SBIRT) for gambling-related harm.

Strengthens Treatment and Recovery Services

Provides funding for outpatient treatment, telehealth services, peer recovery support such as Gamblers Anonymous, and the operation of 24/7 problem gambling helplines.

Urge Congress to Act

Contact your Member of Congress and ask them to co-sponsor the POINTS Act.

Learn more and show your support at

pointsact.org

Problem Gambling

A Growing Public Health Issue

NCPG
National Council on Problem Gambling

What is Problem Gambling?

Problem gambling, sometimes called gambling addiction or gambling disorder, occurs when gambling behavior causes harm to a person or their family and interferes with daily life. Anyone who gambles can be at risk of developing a problem.

Gambling disorder is recognized by the American Psychiatric Association in the DSM-5 as a clinical behavioral health condition.

Problem Gambling in the United States

$14 BILLION ANNUALLY

Untreated problem gambling is estimated to cost the United States through healthcare expenses, bankruptcy, crime, and lost productivity.[3]

2.5 MILLION

U.S. adults are estimated to meet the criteria for severe gambling problem in a given year. Another 5-8 Million meet the criteria for mild or moderate gambling problems.[1]

8% OF AMERICAN ADULTS

almost 20 million people, reported experiencing at least one indicator of problematic gambling behavior "many times" in the past year.[8]

The Growing Impact of Problem Gambling

Higher-Risk Populations:

Young men, servicemembers and veterans, and Native American communities experience higher rates of gambling problems.[1, 2]

Elevated Suicide Risk:

People with gambling problems face up to 15 times higher risk of suicide attempts.[5]

Negative Family Impact:

82% of affected families experience harm, including divorce, social isolation, and increased mental health risks for children.[6, 7]

Increased Depression:

Individuals with gambling problems experience 3 times higher rates of depression.[9]

Co-Occurring Alcohol Use Disorder:

Nearly two-thirds of people with gambling problems also experience an alcohol use disorder.[10]

Financial Strain:

1 in 5 individuals with gambling problems ultimately files for bankruptcy.[9]

Addressing gambling addiction requires sustained federal investment in prevention, screening, and treatment to ensure communities across the country have access to the resources they need.

Learn more about problem gambling at www.pointsact.org

[1] **FAQs: What is Problem Gambling?** (n.d.). National Council on Problem Gambling. Retrieved September 29, 2025, from https://www.ncpgambling.org/help-treatment/faqs-what-is-problem-gambling/

[2] **van der Maas, M., & Nower, L. (2021). Gambling and military service:** Characteristics, comorbidity, and problem severity in an epidemiological sample. Addictive Behaviors, 114, 106725. https://doi.org/10.1016/j.addbeh.2020.106725.

[3] **Lutz, Z. (2024, December 17). Where is Online Casino Legal?** State-by-State iGaming Legality. Birches Health. https://birchesheath.com/resources/online-casino-igaming-legality#

[4] **Yeola, A., Allen, M. R., Desai, N., Poliak, A., Yang, K. H., Smith, D. M., & Ayers, J. W. (2025). Growing Health Concern Regarding Gambling Addiction in the Age of Sportsbooks.** JAMA Internal Medicine, 185(4), 382–389. https://doi.org/10.1001/jamainternmed.2024.8193

[5] **Karlsson, A., & Håkansson, A. (2018). Gambling disorder, increased mortality, suicidality, and associated**

[6] **Banks, J., Andersson, C., Best, D., Edwards, M., & Waters, J.L. (2018). Families Living with Problem Gambling: Impacts, Coping Strategies and Help-Seeking.** https://www.gambleaware.org/media/fblay5h5/families-living-with-problemgambling_0.pdf

[7] **Hodgins, D., Shead, N., and Makarchuk, K., (2007). Relationship satisfaction and psychological distress among concerned significant others of pathological gamblers.** Journal of Nervous and Mental Disease, 195, pp. 65–71.

[8] **National Council on Problem Gambling. (2024). Key Findings: National Survey on Gambling Attitudes and Gambling Experiences 3.0.** https://www.ncpgambling.org/wp-content/uploads/2025/06/NGAGE-3.0-Key-Findings-FINAL-FOR-DISTRIBUTION.pdf

[9] **Sharma R, Weinstein A. Gambling disorder comorbidity a narrative review.** Dialogues Clin Neurosci. 2025 Dec;27(1):1-18. doi: 10.1080/19585969.2025.2484288. Epub 2025 Apr 3. PMID: 40177908; PMCID: PMC11980244.

[10] **Gerstein DR, Volberg RA, Toce MT, Harwood H, Johnson RA, Buie T, et al. Gambling Impact and Behavior Study: report to the National Gambling Impact Study Commission.** New York, NY: Christiansen/Cummings Associates; 1999.

Keep MI Kids Tobacco Free ALLIANCE

Tobacco Retail Licensure: A Proven Tool To Reduce Youth Tobacco Use

ATTACHMENT 8

Tobacco retail licensing (TRL) is an effective tobacco prevention measure that requires stores to obtain a state-issued license to sell tobacco products.

IMPACT AREAS

Establish Tobacco Retail Licensing

Eliminate Ineffective Youth Penalties

Tax E-Cigarettes & Vaping Products

Invest Funding to Reduce Tobacco Use

The Problem:

Michigan is one of only nine states that does not require tobacco retailers to have a state license. Without a state license requirement, Michigan cannot effectively enforce existing state laws including our current law prohibiting tobacco sales to minors. During the past three years, 26% of Michigan tobacco retailers failed federal compliance checks and sold tobacco products to an underage purchaser. 95% of youth who attempted to buy e-cigarettes were not turned away because of their age according to the most recent Michigan Youth Tobacco Survey.

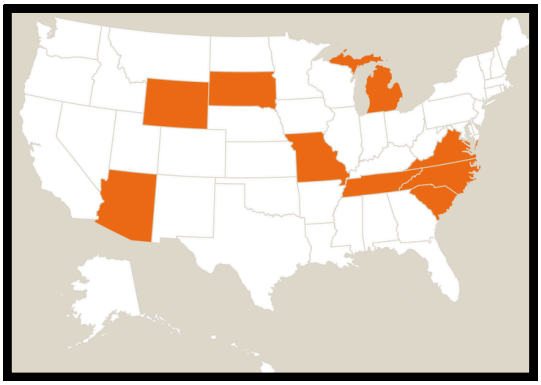
Proposed Policy Change- Senate Bills 462, 464 & 465, sponsored by Sens. Singh & Bellino; House Bills 5368-5370, sponsored by Reps. Slagh and Wortz

- Establish a tobacco retail licensing (TRL) program within Michigan's Department of Licensing and Regulatory Affairs (LARA).
- Require retailers to obtain a state-issued license to sell tobacco products, including e-cigarettes.
- Specify the process by which a retailer applies for, receives and maintains permission to sell tobacco products (e.g., annual renewal process, filing fees and the consequences of failing to meet these requirements).
- Set the initial licensing fee and the renewal fee that will help cover the cost of enforcement and administration.
- Set the penalties for violations, including a graduated system of penalties, starting with fines and escalating to license suspension or revocation for repeated offenses.
- Specify that LARA's enforcement actions include compliance checks.
- Stores are not required to obtain a tobacco license to sell smoking cessation products approved by the U.S. Food and Drug Administration.

The Facts:

- Michigan requires retailers to obtain a state-issued license to sell alcohol and marijuana but not tobacco products. Michigan is one of nine states that does not require tobacco retailers to obtain a state license.
- Research shows that strong TRL policies can decrease youth initiation and usage rates and reduce the sale of tobacco products to underage persons.

How We Match Up: Michigan is one of only nine states without TRL in place



Orange = states without TRL in place

Tobacco in this document refers specifically to commercial tobacco products that are made and sold by tobacco companies. It does not include traditional tobacco used by Indigenous groups for ceremonial purposes.

Updated 7/23/25

Keep MI Kids Tobacco Free ALLIANCE

Repeal Ineffective Penalties on Youth for Purchasing, Using or Possessing Tobacco Products

For decades, the tobacco industry has targeted young people with highly addictive tobacco products including cigarettes, e-cigarettes, smokeless tobacco and nicotine pouches. To prevent youth initiation and reduce the overall harm of tobacco use, federal law and Michigan state law prohibit the sale of tobacco products to persons younger than 21 years of age (Tobacco 21).

IMPACT AREAS

Establish Tobacco Retail Licensing

Eliminate Ineffective Youth Penalties

Tax E-Cigarettes & Vaping Products

Invest Funding to Reduce Tobacco Use

The Problem:

The federal Tobacco 21 law holds retailers responsible for selling tobacco products to individuals under 21; however, Michigan state law targets youth and imposes penalties for the purchase, use or possession of tobacco products ("PUP" penalties).

Proposed Policy Change- Senate Bills 463 & 466, sponsored by Sens. Wojno and Cavanagh; House Bills 5371 & 5372, sponsored by Reps. Young and Scott

- Repeal provisions in the Youth Tobacco Act that impose civil and criminal penalties on minors for tobacco purchase, use or possession.
- Repealing Michigan PUP laws complements our tobacco retail licensing (TRL) policy proposal requiring retailers to obtain a license to sell tobacco products.
- Tobacco retailers and those benefiting financially from tobacco sales should be held accountable and bear the consequences – not minors.

The Facts:

- PUP laws are ineffective, counterproductive and criminalize youth behavior that is largely driven by tobacco and nicotine addiction. PUP penalties:
  - Shift the focus (and resources) away from the tobacco industry's predatory tactics and instead place the burden on young people targeted by an industry that profits from their addiction.
  - Hinder cessation because young people fear punishment and conceal their tobacco addiction and desire for quitting help.
  - Are often enforced inequitably and can result in an increased likelihood of negative encounters with law enforcement.

Learn more at KeepMIKidsTobaccoFree.com

Tobacco in this document refers specifically to commercial tobacco products that are made and sold by tobacco companies. It does not include traditional tobacco used by Indigenous groups for ceremonial purposes.

Updated 5/19/25

SAMHSA
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

April 24, 2026

Dear Colleague:

On July 29, 2025, the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a Dear Colleague letter,[1] outlining the Agency's clear shift away from harm reduction and practices that facilitate illicit drug use and are incompatible with Federal laws, consistent with President Trump's Executive Order on Ending Crime and Disorder on America's Streets.[2]

The letter also provided guidance to state agency leadership and to grantees on what supplies and services previously defined under the umbrella of harm reduction could be supported with SAMHSA funding. Since the SAMHSA Dear Colleague letter was issued, other HHS divisions, including the Administration for Children and Families (ACF)[3], Centers for Disease Control and Prevention (CDC)[4], and Health Resources and Services Administration (HRSA)[5], have referenced this letter in their Strategic Priorities and funding-related announcements to ensure consistency in the use of federal funds.

This Dear Colleague letter provides updated guidance for grantees on the supplies and services previously defined under harm reduction that can be supported with SAMHSA funding. In addition, we are including guidance on supplies and services that cannot be supported with SAMHSA funds.

Supplies and services that CAN be supported with SAMHSA funding:

Life-Saving Overdose Prevention and Response Services

- Opioid overdose reversal supplies, including the purchase and distribution of opioid overdose reversal medications (OORMs) such as naloxone and nalmefene
- Medication lock boxes and medication disposal kits
- Overdose reversal education and training services
- Distribution mechanisms (e.g., bags or metal boxes/containers) for OORMs

[1] https://www.samhsa.gov/sites/default/files/dear-colleague-letter-executive-order-ending-crime-disorder-americas-streets-07302025.pdf
[2] https://www.whitehouse.gov/presidential-actions/2025/07/ending-crime-and-disorder-on-americas-streets/
[3] https://acf.gov/about/acf-vision-mission-values
[4] https://www.cdc.gov/about/cdc/index.html
[5] https://www.hrsa.gov/about/priorities

Infectious Disease Prevention Services

- Wound care supplies
- FDA-approved home testing kits for viral hepatitis (i.e., HBV and HCV) and HIV
- Sharps disposal kits
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, testing, treatment, and care services — including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), prevention of mother to child transmission, and partner services
- Referral to hepatitis A and hepatitis B vaccinations (to reduce risk of viral hepatitis infection)
- Provision of education on HIV and viral hepatitis prevention, testing, and referral to treatment and care services, including for PrEP
- Education and activities to reduce risk of sexually transmitted infectious diseases, including distributing condoms

Other Supplies and Services

- Nicotine cessation therapies

Supplies and Services NOT supported with SAMHSA funding:

- No HHS funding can be used directly or through subsequent reimbursement of grantees or others to purchase or distribute:
    - Syringes or needles used to inject illicit drugs
    - Pipes or other supplies for safer smoking kits
    - Fentanyl test strips or any other substance test kits, including xylazine and medetomidine test strips, intended for use by people using drugs.[6]
- No HHS funding can be used to support "overdose hotlines" that have a primary function of facilitating illicit drugs use by providing people using drugs a virtual or telephonic companion while they are using drugs.
- No HHS funding can be used to purchase or distribute sterile water, saline, or ascorbic acid (vitamin c) used to facilitate drug use
- No HHS funding can be used to purchase or distribute any other drug paraphernalia or supplies that promote or facilitate drug use not listed as acceptable above.

Addressing the addiction and overdose crisis is a top priority for the Administration, HHS, and SAMHSA. To finally bring an end to this crisis and achieve the Great American Recovery, it is essential that the use of federal funding is aligned to common-sense public health strategies that focus on prevention, treatment, and long-term recovery.

[6] This prohibition does not apply to law enforcement, emergency medical services, public health officials, or healthcare professionals using drug testing technologies in the regular course of discharging their professional duties, or as specifically authorized by the program statute.

SAMHSA remains committed to working in partnership with states, territories, tribes, communities, faith-based organizations, and the health sector to save lives, restore families, and help communities thrive.

Thank you for your partnership and collaboration, and we look forward to our continued focused work together.

Sincerely,

Christopher D. Carroll

Christopher Carroll, MSc.
Principal Deputy Assistant Secretary
Substance Abuse and Mental Health Services Administration

LAKESHORE REGIONAL ENTITY

May 2026

Substance Use Disorder Treatment Evaluation Quarterly Monitoring Report

2rd Quarter FY2026

This report outlines data indicators for monitoring and improving key data metrics for substance use disorder treatment and recovery services in the LRE region. Data covered in this report is through the **second quarter of FY26**. As one of Michigan's ten Prepaid Inpatient Health Plans (PIHP), the LRE manages services under contract with the Michigan Department of Health and Human Services, funded by various grants. Treatment and recovery services are provided by Community Mental Health Services Providers across Allegan, Kent, Lake, Mason, Muskegon, Oceana, and Ottawa Counties.

KWB Strategies

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Introduction

This quarterly report provides an update on key performance metrics aligned with four priority areas, along with trends in primary substances reported at admission. These indicators assess how well the regional system is meeting the needs of diverse populations—including those involved in the criminal justice system, individuals with co-occurring disorders, and those with opioid or intravenous drug use—while supporting timely access and smooth transitions across the continuum of care. Data is tracked at both the regional and CMHSP levels to inform planning, guide system improvements, and support ongoing evaluation.

pg 5

Treatment Access

Treatment access refers to how easily and quickly individuals can begin receiving appropriate substance use disorder (SUD) services once they seek help. Metrics in this area assess whether people can get into care in a timely manner and whether access is equitable across different populations and service types.

pg 11

Engagement & Retention

Engagement and retention metrics evaluate how effectively the treatment system keeps individuals connected to services post-initial contact. Early and ongoing engagement correlates with better outcomes, such as lower relapse risk and enhanced long-term recovery. Monitoring these metrics identifies areas needing additional support or system changes to minimize drop-off and improve care continuity.

pg 15

Continuity of Care

Continuity of care metrics evaluate whether people move smoothly to the next level of care after going through detox or short-term residential programs. These transitions are important because during these period clients have a high risk of relapse, overdosing, or losing touch with services.

pg 18

Performance Bonus Incentive Program

Michigan Department of Health and Human Services allocates funding annually to reward PIHPs for strong performance in certain measures such as timely follow-up after an emergency department visit for addiction, decreasing disparities in initiation and engagment in treatment, and supporting social needs like housing and employment. Higher performance on these measures results in a larger bonus.

pg 24

Drug Trends

This section reviews trends in substances reported at admissions. Monitoring these metrics helps identiFYshifts in substance use patterns that can inform system planning and response. Unlike other indicators in this report, these data are not targeted for performance improvement but are tracked for monitoring purposes only.

Using this Report

At the start of each section in this report, you'll find a summary for each metric. This includes a concise explanation of why the metric is important to track, recent findings, and an assessment of whether the trend is improving or declining. Detailed results for each metric related to the region and Community Mental Health Service Providers (CMHSPs) are provided on the pages that follow.

Throughout the report, the following icons have been used to describe data trends.

⚠ Data has worsened and should be monitored

≈ Data has remained relatively stable without a clear pattern

★ Data has been improving

When a data indicator reflects only a portion of admissions and the sample size or count is 10 or less, both the number and the percentage will be presented.

Unless otherwise specified, data analyzed comes from BH TEDS (refreshed on **04/29/26)** and encounters (refreshed on **04/28/26).** Any data entered after these dates will be reflected in subsequent reports. For details on data parameters, refer to the appendix, starting on page 30.

Important Data Limitation: Incomplete CCBHC Data

This year's reports do not include data for CCBHC funded clients. Therefore, variance in trends should be interpreted with caution, as they likely reflect data limitations rather than true operational change. Specifically:

- Encounter data are likely underrepresented and not comparable to prior years.
- Admission data will be substantially impacted, with potential underreporting of up to ~60%.
- Discharge data may be under reported by 10% to 20%

FY26 Q2

Commonly Used Acronyms and Abbreviations:

Q1 - 1st quarter

Q2 - 2nd quarter

Q3 - 3rd quarter

Q4 - 4th quarter

avg - Average

BH - Behavioral Health

CJ - Criminal Justice

CY - Calendar Year

IOP - Intensive Outpatient

LRE - Lakeshore Regional Entity

LOC - Level of care

LT Res - Long term residential level of care

MA - Methamphetamine

MAT- Medication Assisted Treatment

OP- Outpatient

PBIP - Performance Based Incentive Program

Pt./Pts. - Point(s)

OUD - Opioid Use Disorder

ST Res - Short term residential level of care

TTS - Time to Service

WM or West MI - Lake, Mason, & Oceana Counties

Treatment Access

Treatment access refers to how quickly individuals can begin substance use disorder (SUD) services once they seek help and whether access is equitable across different populations and service types. These indicators help determine whether the system is responsive to those who need care—and whether wait times or barriers differ based on location, demographics, or clinical need.

This page provides an overview of the treatment access metrics monitored quarterly by the LRE, the rationale for each indicator and a brief snapshot of current data trends through the most recent quarter. Additional detail for each metric can be found on the pages noted.

Intra-Venous Drug Use (IVDU)

Admissions for individuals with IVDU are prioritized due to elevated risk for overdose, infectious disease, and other serious health complications.

Medication Assisted Treatment (MAT)

Timely access to MAT for individuals with opioid use disorder is prioritized because it reduces the risk of overdose, enhances treatment engagement, and supports long-term recovery. MAT is widely recognized as the gold standard in evidence-based care for opioid use.

Criminal Justice Involved Admissions

Individuals involved in the criminal justice system are prioritized due to their increased risk of overdose and untreated substance use. With the MDOC delegating probation services to PIHPs, timely and coordinated access to treatment is crucial.

Metrics

↓ avg days between request and 1st service for persons with intra-venous drug use (IVDU) (pgs 6-8)

⚠ ***Worsened*** *to a high of 13.4 days in Q2. TTS for clients with IVDU. Across the region there was increased TTS in Detox, Long Term Residential and Outpatient treatment.*

↓ avg days between request and 1st service for persons with opioid use disorder (OUD) to MAT (pg 9)

⚠ ***Worsened*** *to a high of 13.6 days in Q2 with notable increases in Kent County.*

↑ admissions for individuals on parole/probation, in jail, or diverted (pre or post booking) (pg 10)

≈ *Just over one-third (37%) of admissions in Q2 had criminal justice involvement with 26% on probation, 7% on parole, and 4% in jail. Probation had a slight increase, but overall* ***relatively stable*** *since FY24.*

FY26 Q2

Treatment Access

Intra-Venous Drug Use (IVDU)

Metric

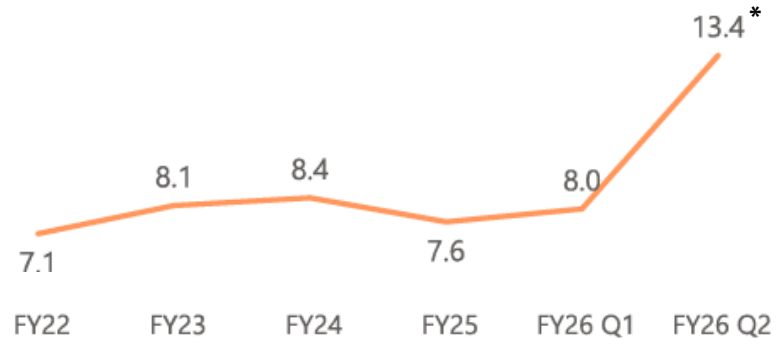
- Decrease the average days between request for service and first service for clients with IVDU.

Data Highlights:

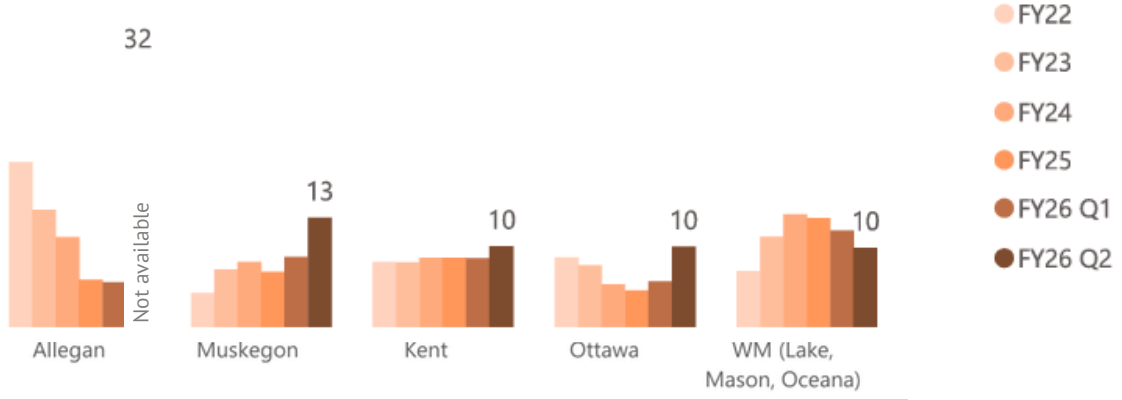
Among admissions for individuals with IVDU, the average time to service was 13.4 days in Q2 which was both a high since FY22 and an increase from Q1 at 8 days.

Across the region, TTS for clients with IVDU ranged from a low of 9.6 in West Michigan to a high of 13.3 days for Muskegon among the 22 clients with IVDU in Q2.

Average Time to Services for Clients with IVDU (Days)



Average Time to Service for Clients w/IVDU by CMHSP



FY22	20.0	4.1	7.9	8.4	6.8
FY23	14.2	7.0	7.8	7.5	10.9
FY24	10.9	7.9	8.4	5.2	13.7
FY25	5.7	6.7	8.4	4.4	13.2
FY26 Q1	5.4	8.5	8.3	5.5	11.7
FY26 Q2	NA	13.3	9.8	9.7	9.6

*Regional rate may be inaccurately high due to invalid data from Allegan County being included.

FY26 Q2

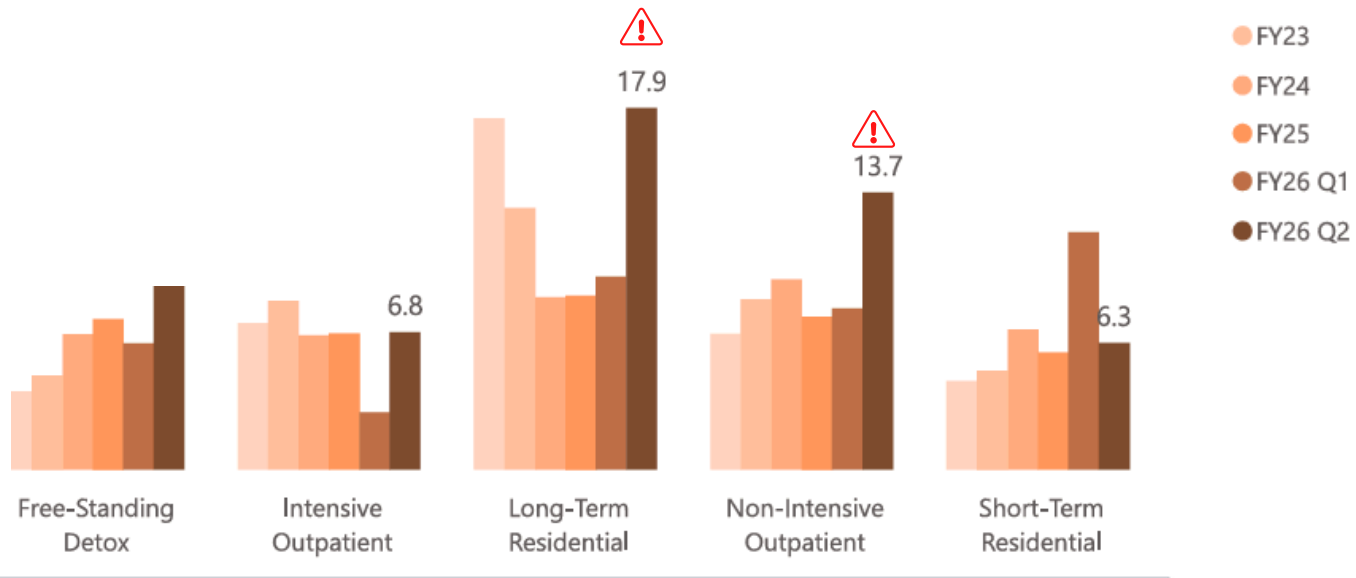
Treatment Access

Intra-Venous Drug Use (IVDU) cont...

Metric

- Decrease the average days between request for service and first service for clients with IVDU.

Average Time to Services for Clients with IVDU by Service Category *



	Free-Standing Detox	Intensive Outpatient	Long-Term Residential	Non-Intensive Outpatient	Short-Term Residential
FY22	3.9	7.3	17.4	6.7	4.4
FY23	4.7	8.4	13.0	8.4	4.9
FY24	6.7	6.7	8.5	9.4	6.9
FY25	7.5	6.8	8.6	7.6	5.8
FY26 Q1	6.3	2.8	9.6	8.0	11.8
FY26 Q2	10.2	6.8	17.9	13.7	6.3 (11)

*Regional rates may be inaccurately high due to invalid data from Allegan County being included.

Data Highlights:

Average time to service for IVDU increased across the continuum of care between Q1 and Q2, except for short term residential. In Q2, long term residential services had the longest Time to Service (TTS) for clients with intravenous drug use (IVDU) at 17.9 days. This is the highest reported TTS since FY22. The average time to service nearly doubled between Q1 and Q2 for both intensive outpatient and long term residential.

FY26 Q2

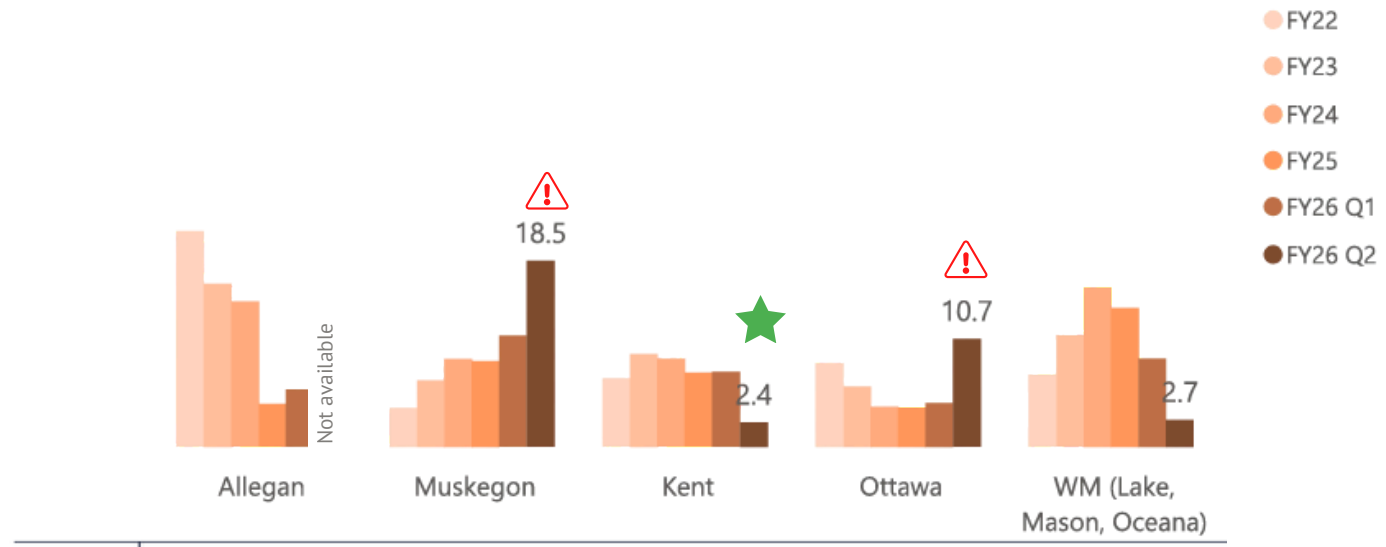
Treatment Access

Intra-Venous Drug Use (IVDU) continued...

Metric

- Decrease the average days between request for service and first service for clients with IVDU.

Average Time to Outpatient (non-intensive) Services for Clients with IVDU by CMHSP



	Allegan	Muskegon	Kent	Ottawa	WM (Lake, Mason, Oceana)
FY22	21.5	3.9	6.8	8.3	7.2
FY23	16.2	6.6	9.2	6.0	11.1
FY24	14.4	8.7	8.8	4.0	15.8
FY25	4.2	8.5	7.3	3.9	13.8
FY26 Q1	5.7 (10)	11.1	7.4	4.4	8.8 (9)
FY26 Q2	NA	18.5	2.4	10.7	2.7 (6)

Data Highlights:

In Q2, Time to Service (TTS) for clients with intravenous drug use (IVDU) seeking outpatient services ranged from 2.4 days in Kent County to 18.5 days in Muskegon. Ottawa saw an increase from 4.4 days in Q1 to a high of 10.7 days to service in Q2. Kent County saw a significant decrease in average time to outpatient services from 7.4 days in Q1 to 2.4 days during Q2. This is the lowest time to service since FY22.

FY26 Q2

Treatment Access

Medication Assisted Treatment (MAT)

Metric

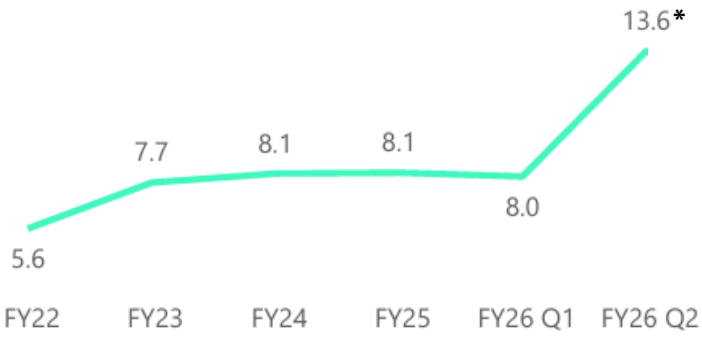
- Decrease average days between request for service and first service for persons living with an opioid use disorder (OUD).

Data Highlights:

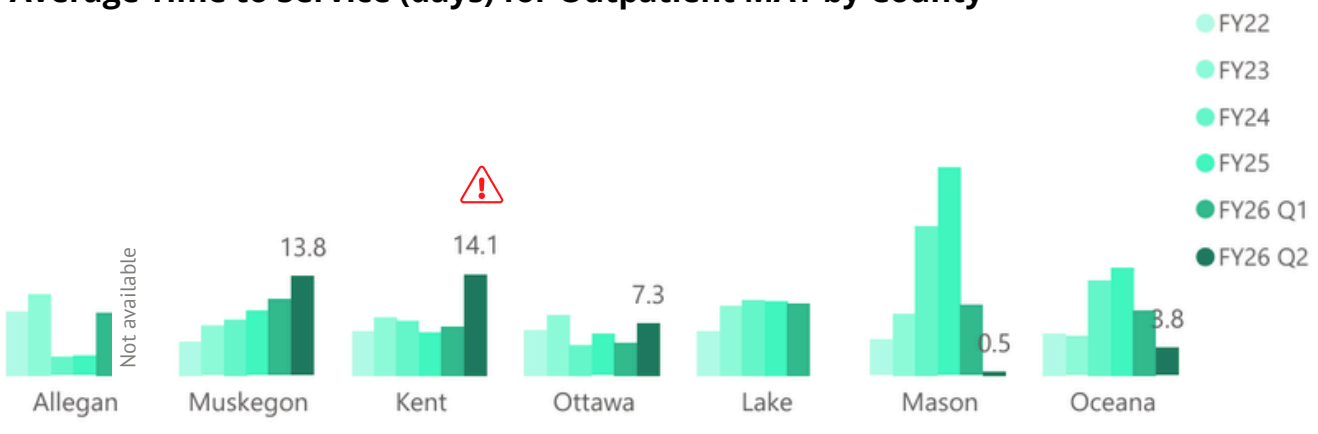
Time to Service (TTS) for individuals with an opioid use disorder (OUD) is most impacted by delays in admission to medication-assisted treatment (MAT). In Q2, the regional average TTS for MAT increased from 8 days to 13.6 days. This is the highest time to service since FY22.

By county, TTS in Q2 ranged from half of a day in Mason County to 14 days in Kent County. Kent County experienced an increase to 14.1 days following a period of relatively stable TTS. Mason County and Oceana County both experienced a significant decrease in TTS for outpatient MAT in Q2. It should be noted that, the number of clients involved were small for Mason and Oceana County which should be considered when interpreting trends.

Average Time to Service (days) for Medication Assisted Treatment (MAT), LRE Region



Average Time to Service (days) for Outpatient MAT by County



	Allegan	Muskegon	Kent	Ottawa	Lake	Mason	Oceana
FY22	9.0	4.7	6.2	6.3	6.2	5.0	5.8
FY23	11.3	6.9	8.1	8.5	9.8 (4)	8.5	5.4
FY24	2.5	7.7	7.6	4.3	10.5 (4)	20.7	13.2
FY25	2.7	9.0	5.9	5.8	10.4 (5)	28.9	15.0
FY26 Q1	8.8	10.6	6.8	4.5	10.0	9.8	9.0
FY26 Q2	NA	13.8	14.1	7.3		0.5 (4)	3.8 (6)

*Regional rate may be inaccurately high due to invalid data from Allegan County being included.

TTS:
Time to Service is the number of days between the request for service and date of first service received.

FY26 Q2

Treatment Access

Criminal Justice Involved Admissions

Metric

- Increase admissions with legal status, on parole/probation
- Increase admissions with legal status as diversion pre or post booking
- Increase admissions with legal status as 'in jail'

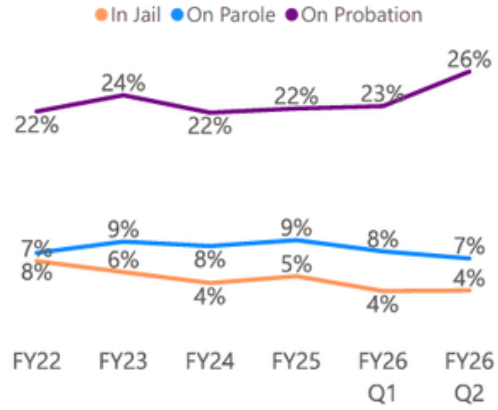
Data Highlights:

Region-wide, 37% of admissions had criminal justice involvement in Q2. The majority of these were individuals 'on probation'.

The rate for admissions with legal status as pre- or post-booking diversion remains consistently low (<1%).

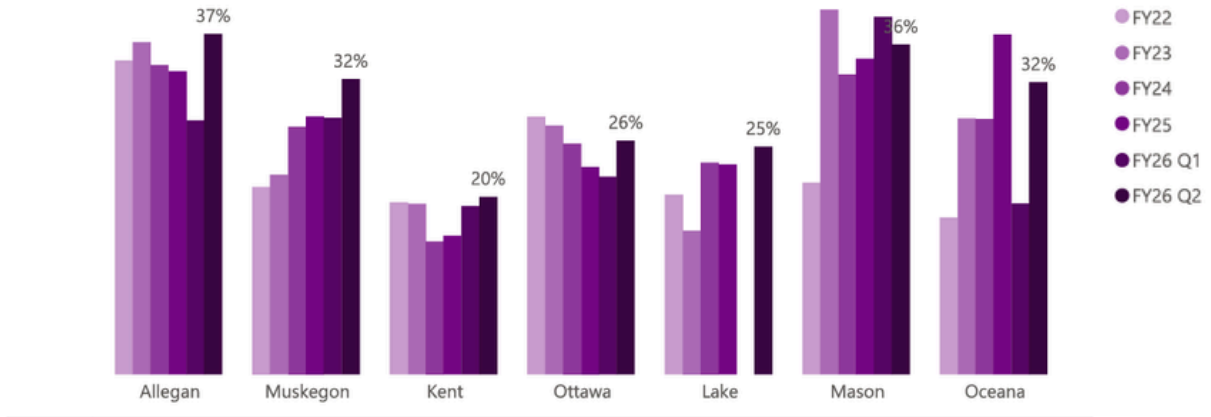
Rates of admissions for individuals on probation increased in Allegan, Muskegon, and Oceana Counties this quarter in comparison to Q1. However, Allegan and Oceana counties had rates that seemed to be unusually low in Q1, with rates restabilizing during Q2.

Percent of Admissions by Legal Status at Admission, LRE Region



Engaging criminal justice-involved populations in services when they return to the community is a priority.

Percent of Admissions with Legal Status as 'On Probation' at Admission by County



	Allegan	Muskegon	Kent	Ottawa	Lake	Mason	Oceana
FY22	34.5%	20.6%	18.9%	28.3%	19.7%	21.1%	17.2%
FY23	36.5%	21.9%	18.7%	27.3%	15.8%	40.1%	28.1%
FY24	34.0%	27.2%	14.6%	25.4%	23.3%	32.9%	28.0%
FY25	33.3%	28.3%	15.2%	22.8%	23.1%	34.7%	37.3%
FY26 Q1	27.9%	28.2%	18.5%	21.7%		39.3%	18.8%
FY26 Q2	37.4%	32.4%	19.5%	25.7%	25.0% N=2	36.2%	32.1%

FY26 Q2

Engagement and Retention

Engagement and retention metrics help assess how well the treatment system is supporting individuals to stay connected to services after their initial contact. Early and sustained engagement is linked to better outcomes, including reduced relapse risk and improved long-term recovery. Tracking these indicators helps identiFYwhere additional support or system changes may be needed to reduce drop-off and strengthen care continuity.

This page provides an overview of the engagement and retention metrics monitored quarterly by the LRE, the rationale for each indicator and a brief snapshot of current data trends through the most recent quarter. Additional detail for each metric can be found on the pages noted.

Integrated Treatment for Co-Occurring Disorders (COD)

Individuals with co-occurring mental health and substance use disorders have more complex needs, and receiving integrated care helps improve outcomes and retention by ensuring both conditions are addressed in a coordinated, person-centered approach.

One Encounter

The percent of treatment episodes with no second visit is a key indicator of early engagement. A high rate may suggest barriers to continued care—such as accessibility issues, unmet needs, or poor treatment fit—and can signal where additional support or system improvements are needed to keep individuals engaged in services.

Metrics

↑ % of clients w/ co-occurring diagnosis (COD) receiving integrated services (pg 12)

★ *The % of clients with COD reported as having received integrated treatment has **continued to increase**, with a high of 36% in Q1, and remaining stable in Q2.*

In Q2, the percentage of clients with COD receiving integrated care, ranged from a low of 16% in West Michigan to a high of 55% in Ottawa, with a notable increase in Allegan County.

↓ % of treatment episodes with no 2nd visit (pgs 13-14)

⚠ *Episodes w/ only 1 encounter increased throughout the region to a high of 12%. However this may be due to delays in data entry for these most recent time periods. In Q2, rates were highest for Outpatient (55%) and Outpatient MAT (39%).*

FY26 Q2

Engagement and Retention

Integrated Treatment for Co-Occurring Disorders (COD)

Metric

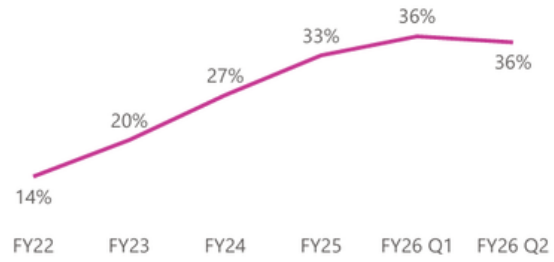
- Increase % of clients with co-occurring diagnosis that received integrated services.

Data Highlights:

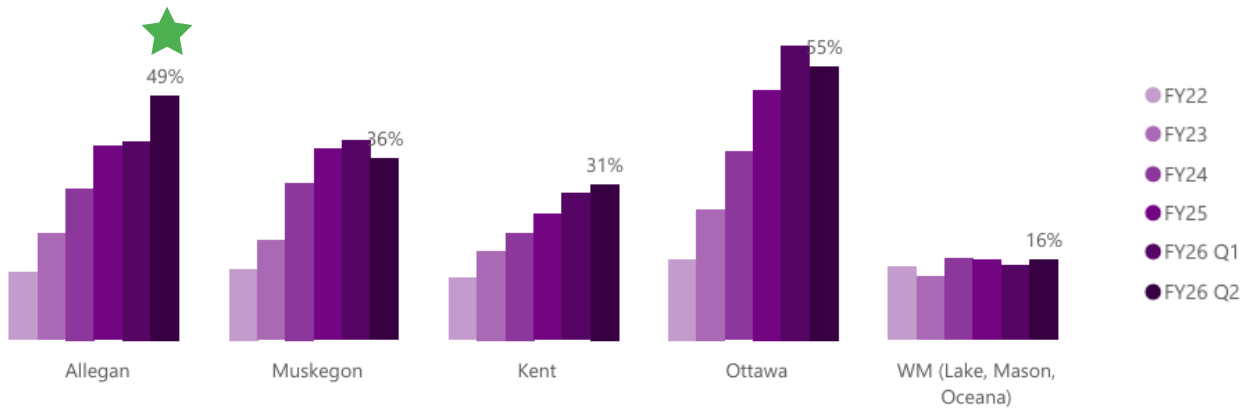
The percentage of clients with COD that were reported as having received integrated treatment has been continually increasing since 2017, reached a high of 36% in Q1 of FY26 and remained steady during Q2.

Rates of integrated treatment in Q2 ranged from a low of 16% for WM to a high of 55% in Ottawa County. When looking at CMHSPs, Allegan and Kent county rates of integrated treatment continue to increase. Muskegon, Ottawa, and West Michigan remained relatively stable this quarter.

Percent of Clients with Co-Occurring Disorders that Received Integrated Treatment, LRE Region



Percent of Clients with COD that Received Integrated Treatment by CMHSP



	Allegan	Muskegon	Kent	Ottawa	WM (Lake, Mason, Oceana)
FY22	13.6%	14.2%	12.4%	16.2%	14.7%
FY23	21.4%	20.1%	17.9%	26.3%	12.8%
FY24	30.5%	31.5%	21.5%	37.9%	16.4%
FY25	39.0%	38.4%	25.4%	50.2%	16.1%
FY26 Q1	40.0%	40.1%	29.4%	59.2%	15.0%
FY26 Q2	49.2%	36.5%	31.3%	55.0%	16.1%

FY26 Q2

Engagement and Retention

One Encounter

Metric

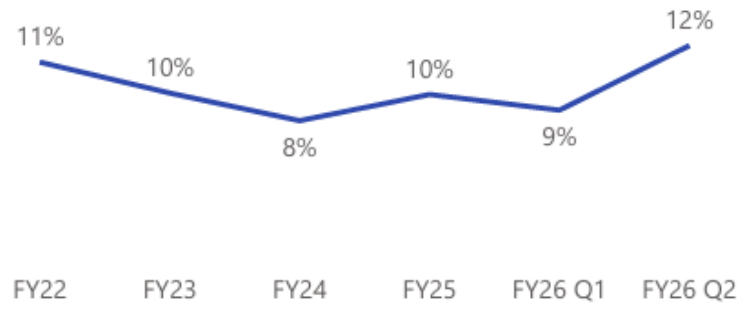
- Decrease % of treatment episodes with no 2nd visit.

Data Highlights:

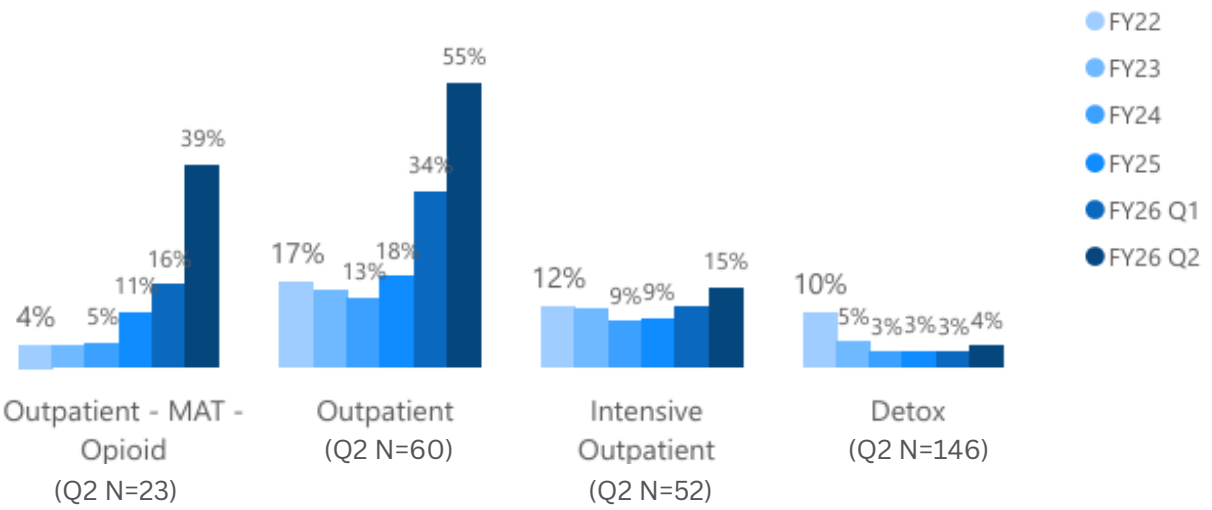
For treatment episodes that warranted more than an assessment, the percentage of treatment episodes with only one encounter increased slightly to 12% in Q2. However, this increase may be due to encounter data that was not yet entered for these most recent time periods.

OP treatment episodes with only one encounter continued to increase in Q2 to a high of 55%. OP MAT also saw an increase in treatment episodes with one encounter, however the count was small which should be considered when interpretting the data.

Percent of Treatment Episodes with One Encounter, LRE Region



Percent of Treatment Episodes with One Encounter* by Level of Care



Treatment episodes with only an assessment that had a discharge reason reported as something other than having 'dropped out' are excluded from the analysis.

FY26 Q2

Engagement and Retention

One Encounter Continued...

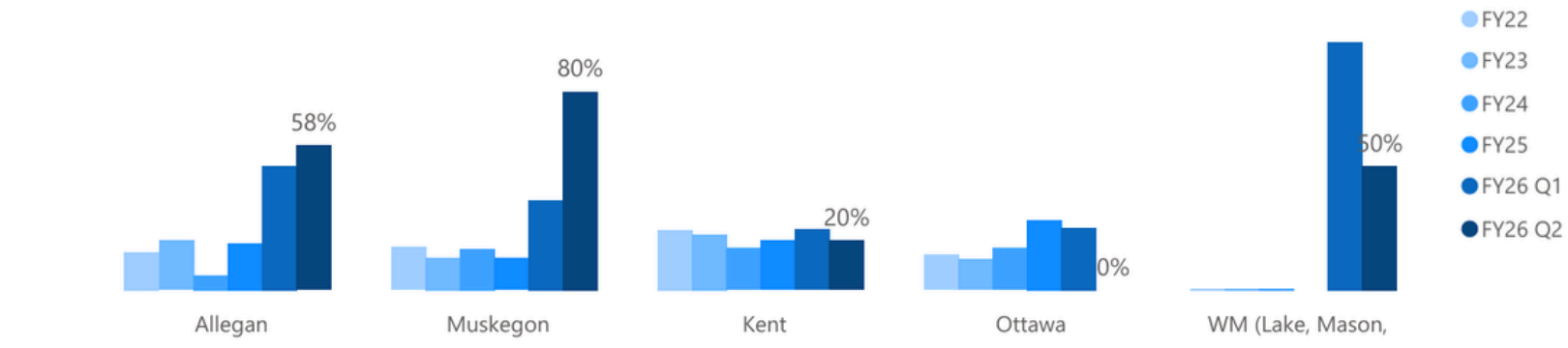
Metric

- Decrease % of treatment episodes with no 2nd visit.

The chart below shows the percentage of outpatient treatment episodes with only one encounter for each CMHSP. Rates vary across CMHSPs and time periods. Those showing substantially higher rates in the most recent quarters may be attributable to incomplete data entry for encounters at the time records were pulled for this review.

Use caution when reviewing the most recent time periods, as delays in the entry of service encounters can limit the validity of results. Allegan, Kent, and WM had a very small number of episodes with only one encounter making up the percentage, which should be considered when looking at this data.

Percent of Outpatient Treatment Episodes with Only One Encounter by CMHSP (excluding MAT)



	Allegan	Muskegon	Kent	Ottawa	WM (Lake, Mason,
FY22	15.2%	17.2%	24.1%	14.1%	0.4% (1)
FY23	20.0%	13.0%	22.4%	12.4%	0.3% (1)
FY24	5.9%	16.7%	16.8%	16.8%	0.4% (1)
FY25	18.8%	12.9%	20.0%	28.1%	(0)
FY26 Q1	50.0% (7)	36.1%	24.4%	25.0%	100.0% (3)
FY26 Q2	58.3% (7)	80.0%	20.0% (3)	0.0%	50.0% (2)

The count is provided in parentheses for rates calculated for a count of 10 or less episodes.

Note: This analysis only includes treatment episodes meeting the following criteria: 1) warranted more than an assessment, 2) discharge date entered, and 3) at least one service encounter entered. Due to this, more recent data periods have a small sample size and may not reflect all service encounters.

Continuity of Care

Continuity of care metrics assess whether individuals successfully transition to the next level of care following high-intensity services of detoxification and short-term residential (ST Res). These transitions are critical periods when individuals are especially vulnerable to relapse, overdose, or disengagement from services. Monitoring these metrics helps ensure individuals don't fall through the cracks during this high-risk period and that the treatment system is working as a coordinated continuum rather than a series of disconnected services.

This page provides an overview of continuity of care metrics monitored quarterly by the LRE, the rationale for each indicator and a brief snapshot of current data trends through the most recent quarter. Additional detail for each metric can be found on the pages noted.

Timely Transition after Detox/ST Res

Timely transition to the next level of care following discharge from detox or short-term residential is critical for sustaining treatment momentum and reducing the risk of relapse, overdose, or dropout during a vulnerable period in early recovery.

Metrics such as the percent of clients admitted within 7 days and the average number of days between discharge and admission offer complementary ways to assess how effectively the system supports seamless, coordinated care.

ST Res Discharge Reason

Discharges incorrectly coded as "completed treatment" instead of "completed program/transferred to another provider" can skew state-level analysis of outcomes for the region. Accurate coding is essential for understanding completion rates, monitoring service transitions, and ensuring individuals receive the full continuum of recommended care.

FY26 Q2

Metrics

↑ % of discharged detox and ST Res clients successfully transitioned to the next LOC w/in 7 days (pg 16)

★ *The % of clients discharged from ST Res and successfully admitted to the next LOC within 7 days reached a **high** of 76% during Q2 of FY26, compared to 41% in FY25.*

↓ average # days between discharge and admission to next level of care for ST Residential (pg 16)

★ *In Q2, the time between discharge and readmission averaged half a day for those who were readmitted within 7 days. Among the 15% of clients discharged from ST Res who were readmitted between 8 & 30 days, the avg time to readmission was 16.8 days. **Relatively stable** since FY22.*

↓ discharges from detox and ST Res levels of care with discharge reason as 'completed treatment' (pg 17)

★ *In Q2 of FY26, incorrect reporting of discharges from ST Res coded as "completed treatment" **continued to improve** to a low of 19%. Detox discharge reported as "completed treatment" also **improved** to a low of 12% in Q2.*

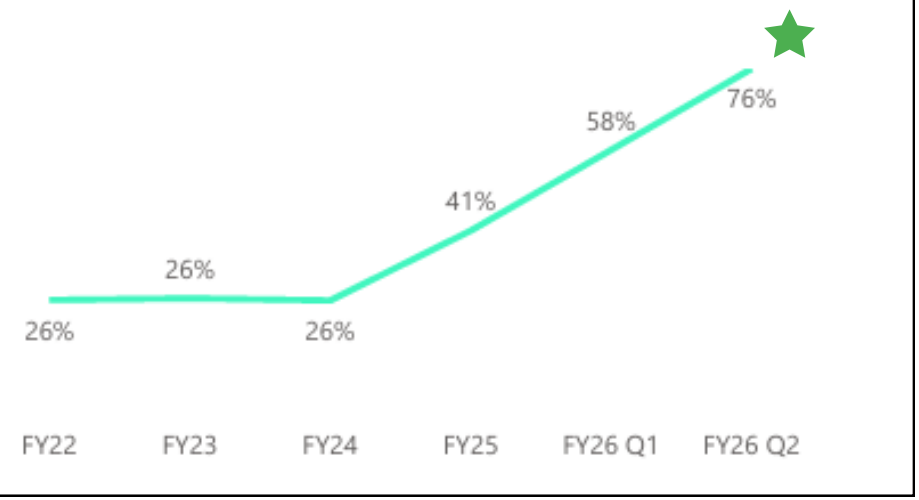
CONTINUITY OF CARE

Timely Transition after Detox/ST Res

Metrics

- ↑ % of discharged ST Res clients successfully transitioned to the next LOC w/in 7 days.
- ↓ average # days between discharge and admission to next level of care for ST Residential

Percent of Discharges from ST Res Admitted to Next Treatment Episode w/in 7 days, Region

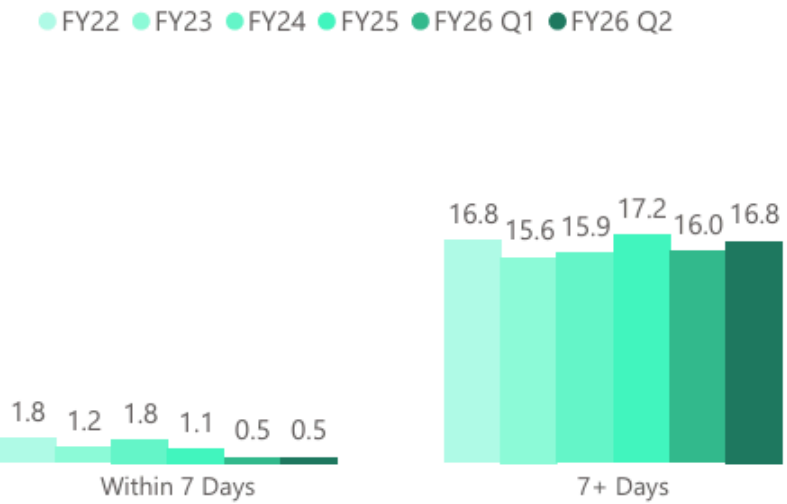


Percent of Discharges from ST Res Admitted to Next Treatment Episode w/in 7 days by CMHSP

	FY22	FY23	FY24	FY25	FY26 Q1	FY26 Q2
Allegan	14%	18%	24%	15% (4)	0% (0)	50% (1)
Muskegon	30%	18%	8%	42%	70%	76%
Kent	23%	25%	17%	0%	100% (1)	(0)
Ottawa	32%	30%	40%	60%	71% (5)	100% (8)
WM (Lake, Mason, Oceana)	30%	33%	33%	43%	75% (3)	60%

The count is provided in parentheses for rates calculated for a count of 10 or less episodes.

Average # Days between Discharge from ST Res and Admission to Next Level of Care



Data Highlights:

Following detox (24-hour), clients typically transition to ST Res at the same service provider. Following discharge from ST Res, it is ideal for clients to engage in services at a lower level of care as soon as possible, with a goal of no more than 7 days between discharge and the subsequent admission.

Rates of readmission within 7 days have continued to improve in Q2 of FY26 at a high of 76%.

- Among discharges with a corresponding admission to the next level of care within 7 days, the average time between discharge and readmission was half a day, representing 85% of all ST Res discharges with a readmission.
- Among discharges admitted to the next level of care between 8 and 30 days post-discharge, the average time to readmission was 16.8 days, representing 15% of ST Res discharges with a readmission.

FY26 Q2

CONTINUITY OF CARE

ST Res Discharge Reason

Metric

- Decrease discharges from detox and/or residential levels of care with discharge reason identified as 'completed treatment'

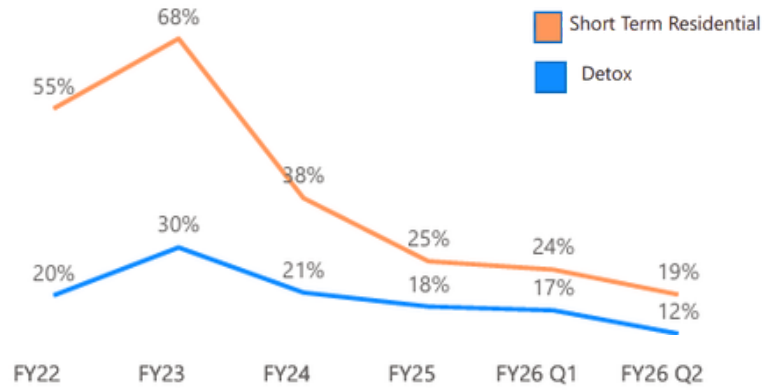
Data Highlights:

The percentage of discharges from ST Res incorrectly reported as 'completed treatment' continues to improve and reached a low of 19% in Q2 of FY26.

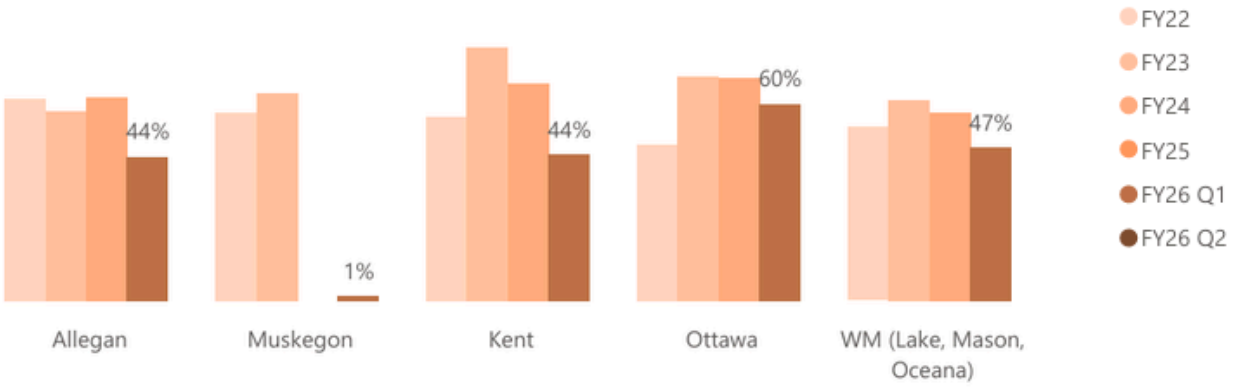
Rates for discharges from detox reported as having "completed treatment" have also improved to 12% during Q2 of FY26.

In the table below, the count has been provided for recent quarters. Because of the small number of cases, use caution when interpreting trends.

Discharges from ST Res and Detox w/ Reason as "Completed Treatment"



Percent of Discharges from ST Res w/ Reason as "Completed Treatment" by CMHSP



	Allegan	Muskegon	Kent	Ottawa	WM (Lake, Mason, Oceana)
FY22	61.5%	57.2%	56.0%	47.4%	52.9%
FY23	57.7%	63.3%	77.4%	68.4%	61.2%
FY24	62.0%	0.0%	66.1%	68.0%	57.4%
FY25	43.9%	1.3%	44.4%	60.0%	46.6%
FY26 Q1	35.3% (6)	0.0% (0)	0.0% (0)	40.0% (6)	83.3% (10)
FY26 Q2	57.1% (4)	0.0% (0)	(0)	36.4% (4)	44.4% (8)

The count is provided in parentheses for rates calculated for a count of 10 or less episodes.

Discharge reason for detox and ST Res should never be "Completed Treatment"

FY26 Q2

Performance Bonus Incentive Program

The Michigan Department of Health and Human Services (MDHHS) sets aside a small portion of funding each year to reward PIHPs for strong performance. To earn this bonus, PIHPs must meet key goals like making sure people get timely follow-ups after emergency visits, improving access to care, addressing racial disparities, and helping people with social needs like housing and employment.

The better the region does on these measures, the more of the bonus they earn.
PBIP metrics relevant to SUD treatment are summarized below.

Metrics

Employment/Education

The state monitors whether a higher % of clients are employed or enrolled in school at discharge compared to admission as an indicator of recovery progress.

↑ % of clients who report they are employed or in school at discharge, compared to admission. (pg 19)

During Q2 Kent, Muskegon and West Michigan achieved an improvement between admission and discharge with a regional relative improvement of 38% (from 13% to 18%).

Living Arrangements

The state monitors whether a higher % of clients report a stable living condition at discharge compared to admission as an indicator of recovery progress.

↑ % of clients who report a stable living condition at discharge, compared to admission. (pg 20)

During Q2, Muskegon, & Kent achieved small improvements. Regionally, rates increased from 61% for admission to 63% at discharge.

Follow Up After Emergency Dept. Visit

The state monitors follow-up after ED Visits for SUD disorder or overdose for Medicaid beneficiaries as a measure of coordination across care settings.

Decrease disparities for the % of emergency department (ED) visits for SUD that receive follow up within 30 days. (FUA 30) (pg 21)

No new data. Will be updated in 3Q report when 2025 CC260 data is released.

Initiation & Engagement in Treatment

The state monitors these metrics to assess initiation and engagement in SUD services for Medicaid beneficiaries following SUD diagnosis at a BH provider or hospital.

Initiation: The % of new treatment episodes who initiate treatment within 14 calendar days of the diagnosis. (pg 22)

No new data. Will be updated in 3Q report when 2025 CC260 data is released.

Engagement: % of new treatment episodes with 2+ services within 34 calendar days of initiation visit. (pg 23)

No new data. Will be updated in 3Q report when 2025 CC260 data is released.

Performance Bonus Incentive

Employment/Education

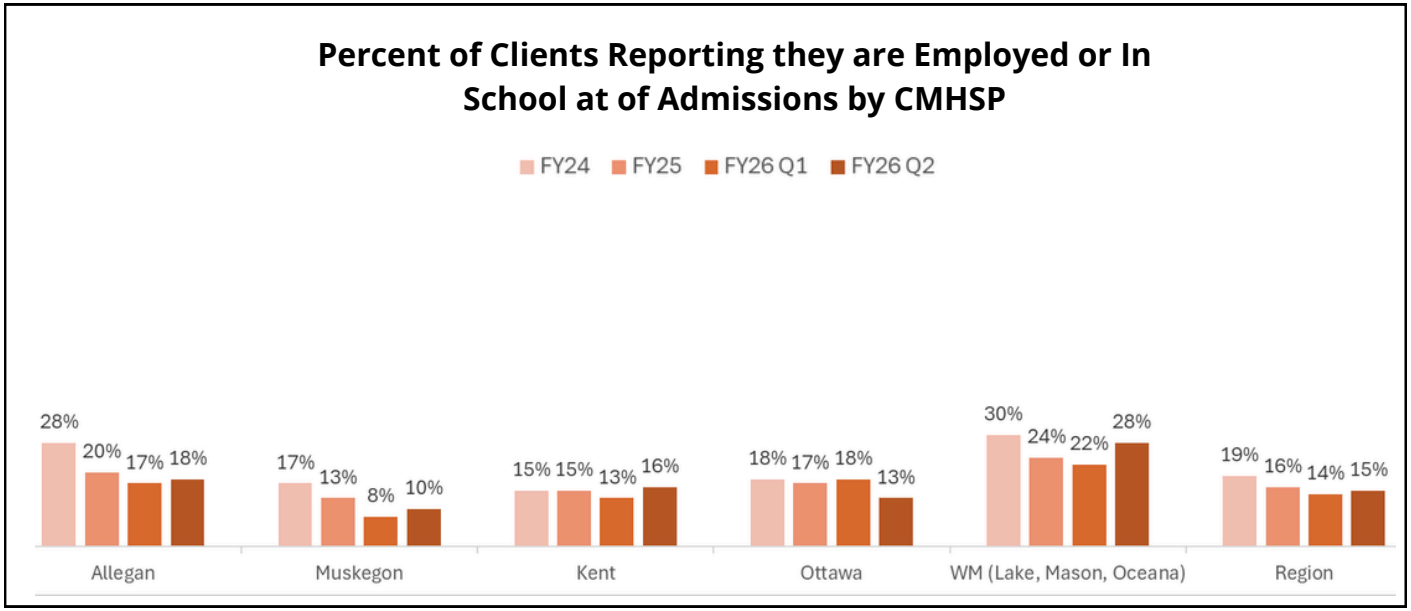
Metric

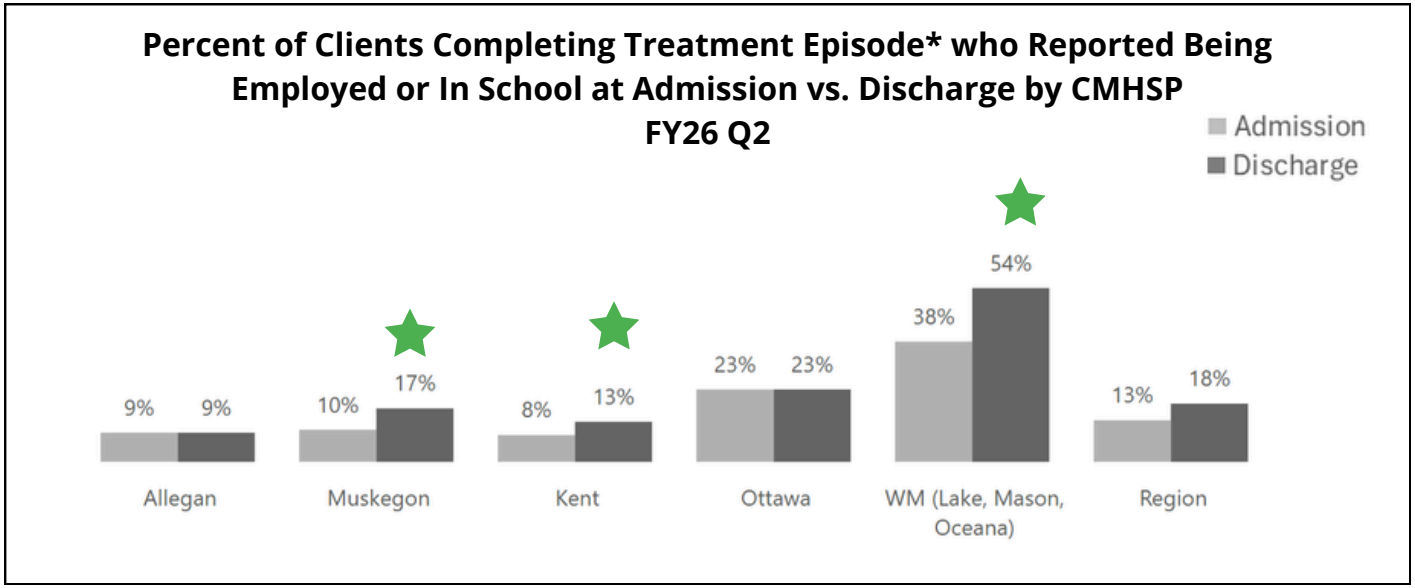
- ↑ % of clients employed or in school between admission & discharge.

Data Highlights:

Among clients who were admitted to services during Q2, the proportion of admissions where clients indicated they were either employed or attending school ranged from a low of 10% in Muskegon and a high of 28% in WM counties. Every county except Ottawa experienced an increase in clients reporting they were employed or in school at admission between Q1 and Q2, with the largest noted increase in WM. Overall, the % of clients reporting they are employed or in school at time of admission are relatively stable compared to FY25 rates for the region and Kent. Allegan, Muskegon and Ottawa experienced a decrease when comparing Q2 rates with FY25.

The graph to the right shows admission and discharge employment/education status for clients who were discharged during Q2 and their corresponding admissions. Muskegon, Kent, and WM reported increases between admission and discharge, resulting in a regional relative improvement of 5%. Allegan and Ottawa had the same percentage of clients who reported being employed or in school at admission and discharge.





**Analysis includes clients who were in services for at least 6 weeks and were discharged as having completed treatment or transferring to another program.*

FY26 Q2

Performance Bonus Incentive

Living Arrangements

Metric

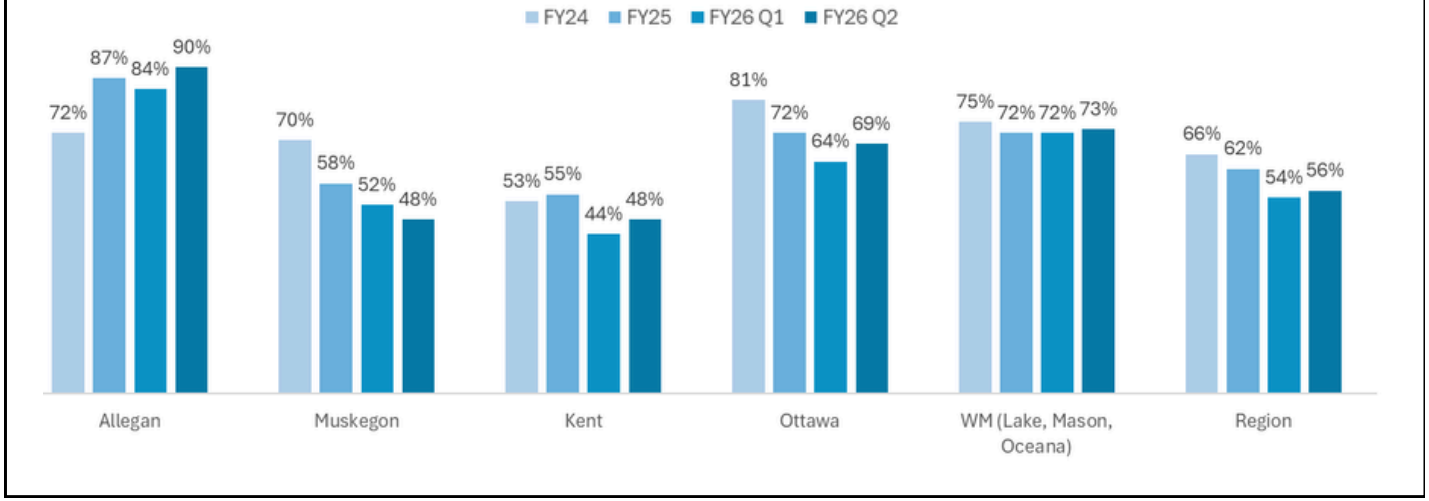
- ↑ % of clients with a stable living condition between admission & discharge.

Data Highlights:

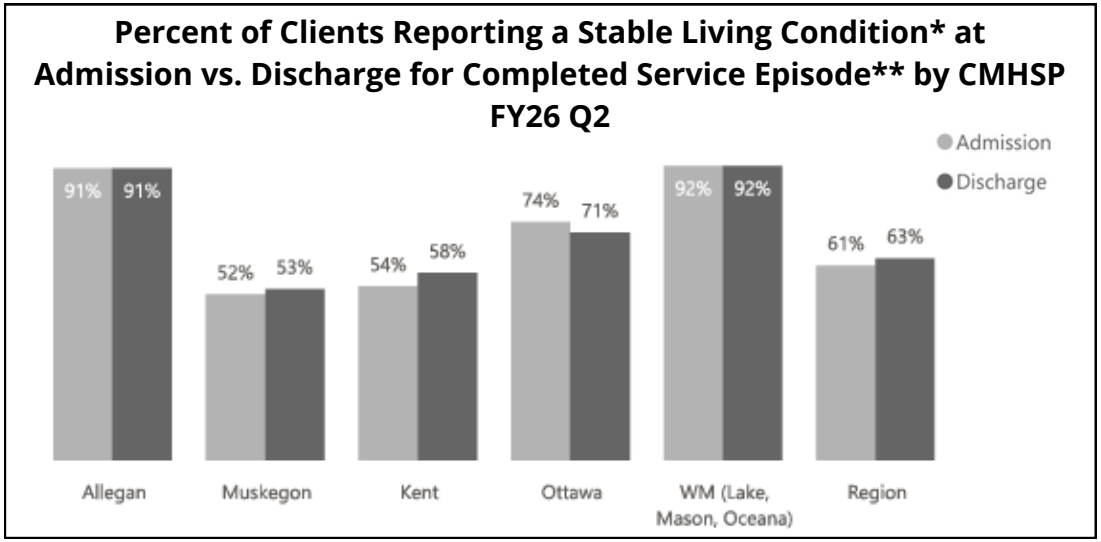
Among clients who were admitted to services during Q2, the proportion of admissions where clients indicated they had a stable living condition varied, with a low of 48% in both Kent and Muskegon and a high of 90% in Allegan. Additionally, the percentage of clients reporting a stable living condition at the time of admission has improved in Allegan compared to FY25, while it has worsened in Kent, Muskegon, and Ottawa Counties. Housing rates have remained stable in WM. As a region, housing stability at admission has decreased since FY25.

The graph to the right shows the percentage of clients discharged from treatment during Q2 who reported a stable living condition at admission compared to at discharge. In Q2, Kent and the region overall experienced a slight increase in clients who reported a stable living condition at admission vs discharge. In contrast Ottawa saw a slight decrease from admission to discharge.

Percent of Admissions for Clients Reporting a Stable Living Condition* by CMHSP



Percent of Clients Reporting a Stable Living Condition* at Admission vs. Discharge for Completed Service Episode by CMHSP FY26 Q2**



**Stable Living is defined as Living Arrangement = Independent*

***Analysis includes clients who were in services for at least 6 weeks and were discharged as having completed treatment or transferring to another program.*

FY26 Q2

Performance Bonus Incentive

Follow Up After ED Visit (FUA)

No New Data

Metric

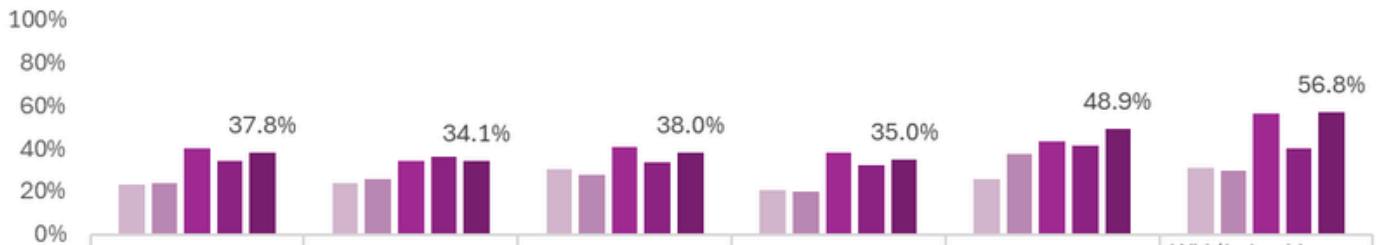
Decrease disparities for the % of emergency department (ED) visits for SUD that receive follow up within 30 days. (FUA 30)

Source: CC360 KPI Summary Dashboard

This PBIP measure tracks the percentage of ED Visits for Medicaid Beneficiaries with an SUD diagnosis recorded that received an SUD service (i.e. medication treatment or visit) within 30 days of the ED Visit w/ SUD diagnosis.

The state is incentivizing a reduction in the disparity between the index population (white beneficiaries) compared to minority groups. To do this, the state monitors the disparity between white beneficiaries and each minority group with a sufficient sample size.

Percent of ED Visits for AOD by Medicaid Beneficiaries that have a follow up service within 30 days of the ED visit (FUA 30)



	Region	Allegan	Muskegon	Kent	Ottawa	WM (Lake, Mason, Oceana)
CY 2020	23.2%	23.9%	30.3%	20.2%	26.0%	31.0%
CY 2021	23.8%	26.0%	27.8%	19.6%	37.3%	29.8%
CY 2022	39.9%	34.1%	40.7%	38.2%	43.4%	56.0%
CY 2023	34.0%	36.1%	33.3%	32.4%	41.4%	40.2%
CY 2024	37.8%	34.1%	38.0%	35.0%	48.9%	56.8%

Note: Data feeds are not available to support local identification of individuals with an ED Visit for SUD to prompt follow-up.

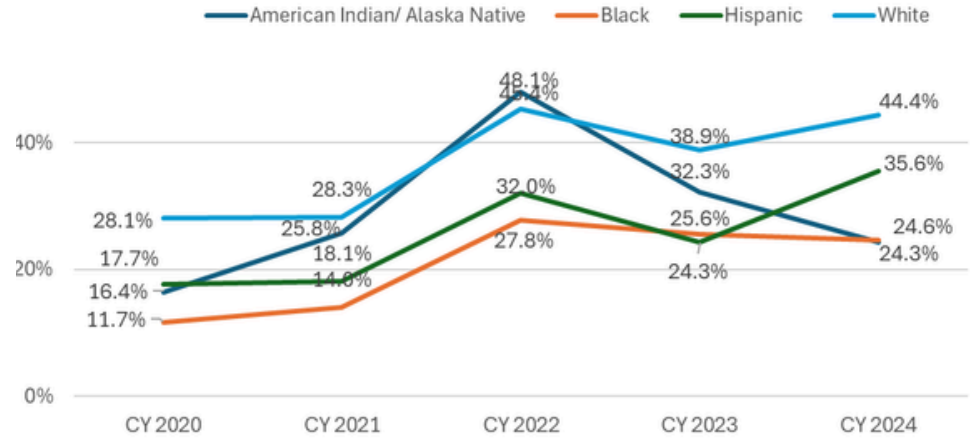
Data Highlights:

Overall, follow-up rates improved slightly between 2023 and 2024 with 4-of-5 CMHSPs seeing an overall increase.

Between 2023 and 2024:

- Rates were highest for white beneficiaries and increased (from 38.9% to 44.4%).
- Rates for Amer. Indian/Alaskan Native beneficiaries worsened (from 32.3% to 24.3%); a 7% pt. disparity in 2023 increased to 20% pts.
- Rates for Black beneficiaries worsened slightly (from 25.6% to 24.6%); a 13% pt. disparity in 2023 worsening to 20% pts. in 2024
- Rates improved for Hispanic beneficiaries (from 24.3% to 35.6%); w/ a 15% pt. disparity in 2023 narrowing to 9% pts. in 2024.

Percent of ED Visits for AOD by Medicaid Beneficiaries that have a follow up service within 30 days of the ED visit (FUA 30)



Data excluded for Asian and Native Hawaiian/Pacific Islander due to sample sizes of <30 in CY2024.

FY26 Q2

Performance Bonus Incentive

Initiation (IET 14)

No New Data

Metrics

- Initiation: The % of new treatment episodes who initiate treatment within 14 calendar days of the diagnosis. (IET 14)

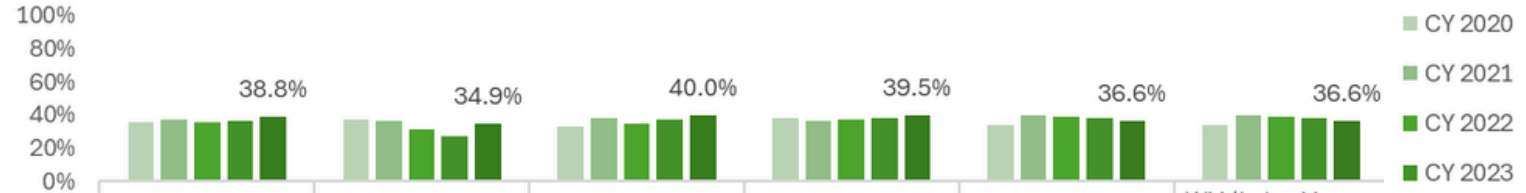
Source: CC360 KPI Summary Dashboard

This PBIP initiation measure tracks the percentage of Medicaid beneficiaries ages 18-64 who received SUD diagnosis (at a behavioral health provider, or at a hospital) and whether they received an SUD service (medication treatment or visit) within 2 weeks of the diagnosis event.

The state is incentivizing overall improvement as well as reduction of disparity between the index population (white beneficiaries) compared to minority groups with a sufficient sample size.

Note: The state benchmark for LRE's overall rate for CY24 is 40%.

Percent of New Treatment Episodes for Adult Medicaid Beneficiaries who Initiate Treatment Within 14 Calendar Days of Diagnosis - By CMHSP



	Region	Allegan	Muskegon	Kent	Ottawa	WM (Lake, Mason, Oceana)
CY 2020	35.2%	37.0%	32.6%	37.8%	33.7%	33.7%
CY 2021	36.9%	36.5%	37.8%	36.7%	40.0%	40.0%
CY 2022	35.8%	31.3%	34.4%	37.2%	39.0%	39.0%
CY 2023	36.7%	27.1%	37.6%	37.8%	37.7%	37.7%
CY 2024	38.8%	34.9%	40.0%	39.5%	36.6%	36.6%

% New Treatment Episodes for Adult Medicaid Beneficiaries who Initiate Treatment W/in 14 Days of Diagnosis

	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
Amer. Ind./ Alaska Native	29.0%	39.4%	28.8%	37.4%	41.7%
Black	32.8%	32.4%	31.9%	34.9%	35.6%
Hispanic	28.6%	32.5%	31.0%	33.7%	33.5%
White	37.1%	38.5%	38.2%	37.8%	40.8%

Data excluded for Asian and Native Hawaiian/Pacific Islander due to sample sizes of <30 in CY24

Data Highlights:

Overall, initiation rates improved slightly between 2023 and 2024 with 3-of-5 CMHSPs seeing an increase.

In CY24, rates of initiation were highest for American Indian/Alaska Native (AA/AN) (41.7%) followed by white (40.8%)beneficiaries, both improving from CY23.

Between 2023 and 2024:

- Rates for Black beneficiaries increased slightly (from 34.9% to 35.6%); a 3% pt. disparity in 2023 increasing to 5.2% pts. in 2024.
- Rates for Hispanic beneficiaries remained stable (from 33.7% to 33.5%); a 4% pt. disparity in 2023 increasing to 7% pts. in 2024.

FY26 Q2

Performance Bonus Incentive

Engagement (IET)

No New Data

Metrics

- Engagement: The % of new treatment episodes with 2+ services within 34 calendar days of the initiation visit. (IET 34)

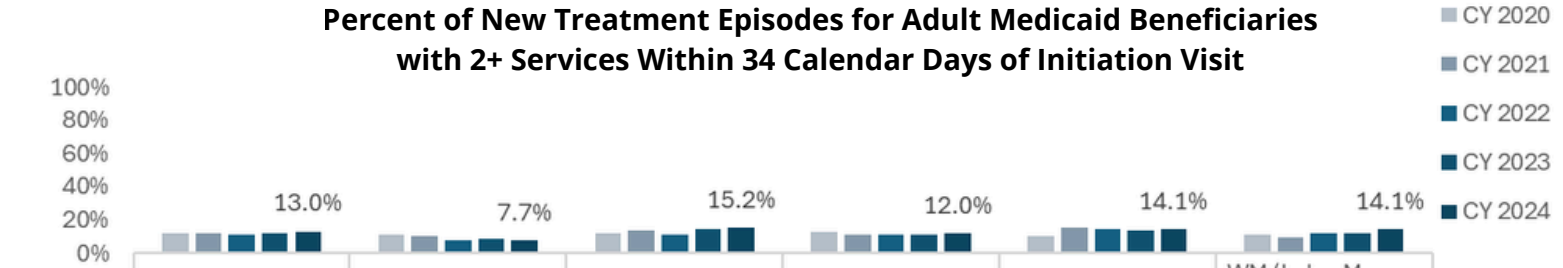
Source: CC360 KPI Summary Dashboard Title

This PBIP engagement measure tracks the percentage of Medicaid beneficiaries ages 18-64 who received SUD diagnosis (at a behavioral health provider or hospital) who received 2+ SUD services (medication treatment or visit) within 34 days of the initiation event.

The state is incentivizing overall improvement as well as a reduction in disparity between the index population (white beneficiaries) compared to minority groups with a sufficient sample size.

Note: The state calculated benchmark for LRE's overall rate for CY24 is 14%

Percent of New Treatment Episodes for Adult Medicaid Beneficiaries with 2+ Services Within 34 Calendar Days of Initiation Visit



	Region	Allegan	Muskegon	Kent	Ottawa	WM (Lake, Mason, Oceana)
CY 2020	11.8%	10.6%	11.7%	12.4%	10.5%	11.1%
CY 2021	12.0%	10.2%	13.5%	11.1%	15.2%	9.6%
CY 2022	11.2%	7.2%	11.2%	10.9%	14.2%	12.1%
CY 2023	12.2%	8.7%	14.8%	11.2%	13.6%	11.5%
CY 2024	13.0%	7.7%	15.2%	12.0%	14.1%	14.1%

Data Highlights:

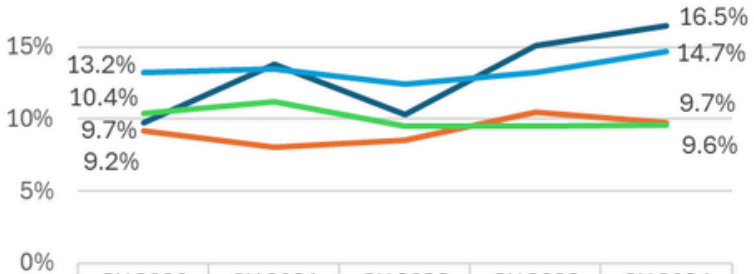
Overall, engagement rates have remained relatively stable with a small increase between 2023 and 2024 to a high of 13.0% for the region.

In CY24 rates of initiation were highest for American Indian/Alaska Native (AA/AN) (16.5%) followed by white (14.7%) beneficiaries, both improving slightly from CY23.

Between 2023 and 2024:

- Rates for Black beneficiaries decreased slightly (from 10.5% to 9.6%), with a 3% pt. disparity in CY23 increasing to 5% pts. in CY24.
- Rates for Hispanic beneficiaries: remained stable (from 9.5% to 9.6%); with a 4% pt. disparity in CY23 increasing to 5% pts. in CY24.

Percent of New Treatment Episodes for Adult Medicaid Beneficiaries with 2+ Services Within 34 Calendar Days of Initiation Visit



	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
Amer. Ind./ Alaska Native	9.7%	13.8%	10.3%	15.1%	16.5%
Black	9.2%	8.0%	8.5%	10.5%	9.7%
Hispanic	10.4%	11.2%	9.5%	9.5%	9.6%
White	13.2%	13.5%	12.4%	13.2%	14.7%

Data excluded for Asian and Native Hawaiian/Pacific Islander due to sample sizes of <30 in CY24

FY26 Q2

Drug Trends

This section provides an overview of trends in primary drug of choice at admission and methamphetamine-involved admissions across the region. These metrics are monitored to help identiFYshifts in substance use patterns over time, which can inform planning, resource allocation, and community awareness efforts. Unlike other indicators in this report, these data points are not currently targeted for performance improvement but are reviewed regularly to support system-level understanding and readiness.

Primary Drug at Admission *pgs 25-27*

At admission, clients can report up to three primary substances. We track the percentage of admissions for each substance to monitor trends and identiFYwhich substances most frequently drive treatment entry in the region.

Methamphetamine-Involved Admissions *pg 28*

Methamphetamine-involved admissions are monitored separately due to underreporting as a primary substance. Clients may list other drugs to secure detox services, leading to meth being underrepresented in data. Tracking overall involvement offers a clearer understanding of meth use in the region.

Opioid & Methamphetamine-Involved Admissions *pg 29*

We monitor admissions involving both opioids and methamphetamine due to unique treatment challenges and risks of co-use. These substances are often used in alternating or combined patterns, which can complicate treatment and increase the risk of relapse or overdose.

CMHSP Drug Trends

Allegan County: Alcohol remains the leading primary drug, followed by methamphetamine (MA). MA-involved admissions remained high (41.7%) and MA-opioid co-use also remained high (13.9%) .

Muskegon County: Alcohol remains the leading primary drug, followed by heroin (18.2%) and methamphetamine (17.7%). MA-involved admissions decreased slightly (28.9%) in Q2. MA-opioid co-use also was 11.7% in Q2.

Kent County: Alcohol remains the leading primary drug, followed by cocaine (18%). MA-involved admissions remained low at 18% in Q2, with MA-opioid co-use also low at 4.1%.

Ottawa County: Alcohol remains the leading primary drug, followed by methamphetamine (13.8%). MA-involved admissions were at 22.6% & MA-opioid co-use remained relatively stable at 6.1%.

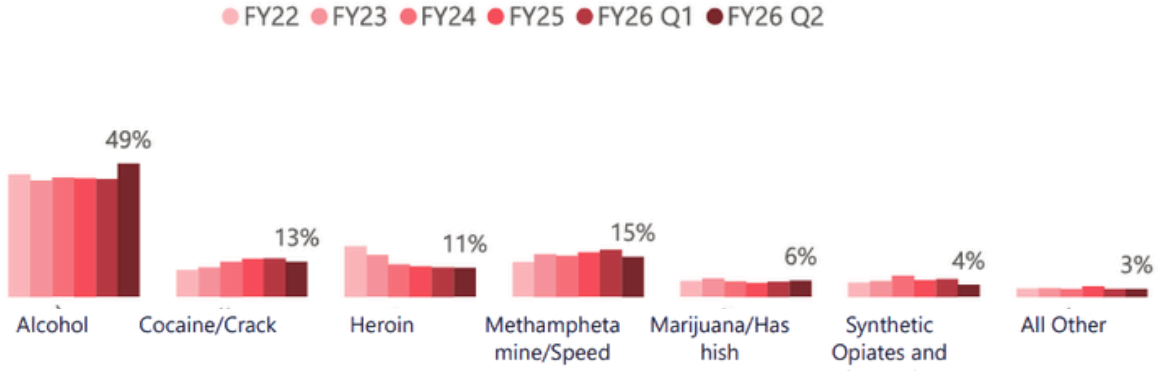
West MI: Alcohol remains the leading primary drug, followed by methamphetamine (21.8%). MA-involved admissions remain high in each county with a notable spike in Mason County (43%). MA-opioid co-use notably high in Mason (19%) in Q2.

Drug Trends: Primary Drug at Admission

LRE Region

Data Highlights: Alcohol remains the most frequently reported primary drug at admission in the LRE region. Admissions for each substance have remained relatively stable.

Percent of Treatment Admissions by Primary Drug, LRE Region

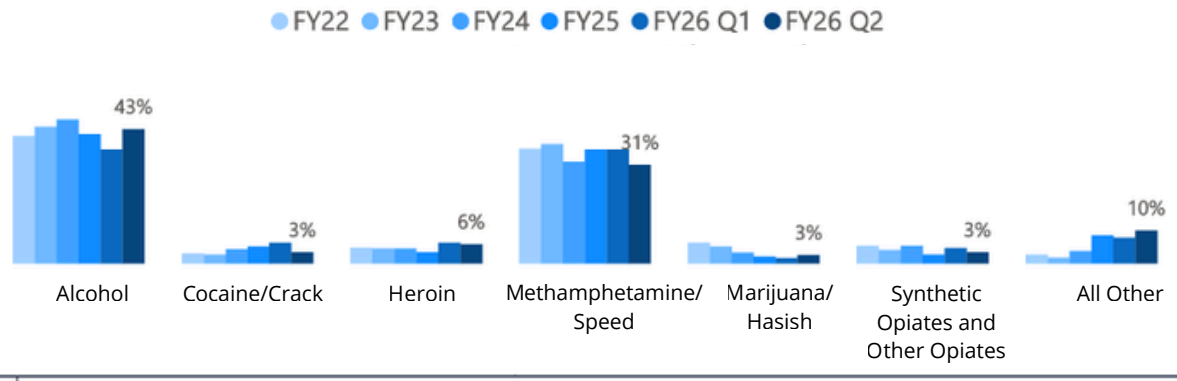


FY22	45.1%	9.7%	18.6%	12.7%	5.7%	5.2%	3.0%
FY23	42.8%	10.6%	15.3%	15.7%	6.7%	5.7%	3.1%
FY24	43.9%	13.0%	12.0%	15.1%	5.6%	7.6%	2.8%
FY25	43.7%	14.0%	11.2%	16.3%	5.1%	6.0%	3.7%
FY26 Q1	43.3%	14.1%	10.8%	17.3%	5.4%	6.4%	2.8%
FY26 Q2	49.1%	12.8%	10.5%	14.7%	5.9%	4.3%	2.8%

Allegan County

Data Highlights: In Allegan County, alcohol is the most frequently reported primary drug of choice followed by methamphetamine which is substantially higher than region-wide (31.3% vs. 14.7% in Q2). Admissions for cocaine decreased in Q2.

Percent of Treatment Admissions by Primary Drug, Allegan County



FY22	40.4%	3.1%	5.0%	36.4%	6.6%	5.6%	2.8%
FY23	43.3%	2.9%	4.7%	37.8%	5.2%	4.2%	1.8%
FY24	45.7%	4.5%	4.7%	32.3%	3.3%	5.6%	3.9%
FY25	41.1%	5.4%	3.5%	36.1%	2.2%	2.8%	8.9%
FY26 Q1	36.1%	6.6%	6.6%	36.1%	1.6%	4.9%	8.2%
FY26 Q2	42.6%	3.5%	6.1%	31.3%	2.6%	3.5%	10.4%

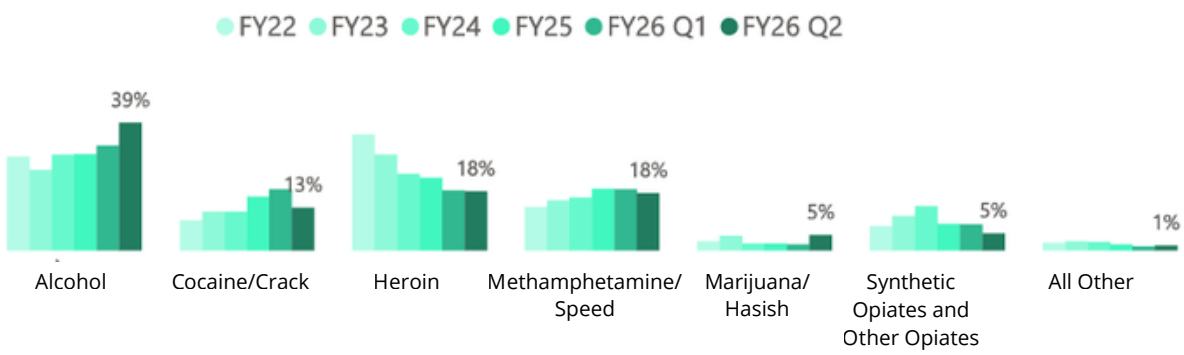
FY26 Q2

Drug Trends: Primary Drug at Admission, continued...

Muskegon County

Data Highlights: Alcohol continues to be the most frequently reported primary drug in Muskegon County, followed by methamphetamine and heroin. Admissions for heroin (18.2% vs 10.5% in Q2) and methamphetamine (17.7% vs 14.7% in Q2) remain higher than region wide.

Muskegon County - Percent of Admissions by Primary Drug

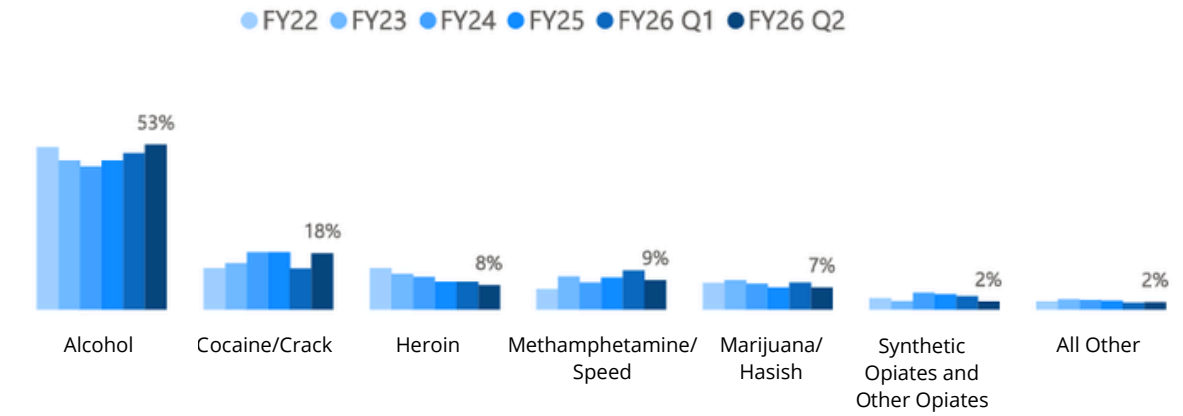


FY22	29.1%	9.3%	35.8%	13.4%	2.7%	7.4%	2.3%
FY23	24.9%	12.0%	29.7%	15.5%	4.5%	10.7%	2.7%
FY24	29.7%	12.0%	23.7%	16.3%	2.1%	13.7%	2.5%
FY25	29.8%	16.6%	22.4%	19.0%	2.0%	8.1%	1.9%
FY26 Q1	32.5%	18.9%	18.6%	18.9%	1.9%	8.0%	1.2%
FY26 Q2	39.4%	13.2%	18.2%	17.7%	4.7%	5.2%	1.5%

Kent County

Data Highlights: In Kent County, admissions for alcohol continue to surpass other substances with 52.9% of admissions, followed by cocaine, which is higher than the region wide (18% vs 12.8%).

Kent County - Percent of Admissions by Primary Drug



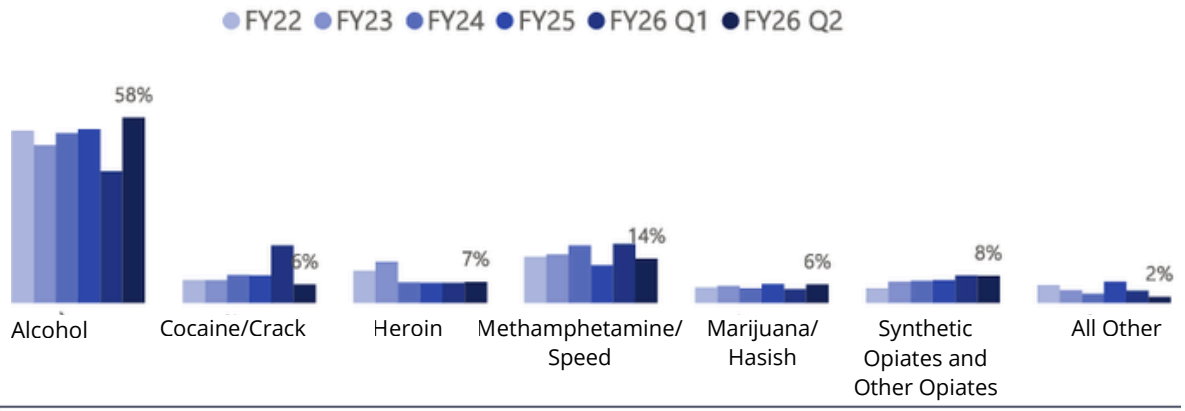
FY22	52.1%	13.3%	13.4%	6.5%	8.5%	3.7%	2.5%
FY23	47.8%	14.9%	11.4%	10.7%	9.4%	2.6%	3.2%
FY24	45.8%	18.4%	10.4%	8.6%	8.3%	5.5%	3.0%
FY25	47.7%	18.4%	8.9%	10.2%	7.0%	4.9%	2.8%
FY26 Q1	50.1%	13.2%	8.9%	12.6%	8.7%	4.3%	2.2%
FY26 Q2	52.9%	18.0%	7.8%	9.4%	7.0%	2.5%	2.3%

FY26 Q2

Drug Trends: Primary Drug at Admission, conti...

Ottawa County

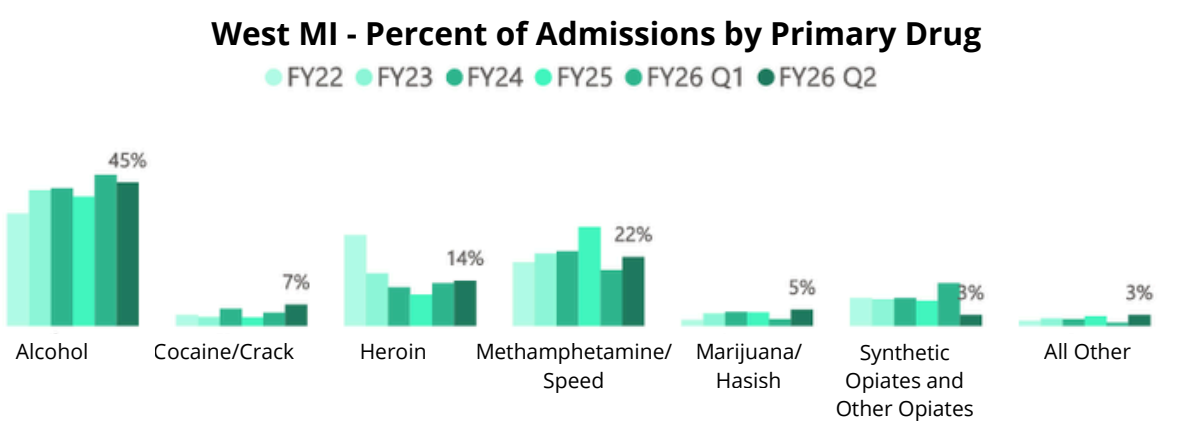
Data Highlights: In Ottawa County, alcohol remains the most frequently reported primary drug, representing 58% of admissions in Q2. Admissions for cocaine decreased from the high of 17.9% in Q1 to 5.7% during Q2. The rate of admissions for synthetic opiates and other opiates is higher than region wide (8.4% vs 4.3% in Q2).



FY22	53.7%	7.1%	10.0%	14.4%	4.8%	4.5%	5.6%
FY23	49.2%	7.1%	12.8%	15.1%	5.2%	6.5%	4.0%
FY24	53.0%	8.6%	6.4%	17.9%	4.4%	6.8%	2.8%
FY25	54.2%	8.5%	6.1%	11.8%	5.8%	7.0%	6.6%
FY26 Q1	41.0%	17.9%	6.1%	18.4%	4.2%	8.5%	3.8%
FY26 Q2	57.9%	5.7%	6.5%	13.8%	5.7%	8.4%	1.9%

West Michigan Counties

Data Highlights: In West MI counties, alcohol remains the most frequently reported primary drug representing 45% of admissions in Q2, followed by methamphetamine at 22%. Admissions for heroin (14.3% vs 10.5% for LRE Region in Q2) and methamphetamine (21.8% vs 14.7% for LRE Region in Q2) were higher than region wide.



FY22	35.5%	3.4%	28.9%	20.2%	1.9%	8.7%	1.5%
FY23	43.0%	2.9%	16.6%	23.0%	3.9%	8.4%	2.3%
FY24	43.6%	5.3%	12.1%	23.7%	4.4%	8.7%	2.1%
FY25	40.8%	2.6%	9.9%	31.3%	4.2%	7.9%	3.1%
FY26 Q1	47.9%	4.2%	13.5%	17.7%	2.1%	13.5%	1.0%
FY26 Q2	45.4%	6.7%	14.3%	21.8%	5.0%	3.4%	3.4%

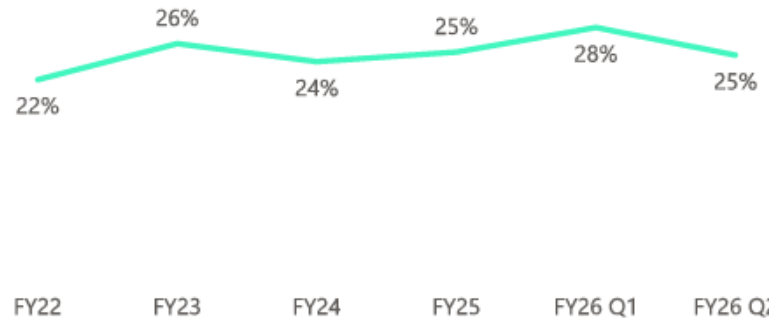
FY26 Q2

Drug Trends: Methamphetamine-Involved Admissions

Methamphetamine-involved admissions are monitored separately due to underreporting as a primary substance. Clients may list other drugs to secure detox services, leading to meth being underrepresented in data. Tracking overall involvement offers a clearer understanding of MA use in the region.

"Involved"
An admission with the substance reported as the primary, secondary, or tertiary drug of choice.

Percent of Admissions that were Methamphetamine (MA)-Involved, LRE Region

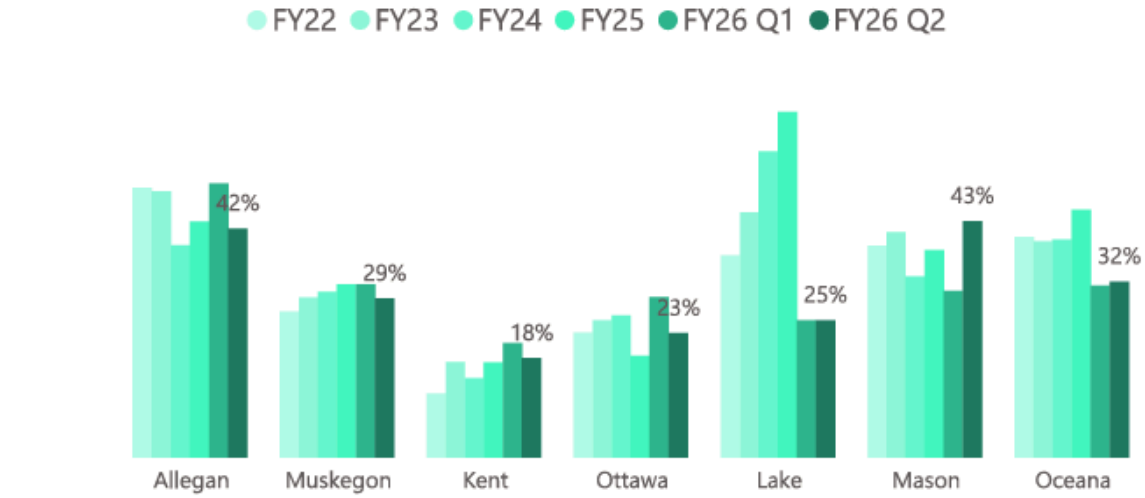


Data Highlights:

In FY25, 25% of admissions were MA-involved which remained steady at 25% during Q2 of FY26 following a slight increase in Q1.

During Q2, MA-involved admissions remain highest in Allegan (41.7%), Mason (43.1%) and Oceana (32%) counties. Lake County has seen a large decrease in treatment admissions that were MA-involved from 63.1% of admissions in FY25 to 25.0% in Q2 of FY26.

Percent of Admissions That Were MA-Involved by County



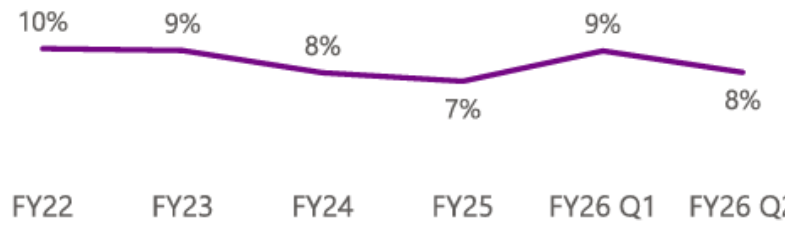
	Allegan	Muskegon	Kent	Ottawa	Lake	Mason	Oceana
FY22	49.2%	26.6%	11.6%	22.7%	36.8%	38.6%	40.2%
FY23	48.6%	29.2%	17.4%	25.0%	44.7%	41.1%	39.4%
FY24	38.7%	30.2%	14.4%	25.8%	55.8%	32.9%	39.7%
FY25	43.0%	31.5%	17.3%	18.5%	63.1%	37.8%	45.2%
FY26 Q1	50.0%	31.6%	20.8%	29.2%	25.0%	30.4%	31.3%
FY26 Q2	41.7%	28.9%	18.0%	22.6%	25.0%	43.1%	32.1%

FY26 Q2

Drug Trends: Opioid & Methamphetamine-Involved

Admissions involving both opioids and methamphetamine are monitored due to the unique clinical challenges they pose. Research indicates that individuals using both substances have lower treatment retention and completion rates compared to those using opioids alone. In addition, the alternating or combined use of these drugs complicates withdrawal management and raises overdose risks.

Percent of Admissions that Involved Both Methamphetamine (MA) and an Opioid, LRE Region

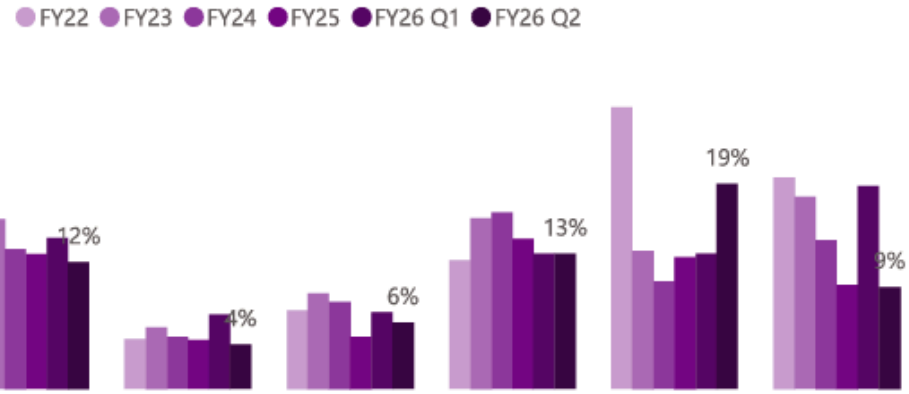


Data Highlights:

Admissions involving both an opioid and methamphetamine have remained relatively stable since FY24, with a rate of 8% in Q2.

Admissions involving both an opioid and methamphetamine increased substantially in Q2 for Allegan (13.9%) and Mason (19%) counties. Rates in Oceana spiked during Q1, but returned to the same rate as FY25 during Q2. Rates remain stable in Muskegon, Kent, Ottawa, and Lake counties.

Percent of Admissions that Involved Both an Opioid & MA by County



	Allegan	Muskegon	Kent	Ottawa	Lake	Mason	Oceana
FY22	10.3%	15.0%	4.6%	7.3%	11.8%	26.1%	19.5%
FY23	7.1%	15.7%	5.7%	8.8%	15.8%	12.8%	17.7%
FY24	4.2%	12.9%	4.8%	8.1%	16.3%	9.9%	13.8%
FY25	6.5%	12.4%	4.5%	4.8%	13.8%	12.2%	9.6%
FY26 Q1	11.5%	13.9%	6.9%	7.1%	12.5%	12.5%	18.8%
FY26 Q2	13.9%	11.7%	4.1%	6.1%	12.5%	19.0%	9.4%

Appendix Data Parameters

The following provides data parameters used for analysis for data referenced throughout this report. For all data that includes County, County = If no data provided in BHTEDS - falls under 'Out of Region'

Pg. 6 **Average Time to Service (days) for Medication Assisted Treatment (MAT)**

- BHTEDS Fields Used: Service Start Date, County of Residence, Time to Treatment, State Provider Identifier, Type of Treatment Service Setting and Medication-assisted Opioid Therapy
- Time to Service = Days between request for service and date of first service received.
- MAT is based on Admission Opioid Therapy = Yes and LOC = Outpatient
- Excludes those Admissions where Time to Treatment was not provided

Pg. 7 **Average Time to Services for Clients with IVDU by Service Category**

- BHTEDS Fields Used: Service Start Date, County of Residence, Time to Treatment, Type of Treatment Service Setting, Primary and Secondary and Tertiary Route of Admission, Substance Use Diagnosis
- Time to Service = Days between request for service and date of first service received.
- IVDU = Primary, Secondary or Tertiary Route of Admission =Injection
- Excludes those Admissions where Time to Treatment was not provided.

Pg. 10 **Percent of Admissions by Legal Status at Admission**

- BHTEDS Fields Used: Service Start Date, County of Residence, Corrections Related Status

Pg. 12 **Percent of Clients with Co-Occurring Disorders that Received Integrated Treatment**

- BHTEDS Fields Used: Service Update/End Date, County of Residence, Co-occurring Disorder/Integrated Substance Use and Mental Health Treatment
- Integrated services identified in discharge record for clients reports as "Client with co-occurring substance use and mental health problems is being treated with an integrated treatment plan by an integrated team."
- Only includes those episodes with a Discharge Date

Pg. 13 **Percent of Treatment Episodes with One Encounter**

- Data Source: BHTEDS and LRE Encounters
- Data only includes those episodes with a Discharge Date
- Data only includes those with a Service in the Encounter Database
- Excluded Services Codes: H0020 (Methadone Dosing) and S9976 (Room and Board)
- Excludes episodes where the only service code is H0001 and has a Discharge Reason of Completed Treatment, Death or Transferring to Another Program
- Program or facility/Completed Level of Care
- MAT is based on BHTEDS Admission Opioid Therapy= Yes and LOC = Outpatient

Appendix Data Parameters Continued...

Pgs. 10-11 **Percent of Treatment Episodes with One Encounter by Level of Care**

- Data Source: BHTEDS and LRE Encounters
- Data only includes those episodes with a Discharge Date
- Data only includes those with a Service in the Encounter Database
- Excluded Services Codes: H0020 (Methadone Dosing) and S9976 (Room and Board)
- Excludes episodes where the only service code is H0001 and has a Discharge Reason of Completed Treatment, Death or Transferring to Another Program or facility/Completed Level of Care
- MAT is based on BHTEDS Admission Opioid Therapy = Yes and LOC = Outpatient

Pg. 16 **Percent of Discharges from ST Res Admitted to Next Treatment Episode w/in 7 days**

- BHTEDS Fields Used: Service Start Date, Service Update/End Date, County of Residence, and Type of Treatment Service Setting
- If Admit Setting did not equal Discharge Setting, assumption made that readmit days is 0.
- Only includes those episodes with a Discharge Date
- Excludes discharges from ST Res that were admitted to 24-hour detox.

Pg. 16 **Average # Days between Discharge from ST Res and Admission to Next Level of Care**

- BHTEDS Fields Used: Service Start Date, Service Update/End Date, County of Residence, and Type of Treatment Service Setting
- Only includes those episodes with a Discharge Date in the Reported FY
- Only includes those episodes with a Readmit within 30 days of Discharge
- Excludes those Readmits with a new Admission Date that is prior to the Discharge Date
- If Admit Setting did not equal Discharge Setting, assumption made that readmit days is 0

Pg. 17 **Discharges from Detox & ST Res w/ Reason as "Completed Treatment"**

- BHTEDS Fields Used: Service Update/End Date, County of Residence, Reason for Service Update/End and Type of Treatment Service Setting at Discharge
- Detox Includes both Ambulatory - Detox and Detox 24-hr free-standing residential
- Excludes those Discharges where Time to Treatment was not provided.

Pg. 19 **Percent of Treatment Admissions reporting Employed or In-School**

- BHTEDS Fields Used: County of Residence, Employment Status, Detailed Not in the Competitive, Integrated Labor Force, and Service Start Date
- Includes: Employment status identified as "Part-Time Competitive, Integrated Employment" or "Full-Time Competitive, Integrated Employment" and individuals identified as a "Student" in Detail for Not in Competitive, Integrated Labor Force

Appendix Data Parameters Continued...

Pg. 20 **Percent of Treatment Admissions reporting Stable Living Condition**

- BHTEDS Fields Used: County of Residence, Living Arrangement, and Service Start Date
- Stable Living is defined as Living Arrangement = Independent

Pg. 20 **Percent of Clients Reporting a Stable Living Condition at Admission vs. Discharge**

- BHTEDS Fields Used: Service Update/End Date, Reason for Service Update/End, Living Arrangement, and Service Start Date
- Only includes Discharges with the Discharge Reason = Treatment Completed and Transferred to Another Program or Facility/Completed Level of Care.
- Only includes Episodes discharged that had a minimum of 6 weeks of Service (42 days or more).
- Stable Living is defined as Living Arrangement = Independent

Pg. 21 **Percent of ED Visits for AOD by Medicaid Beneficiaries that have a follow up service within 30 days of the ED visit (FUA 30)**

- Source: CC360 Multiple Measures Client Level Detail Extracts
- Denominator: Number of ED visits ((ED Value Set), with a principal diagnosis of SUD (AOD Abuse and Dependence Value Set) or any diagnosis of drug overdose (Unintentional Drug Overdose Value Set) on or between January 1 and December 1 of the measurement year where the beneficiary was age 18 or older on the date of the visit. If a beneficiary has more than one ED visit, all eligible ED visits are counted in the denominator.
- Exclusions: ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or non-acute inpatient care setting on the date of the ED visit or within 30 days after. Members in hospice or receiving hospice services anytime during the measurement period excluded.
- Numerator: A follow-up visit or pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

Pg. 22 **Percent of New Treatment Episodes for Medicaid Beneficiaries who Initiate Treatment Within 14 Calendar Days of Diagnosis**

- Source: CC360 Multiple Measures Client Level Detail Extracts
- Denominator: Eligible population with a new episode of SUD during the intake period. Number of beneficiaries, ages 18-64 as of the last day of the measurement period, with a diagnosis for alcohol or opioid use or dependence or other substance use disorder, who had continuous enrollment during reporting period.
  - Continuous enrollment defined as 194 days prior to index episode thru 47 days after episode date for total of 242 days.
  - SUD diagnosis may have occurred during a hospital stay or short-term hospital monitoring, or in SUD services including (OP, IOP, and Residential).
  - Exclusions:
    - Dual-enrolled Medicare/Medicaid and spenddown beneficiaries are not included in the denominator.
    - Beneficiaries who do not meet continuous enrollment requirement or who died during the measurement period.
- Numerator: Number of new and recurring (no SUD treatment in past 6 months) episodes of SUD who received the first medication or treatment or visit within 2 weeks (14 days) of a new/recurring SUD diagnosis. Note: If the 1st SUD encounter with initial diagnosis is an inpatient stay or is a monthly-billed opioid treatment service, the standard is considered met.

Data Parameters Continued...

Pg. 23 **Percent of New Treatment Episodes for Adult Medicaid Beneficiaries with 2+ Services Within 34 Calendar Days of Initiation Visit**

- Source: CC360 Multiple Measures Client Level Detail Extracts
- Denominator: Eligible population with a new episode of SUD during the intake period. Number of beneficiaries, ages 18-64 as of the last day of the measurement period, with a diagnosis for alcohol or opioid use or dependence or other substance use disorder, who had continuous enrollment during reporting period.
  - Continuous enrollment defined as 194 days prior to index episode thru 47 days after episode date for total of 242 days.
  - SUD diagnosis may have occurred during a hospital stay or short-term hospital monitoring, or in SUD services including (OP, IOP, and Residential).
  - Exclusions:
    - Dual-enrolled Medicare/Medicaid and spenddown beneficiaries are not included in the denominator.
    - Beneficiaries who do not meet continuous enrollment requirement or who died during the measurement period.
- Numerator: Number of new and recurring (no SUD treatment in past 6 months) episodes where the beneficiary received 2 additional treatment/visits within 34 days following the initiation visit. Note: If the 1st SUD encounter with initiation visit is an inpatient stay or is a monthly-billed opioid treatment service, the standard is considered met.

Pgs. 25-27 **Percent of Treatment Admissions by Primary Drug**

- BHTEDS Fields Used: County of Residence, Service Start Date, Primary, Secondary and Tertiary Substance Use Problem

Pg. 28 **Percent of Admissions that were Methamphetamine (MA)-involved**

- BHTEDS Fields Used: County of Residence, Service Start Date
- Primary, Secondary and Tertiary Substance Use Problem
- Involved includes admission with MA/Speed identified as primary, secondary or tertiary drug of choice.
- Primary includes admission with MA/Speed identified as the primary drug of choice.
- Non-Primary includes admission with MA/Speed identified as secondary or tertiary drug of choice.

Pg. 29 **Percent of Admissions that Involved Both an Opioid & MA by County**

- BHTEDS Fields Used: Service Start Date, County of Residence, Primary, Secondary and Tertiary Substance Use Problem
- Includes all Admissions with Both Methamphetamine/Speed and an Opioid (Heroin, Methadone, Synthetic Opioid) identified within Primary, Secondary or Tertiary Drug of Choice response.

Lakeshore Regional Entity's Legislative Update – 5/15/2025

This document contains a summary and status of bills in the House and Senate, and other political and noteworthy happenings that pertain to both mental and behavioral health, and substance use disorder in Michigan and the United States.

Prepared by Melanie Misiuk, SEDW & 1915(i)SPA Specialist & Stephanie VanDerKooi, Chief Operating Officer

Highlight = new updates
Highlight = old bill, no longer active
Highlight = Suggestions for Action & Supported/Opposed by CMHAM (Community Mental Health Association of Michigan) and/or the LRE
Highlight = Artificial Intelligence – New Section

STATE LEGISLATION

BILLS & REGULATIONS PERTAINING TO MENTAL HEALTH				
Priority	**BILL #**	**SUMMARY**	**SPONSOR**	**ACTION DATE**
	HB 4032	Removes interstate medical licensure compact sunset (LARA Lead)	Rylee Lynting	1/28/25: Introduced, Referred to Committee on Health Policy 2/26/25: Referred to a second reading 3/5/25: Placed on a third reading, read a third time, passed 3/12/25: Passed by House with Immediate Effect, Referred to Committee on Health Policy
	HB 4037 & 4038	Establishes certain requirements to operate a health data utility (DHHS Lead)	Julie Rogers Curtie VanderWall	1/29/25: Introduced, Read, referred to the Committee on Health Policy 5/21/25: Referred to a second reading
	HB 4095	Requires insurance providers to panel mental health provider within a certain time period of application process (DIFS Lead)	Noah Arbit	2/20/25: Introduced, Read a first time, referred to Committee on Insurance
	SB 3-5	Creates prescription drug cost and affordability review act, and requires compliance (DIFS/DHHS/LEGAL)	Darrin Camilleri	1/8/25: Introduced, Referred to Committee on Finance, Insurance, and Consumer Protection 4/24/2025 – Referred to Committee of the Whole with substitute, placed on order of third reading, placed on immediate passage, amendments adopted, passed roll call, received in House, read a

BILLS & REGULATIONS PERTAINING TO MENTAL HEALTH				
Priority	**BILL #**	**SUMMARY**	**SPONSOR**	**ACTION DATE**
				first time, referred to Committee on Government Operations
	SB 18	Provides conditions on the use of certain federal benefits, including disability benefits, for a child in foster care. (DHHS/LEGAL)	Jeff Irwin	1/22/25: Introduced, Referred to the Committee on Housing and Human Services 3/20/25: Reported favorably without amendment, Referred to Committee of the Whole 4/16/2025: Reported by Committee of the Whole favorably without amendment, placed on order of third reading. 4/17/2025: Passed roll call, received in House, read a first time, referred to Committee on Families and Veterans
	SB 111	The bills would enhance protections against financial exploitation, abuse, and neglect of vulnerable adults. Specifically, they would create a process for certain elder and vulnerable adults to petition a circuit court to enter an elder and vulnerable adult personal protection order (PPO). They also would allow a county or region to create a vulnerable adult multidisciplinary team (team) that would work within that area to protect against and bring awareness to vulnerable adult abuse, neglect, and financial exploitation.	Jeff Irwin	2/27/25: Introduced, Referred to the Committee on Civil Rights, Judiciary, and Public Safety 3/18/25: Reported Favorably Without Amendment, Referred to the Committee of the Whole, Rules suspended for immediate consideration, reported by Committee of the Whole favorably without amendment, placed on order of Third Reading 4/16/2025: Passed roll call, received in House, read a first time, referred to Committee on Judiciary
	HB 4218 SB 142	These bills would make changes to the state recipient rights advisory committee to explicitly include a representative from Disability Rights Michigan, the Mental Health Association in Michigan, and the Arc Michigan.	Rep - Jamie Thompson Sen – Michael Webber	3/12/25: Introduced, read a first time, referred to the Committee on Health Policy (4218) 3/12/25: Introduced, Referred to the Committee on Housing and Human Services (142) 6/4/25: Referred to a second reading 7/24/25: Read a second time, placed on a third reading 9/4/25: Read a third time, passed House 9/9/25: Referred to Senate Committee on Housing and Human Services

BILLS & REGULATIONS PERTAINING TO MENTAL HEALTH				
Priority	**BILL #**	**SUMMARY**	**SPONSOR**	**ACTION DATE**
	HB 4219 SB 143	These bills would require that patient's rights during mental health treatment, including the objection to treatment, must be communicated orally and in writing to the patient.	Rep - Jamie Thompson Sen – Rick Outman	3/12/25: Introduced, read a first time, referred to the Committee on Health Policy (4219) 3/12/25: Introduced, Referred to the Committee on Housing and Human Services (143) 6/4/25: Referred to a second reading 7/24/25: Read a second time, placed on a third reading 8/19/25: Read a third time 9/4/25: Read a third time, passed House 9/9/25: Referred to Senate Committee on Housing and Human Services
	SB 129	This bill would amend the Open Meetings Act to allow an appointed member of a public body who has a disability to fully participate in a meeting remotely upon request. The bill would not apply to a member of a public body who was elected by electors to serve.	Sean McCann	3/6/25: Introduced, Referred to the Committee on Civil Rights, Judiciary, and Public Safety 3/18/25: Reported favorably without amendment, referred to the Committee of the Whole 4/16/2025: Reported by the Committee of the Whole favorable without Amendment, placed on order of third reading 4/17/2025: Passed Roll Call, received in the House, read a first time, referred to Committee on Government Operations
	HB 4530	A bill to modify the deadline for mental health professionals to release mental health records or information pertinent to child abuse or neglect investigation to the department.	Laurie Pothusky	6/3/2025: Introduced, read a first time, referred to Committee on Families and Veterans *10/28/2025: Committee Hearing in House* 12/9/25: Referred to a second Reading
	HB 4535	Modifies eligibility for mental health court.	Kara Hope	6/3/2025: Introduced, read a first time, referred to Committee on Judiciary *10/28/2025: Committee Hearing in House*
	SB 221	A bill to provide for outpatient treatment for misdemeanor offenders with mental health issues	Sylvia Santana	4/17/2025: Introduced, referred to committee on Health Policy

BILLS & REGULATIONS PERTAINING TO MENTAL HEALTH				
Priority	**BILL #**	**SUMMARY**	**SPONSOR**	**ACTION DATE**
				5/8/2025: Reported favorably without amendment, referred to Committee of the Whole 5/20/2025: Referred to Committee of the Whole 5/21/2025: passed roll call, received in House, read a first time, referred to Committee on Health Policy
	SB 334	Police Training; Requires mental health and law enforcement response training for law enforcement officers.	Jeff Irwin	5/29/2025: Introduced, Referred to the Committee on Civil Rights, Judiciary, and Public Safety 9/9/2025: Referred to Committee of the Whole with Substitute
	HB 4676	A bill to amend Chapter 6 (Guardianship for the Developmentally Disabled) of the Mental Health Code to require courts to consider alternatives to appointing a guardian for an individual with a developmental disability who the court has determined is likely to need protection based on factors set forth in Chapter 6.	Sharon MacDonell	6/25/25: Introduced, Read a first time, referred to the Committee on Families and Veterans 8/13/25: Referred to a Second Reading 9/10/25: Read a second time
	HCR 1	**Adverse Childhood Experiences:** A concurrent resolution to urge the Governor of Michigan to issue an executive directive that would require administrating agencies to assess if the implementation of their programs reduce Adverse Childhood Experiences (ACEs) and provide an annual report and data to the Legislature and general public about progress in reducing ACEs in Michigan.	Douglas Wozniak	8/19/2025 – Introduced, Referred to the Committee on Families and Veterans 10/28/2025 – Committee Hearing, Reported with Recommendation without amendment
	HB 5334	A bill to amend the Mental Health Code to require assessment by preadmission screening unit of individual being considered for hospitalization within certain period after notification	Matt Bierlein	12/2/2025 – Introduced, read a first time, referred to the Committee on Health Policy
	HB 4968	*The bill would amend the Insurance Provider Assessment Act to allow the Department of Health and Human Services (DHHS) to continue assessing the current, federally-approved insurance provider assessment unless the Federal Centers for Medicare and Medicaid Services (CMS) ended the current Federal approval.*	*Greg VanWoerkem*	*9/16/2025 – Introduced, read a first time, referred to the Committee on Appropriations* *9/25/2025 – Read a second time, third time,* *9/29/2025 – Passed the House, Sent to Senate Referred to Committee of the Whole,* *10/2/2025 - Placed on Immediate Passage, returned to House* *10/7/2025 – Approved by the Governor. Assigned PA 25'25 with Immediate Effect*

BILLS & REGULATIONS PERTAINING TO MENTAL HEALTH				
Priority	**BILL #**	**SUMMARY**	**SPONSOR**	**ACTION DATE**
	HB 5044	By July 1, 2026, every school district, intermediate school district, and public-school academy board must develop and adopt a policy allowing students with a prescription, recommendation, or order from a private health care specialist to receive medically necessary treatment while at school, in compliance with state and federal laws Upon request, designated school personnel must meet with the student, family, and health care representatives within 30 days to determine how and when treatment will be provided. Treatment must be allowed unless it imposes a fundamental alteration or undue burden on the school.	Pauline Wendzel	9/24/2025 – Introduced, Read a first time, referred to the Committee on Education and Workforce
	HB 4412-4414	House Bill 4412 would amend the Mental Health Code to revise procedures related to assisted outpatient treatment and involuntary mental health treatment. House Bill 4413 would amend the Mental Health Code to revise procedures related to mediation for disputes involving community mental health services and to update requirements for hospital examinations when an individual is presented for evaluation. House Bill 4414 would amend the Mental Health Code by adding a new Chapter 10A to establish procedures for diverting certain misdemeanor defendants to assisted outpatient treatment.	Donni Steele Mark A Tisdel Tom Kuhn	5/1/25 – Introduced, Read a first time, referred to Committee on Health Policy 1/21/26 – Read a second time 3/10/26 – Placed on a third reading 3/18/26 – Read a third time, passed; given immediate effect 3/24/26 – Sent to Senate, Referred to Committee on Health Policy
	SB 973	A bill to provide for the establishment of a state-based health insurance exchange as a nonprofit corporation; to create the board of exchange and prescribe its powers and duties; to provide for assessments and user fees; and to provide for the powers and duties of certain state and local governmental officers and agencies	Kevin Hertel	5/14/26 – Introduced, Referred to Committee on Health Policy

BILLS & REGULATIONS PERTAINING TO SUD				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
	SB 68	A bill to amend 1998 PA 58 to prohibit displaying co-branded alcoholic beverages adjacent to certain products.	Dayna Polehanki	2/5/25: Introduced, Referred to the Committee on Regulatory Affairs 2/26/25: Reported favorable without amendment, Referred to Committee of the Whole 3/6/25: Reported by Committee of the Whole favorable with amendments, placed on order of third reading

BILLS & REGULATIONS PERTAINING TO SUD				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
				3/12/25: Passed Roll Call, Received in House, Read a first time, referred to Committee on Regulatory Reform
	HB 4166 & 4167	Prohibits illicit use of xylazine and provides penalties; Provides sentencing guidelines for illicit use of xylazine.	Kelly Breen Mike Mueller	3/5/2025 – Introduced, referred to the Committee on the Judiciary
	HB 4255 & 4256	Modifies penalties for crime of manufacturing, delivering, or possession of with intent to deliver certain controlled substances; Amends sentencing guidelines for delivering, manufacturing, or possessing with intent to deliver certain controlled substances. ***PLEASE SEE THE MISCELLANEOUS UPDATES SECTION BELOW FOR MORE INFORMATION***	Sarah Lightner Ann Bollin	3/18/2025 – Introduced, referred to the Committee on the Judiciary 4/16/2025 – Reported with recommendation, referred to a second reading 4/23/2025 – Read a third time, passed, transmitted 4/29/2025 – Passed House with immediate effect, referred to Committee on Civil Rights, Judiciary, and Public Safety
	HB 4390 & 4391	Expands methods of testing intoxication or impairment in the Michigan vehicle code to include other bodily fluid.	Brian BeGole Julie Rogers	4/24/2025 – Introduced, read a first time, referred to Committee on Government Operations 5/22/25: Referred to a second reading 6/26/25: Read a second time, placed on a third reading 7/1/25: Read a third time, Passed, given immediate effect, transmitted 7/17/25: Passed by the House with Immediate Effect, moved to the Senate and referred to the Committee on Civil Rights, Judiciary, and Public Safety
	SB 219-222	Expands petition for access to assisted outpatient treatment to additional health providers	Paul Wojno	4/17/2025 – Introduced, Referred to Committee on Health Policy 5/8/2025 – Referred to Committee of the Whole 5/20/2025 – Placed on order of third reading with substitute 5/21/25 – passed roll call, received in the House, read a first time, referred to the Committee on Health Policy

BILLS & REGULATIONS PERTAINING TO SUD				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
	HB 4686	Controlled Substances; Allows creating, manufacturing, possessing, or using psilocybin or psilocin under certain circumstances.	Mike McFall	6/25/2025 – Introduced, Read a first time, Referred to the Committee on Families and Veterans
	SB 400	Prohibits prior authorization for certain opioid use disorder and alcohol use disorder medications.	Kevin Hertel	6/11/2025 – Introduced, Referred to the Committee on Health Policy, Reported favorably without amendment, Referred to the Committee of the Whole, Rules suspended for immediate consideration. 7/1/2025 – Reported favorably without amendment, placed on order of third reading, placed on immediate passage, passed roll call, Received in House, Read a first time, referred to Committee on Insurance
	SB 430 SB 431 SB 432	Modifies crime of manufacturing, delivering, or possession of with intent to deliver heroin or fentanyl to reflect changes in sentencing guidelines; Amends sentencing guidelines for delivering, manufacturing, or possessing with intent to deliver heroin or fentanyl; Allows probation for certain major controlled substances offenses.	Stephanie Chang Sarah Anthony Roger Victory	6/17/2025 – Introduced, Referred to the Committee on Civil Rights, Judiciary, and Public Safety 9/18/2025 – Committee Meeting 10/6/2025 – Reported favorably without amendment, referred to the Committee of the Whole 10/29/2025 – Placed on order of third reading
#1 – Supported by SUD Oversight Policy Board	SB 462, 464-465 *HB 5368-5370*	Legislation to require retailers to obtain a state-issued license to sell tobacco products, including e-cigarettes and nicotine pouches.	Sam Singh Joe Bellino *Jennifer Wortz* *Brad Slagh*	6/26/2025 – Introduced, referred to the Committee on Regulatory Affairs 12/2/25 – Referred to the Committee of the Whole with Substitute 12/16/25 – Reported to the Committee of the Whole with Substitute, Placed on order of Third Reading 12/18/25 – Amendments adopted, Passed Roll Call in Senate, Received in House, Read a first time, Referred to Committee on Regulatory Reform *HB 5368-5370 12/16/25 - Introduced and Referred to*

BILLS & REGULATIONS PERTAINING TO SUD				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
				Committee on Regulatory Reform. No hearings set at this time. Sign the Petition — Tobacco Free
#1 – Supported by SUD Oversight Policy Board	SB 463 SB 466	Legislation that will repeal ineffective penalties on young people -- holding retailers accountable not, children.	Paul Wojno Mary Cavanaugh	6/26/2025 – Introduced, referred to the Committee on Regulatory Affairs 12/2/25 – Referred to the Committee of the Whole with Substitute 12/16/25 – Reported to the Committee of the Whole with Substitute, Placed on order of Third Reading 4/22/26 – Amendments adopted, Passed roll call, received in the House, read a first time, referred to the Committee on Regulatory Reform Sign the Petition — Tobacco Free
	SB 399	To amend Part 74 (Offenses and Penalties) of the Public Health Code to specify that, as used in Sections 7453 to 7461 and Section 7521, "drug paraphernalia" would not include testing products used in determining whether a controlled substance contained chemicals, toxic substances, or hazardous compounds in quantities that could cause physical harm or death. "Testing products" would include fentanyl testing strips.	Jeff Irwin	6/11/25 – Introduced, Referred to Committee on Health Policy 6/26/25 – Referred to Committee of the Whole 7/1/25 – Placed on order of third reading, placed on immediate passage, passed roll call, received in the House, read a first time, referred to the Committee on Insurance
	SB 402	To amend Section 109 of the Social Welfare Act to allow a Medicaid-eligible individual to receive street medicine services, including prescriptions for opioid use disorder, by an eligible provider.	Paul Wojno	6/11/25 – Introduced, Referred to Committee on Health Policy 6/26/25 – Referred to Committee of the Whole 7/1/25 – Placed on order of third reading, placed on immediate passage, passed roll call, received in the House, read a first time, referred to the Committee on Insurance
	SB 592	A bill to require reentry services and support for certain individuals after resentencing.	Sylvia Santana	9/25/25 – Introduced, Referred to Committee on Civil Rights, Judiciary, and Public Safety 12/4/25 – Referred to the Committee of the Whole

BILLS & REGULATIONS PERTAINING TO SUD				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
	SB 582	To establish a 32% tax on the sale and distribution of nicotine, vapor, and alternative nicotine products-"Alternative nicotine product" means a noncombustible product that contains nicotine derived from any source and that is intended for human consumption, whether chewed, absorbed, dissolved, or ingested by any other means.	Stephanie Chang	9/24/25 – Introduced, Referred to the Committee on Appropriations
	HB 5087	To mandate $3,000,000.00 of tax revenue from the sale of tobacco products to be placed in the "Healthy Michigan Fund" each fiscal year for smoking prevention programs.	Phil Green	9/26/25 – Introduced, Read a first time, referred to the Committee on Finance
	SB 597 & 598	The bill would amend the Michigan Regulation and Taxation of Marihuana Act to prohibit the Cannabis Regulatory Agency (Agency) from issuing a marihuana retailer license if doing so would result in more than one marihuana retailer for every 5,000 residents in the applicant's municipality, beginning January 1, 2026	Sam Singh Jeremy Moss	10/2/25 – Introduced, Referred to Committee on Regulatory Affairs
	SB 599-602	The bills would enact the "Industrial Hemp Processing Act" to require a person to hold a license before processing consumable hemp products from industrial hemp. Industrial hemp is generally cannabis with less than 0.3% Tetrahydrocannabinol (THC), the intoxicant in marihuana. • Currently, the licensing of persons engaged in the growing, processing, and handling of industrial hemp is governed by the Industrial Hemp Research and Development Act, which the bills would repeal. • The bills would require the Cannabis Regulatory Agency (CRA) to administer the "Industrial Hemp Processing Act's" licensing and regulatory requirements and to promulgate rules. • They also would establish licensure fees and qualifications and civil and criminal penalties for violations of the proposed Act.	Dayna Polehanki	10/2/25 – Introduced, Referred to Committee on Regulatory Affairs 12/2/25 – Referred to the Committee of the Whole with Substitute 12/9/25 – Placed on order of third reading, placed on immediate passage 12/16/25 – Amendments adopted, Passed roll call in Senate 12/17/25 – Received in House, Read a first time, Referred to Committee on Regulatory Reform
#2 – Supported by SUD Oversight Policy Board	HB 5134 & 5135	To amend MRTMA (or MMFLIA) to say: A person shall not advertise any of the following on a billboard or digital billboard that is located in this state: • Marihuana. • A marihuana-infused product. • A marihuana accessory. • A marihuana establishment.	William Bruck Donovan McKinney	10/23/25 – Introduced, Read a first time, Referred to Committee on Regulatory Reform  121025-OPB-Packet Att 7.pdf
	HB 5122	To amend MLCC to allow "A current photo identification card issued by a local government. A current student photo identification card issued by an educational institution" to be qualified forms of identification to purchase alcohol.	Alicia St. Germaine	10/23/25 – Introduced, read a first time, referred to Committee on Regulatory Reform
	HB 4969	A bill to regulate the distribution, sale, and manufacture of kratom products; to require licensing for certain conduct related to kratom and kratom products; to prohibit the distribution, sale, and	Cam Cavitt	9/17/25 – Introduced, Read a first time, referred to the Committee on Regulatory Reform

BILLS & REGULATIONS PERTAINING TO SUD				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
		manufacturing of certain kratom products; to provide for the powers and duties of certain state governmental officers and entities; to prescribe fines and sanctions; to provide remedies; and to require the promulgation of rules. – A licensee shall not distribute, sell, or offer for distribution or sale in person or through an online website a kratom product to an individual in this state who is less than 21 years of age.		11/13/25 - Referred to second reading in Committee on Regulatory Reform
	HB 5302	A bill to modify a SUD prevention competitive grant program to provide grants for recovery community organizations	Jay DeBoer	12/2/2025 – Introduced, Read a first time, referred to the Committee on Health Policy
	HB 4951	*The bill would enact the "Comprehensive Road Funding Tax Act" to do the following:* *-- Impose a 24% excise tax on the wholesale price of marihuana.* *-- Create the Comprehensive Road Funding Fund and allocate $3.0 million of revenue from the Act in Fiscal Year (FY) 2025-2026 to the Fund and $500,000 of revenue from the Act to the Fund in each following fiscal year.* *-- Allocate the remainder of revenue collected under the Act to the Neighborhood Road Fund.1* *-- Beginning in FY 2027-2028 and in each following fiscal year, require the amount appropriated to the Comprehensive Road Funding Fund to be adjusted by the Consumer Price Index.* *-- Require the Department of the Treasury to administer the Act.* *-- Require a person subject to a tax imposed by the Act to file periodic returns at the times and in the manner prescribed by the Department.*	*Samantha Steckloff*	*9/16/2025 – Introduced, Read a first time, referred to the Committee on Appropriations.* *9/25/2025 – Second & Third Reading, Passed* *9/29/2025 – Sent to Senate, Referred to Committee of the Whole* *10/2/2025 - Placed on Immediate Passage, returned to House* *10/7/2025 – Approved by the Governor. Assigned PA 25'25 with Immediate Effect*
	SB 713-714	A bill to provide for regulation of advertisements and promotions for internet gaming	Erika Geiss	11/13/2025 – Introduced, Referred to the Committee on Regulatory Affairs Sen. Geiss Champions Legislation to Protect Michigan Youth from Gambling, Sports Betting Advertisements - Senator Erika Geiss
	SB 786-788	Bills to prohibit the sale or transfer of certain vapor products; and to prescribe penalties. A person shall not sell or otherwise transfer a vapor product that has a heating element unless the heating element is made of or encased in 1 or both of the following materials: (a) Glass. (b) Ceramic.	Jeff Irwin	2/18/2026 – Introduced, Referred to the committee on Regulatory Affairs
	SB 433	A bill requiring that by not later than July 1, 2026, the department of health and human services shall develop, and provide to the department, an informational notice in English, Spanish, and	Dayna Polehanki	6/24/25 – Introduced, referred to the Committee on Education

BILLS & REGULATIONS PERTAINING TO SUD				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
		Arabic, containing information on the dangers of high-potency THC cannabis products and vaping and resources to support and treatment. The department shall provide the notice developed under this subsection to public schools and nonpublic schools and post the notice on the department's website.		12/11/25 – Referred to Committee of the Whole 1/27/25 – Referred to Committee of the Whole favorably with substitute, Placed on order of third reading
Supported by SUD Oversight Policy Board	HB 5371 - 5372	A bill to repeal penalties that punish kids for possession of tobacco products and, instead, hold companies accountable that profit from tobacco sales.	Helena Scott Stephanie Young	12/16/25 - Introduced, Read a first time, Referred to the Committee on Regulatory Reform We **NEED** your support to show House members how important these bills are. Here's how you can help: **1) Contact your legislator and ask them to support the legislation.** **2) Attend the House hearing on Thursday March 19.** **3) Submit a card of support for Thursday's House hearing. If you cannot attend, we can submit a card on your behalf. Please email Dylan at dsnyder@kelley-cawthorne.com by 5 p.m. on Wednesday 3/18 to submit your card.**
	HB 5537	A bill to To amend the Michigan Penal Code to prohibit a person from growing, synthesizing, selling, offering for sale, giving, importing, or distributing kratom or a synthetic variant of kratom; would not apply to kratom that has been approved by the U.S. Food and Drug Administration (FDA) as a drug product, a dietary supplement, or a food additive in conventional food. This exception would not apply to synthetic variants of kratom	Cameron Cavitt	2/19/26 – Introduced, Read a first time, Referred to Committee on Regulatory Reform 3/18/26 – Read a second, third time, placed on immediate passage, passed given immediate effect 3/24/26 – Sent to Senate, Referred to Committee on Government Operations
	HB 4501	A bill to establish and operate a marihuana reference laboratory. o Collect, transport, and possess marihuana for the purpose of testing and conducting research in support of cannabis regulatory agency investigations and the development and optimization of testing methods performed through the cannabis regulatory agency reference laboratory	Mike Mueller	5/15/25 – Introduced, Read a first time, referred to Committee on Regulatory Reform 1/22/26 – Referred to a second reading
	HB 5756	A bill to amend the Michigan Regulation and Taxation of Marihuana Act (MRTMA) to allow and disallow for certain payment methods between businesses and processors; establish reporting requirements for certain financial information; allow CRA enforcement powers in reference	Joseph Aragona	3/18/26 – Introduced, Read a first time, Referred to the Committee on Regulatory Reform

BILLS & REGULATIONS PERTAINING TO SUD				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
		to financial disclosures.		
	HB 5757	A bill to amend the Michigan Regulation and Taxation of Marihuana Act (MRTMA) to establish fines, penalties, and license revocation for Marijuana caregivers who are exceeding the amount of marijuana grown per cardholder connected to them (6 plants per MM card holder)	Joseph Aragona	3/18/26 – Introduced, Read a first time, Referred to the Committee on Regulatory Reform

BILLS & REGULATIONS PERTAINING TO ARTIFICAL INTELLIGENCE				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
	HB 4667	A bill to add a new section to the Michigan Penal Code to create three felonies related to AI systems, and provide for related penalties.	Sarah Lightner	6/24/25: Introduced, read a first time, referred to the Committee on Judiciary
	HB 4668	A bill to create a new act, the Artificial Intelligence Safety and Security Transparency Act, which would require large developers of foundation models to create and implement certain risk management practices relating to the use of those models, as well as provide for the powers and duties of government officers and entities, protections for certain employees, and related civil causes of action and sanctions.	Sarah Lightner	6/24/25: Introduced, read a first time, referred to the Committee on Judiciary 9/11/25: reported with recommendation for referral to Committee on Communications and Technology 9/18/25: placed on second reading; referred to Committee on Regulatory Reform 3/19/26: Placed on second reading, Referred to Committee on Communications and Technology
	HB 4536	An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall not deny, modify, or delay a claim based on a review using artificial intelligence	Carrie Rheingans	6/3/25: Introduced, read a first time; referred to Committee on Communications and Technology 9/18/25: placed on second reading; referred to Committee on Insurance 3/19/26: Placed on second reading, Referred to Committee on Communications and Technology
	HB 4537	The department or a contracted health plan shall not deny, modify, or delay a claim under the medical assistance program based on a review using artificial intelligence	Carrie Rheingans	6/3/25: Introduced, read a first time; referred to Committee on Communications and Technology 9/18/25: placed on second reading; referred to Committee on Insurance 3/19/26: Placed on second reading, Referred to Committee on Communications and Technology

BILLS & REGULATIONS PERTAINING TO ARTIFICAL INTELLIGENCE				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
	HB 4661	A bill to establish a crime victim communication modernization grant program to provide grants to certain state and local governmental officers to modernize communication with victims of crime and other individuals; to create the crime victim communication modernization fund and provide for the distribution of money from the fund; to provide for appropriations; and to provide for the powers and duties of certain state and local governmental officers and entities.	Curtis VanderWall	6/17/25: Introduced, read a first time, referred to the Committee on Appropriations
	H.R. 5784 [Federal]	AI–WISE Act: To amend the Small Business Act to help small business concerns critically evaluate artificial intelligence tools, and for other purposes.	Rep. Hillary Scholten	10/17/25: Introduced, Referred to the House Committee on Small Business 12/12/25: Reported by Committee on Small Business, Placed on Union Calendar 1/20/26: Mr. Williams (TX) moved to suspend the rules and pass the bill, DEBATE , On motion to suspend the rules and pass the bill Agreed to by voice vote, Motion to reconsider laid on the table Agreed to without objection. 1/26/26: Received in the Senate and Read twice and referred to the Committee on Small Business and Entrepreneurship
	H.R 5764 [Federal]	AI for Main Street Act: To amend the Small Business Act to require small business development centers to assist small business concerns with the use of artificial intelligence, and for other purposes.	Rep. Mark Alford	10/17/25: Introduced, Referred to the House Committee on Small Business 12/12/25: Reported by Committee on Small Business, Placed on Union Calendar 1/20/26: Mr. Williams (TX) moved to suspend the rules and pass the bill, DEBATE , At the conclusion of debate, the Yeas and Nays were demanded and ordered. Pursuant to the provisions of clause 8, rule XX, the Chair announced that further proceedings on the motion would be postponed, On motion to suspend the rules and pass the bill, as amended Agreed to by the Yeas and Nays, Motion to reconsider laid on the table Agreed to without objection. 1/26/26: Received in the Senate and Read twice and

BILLS & REGULATIONS PERTAINING TO ARTIFICAL INTELLIGENCE				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
				referred to the Committee on Small Business and Entrepreneurship
	S. 4113 [Federal]	AI Guardrails Act of 2026: A bill to provide for limitations on the use of artificial intelligence by Department of Defense. This bill ensures a human is involved when deadly autonomous weapons are fired, AI cannot be used to spy on the American people, and that a human is on the switch to launch nuclear weapons.	Elissa Slotkin	3/17/26 – Introduced, Read twice, and referred to the Committee on Armed Services.

FEDERAL LEGISLATION

BILLS & REGULATIONS PERTAINING TO MENTAL HEALTH				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
	H.R. 5725	To direct the Attorney General to establish a grant to support communities transitioning to health-centered responses for mental health-related emergencies	Bonnie Watson Coleman	10/8/25 – Introduced, Referred to the Committee on Energy and Commerce, and in addition to the Committee on the Judiciary
	H.R. 5706	To establish a grant program to assist eligible entities in developing or expanding behavioral health crisis response programs that do not rely primarily on law enforcement, and for other purposes.	Yassamin Ansari	10/8/25 – Introduced, Referred to the Committee on Energy and Commerce
	H.R. 5557	**Mental Health Services for Students Act of 2025:** to amend the Public Health Service Act to revise and extend projects relating to children and to provide access to school-based comprehensive mental health programs.	Andrea Salinas	9/23/25 - Introduced, Referred to the Committee on Energy and Commerce
Supported by LRE	S. 3402 H.R. 8487	**Ensuring Excellence in Mental Health Act:** A bill To amend titles XVIII and XIX of the Social Security Act and the Public Health Service Act to improve the certified community behavioral health clinic program, and for other purposes.	John Cornyn Doris Matsui	Senate: 12/9/25 – Introduced, Read twice, Referred to the Committee on Finance House: 4/23/26 – Introduced, Referred to he Committee on Energy and Commerce, and in addition to the Committee on Ways and Means **Action Alert:** Contact your Senator/Representative - National Council for Mental Wellbeing | Ensuring Excellence in Mental Health Act

	H.R. 8620	**CARES Hotline Act:** To amend the Developmental Disabilities Assistance and Bill of Rights Act of 2000 to establish a hotline for caregivers of individuals with developmental disabilities, and for other purposes.	Robert Menendez	4/30/26 – Introduced, Referred to the House Committee on Energy and Commerce.
	H.R. 8540	**To amend title XIX of the Social Security Act to require coverage of, and expand access to, home and community-based services under the Medicaid program; to award grants for the creation, recruitment, training and education, retention, and advancement of the direct care workforce and to award grants to support family caregivers; and for other purposes.**	Debbie Dingell	4/28/26 – Introduced, Referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and Workforce, Oversight and Government Reform, and Ways and Means

BILLS & REGULATIONS PERTAINING TO SUD				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
	H.R.27 *S. 331*	***HALT Fentanyl Act:*** *This bill permanently places fentanyl-related substances as a class into schedule I of the Controlled Substances Act. Under the bill, offenses involving fentanyl-related substances are triggered by the same quantity thresholds and subject to the same penalties as offenses involving fentanyl analogues (e.g., offenses involving 100 grams or more trigger a 10-year mandatory minimum prison term). Additionally, the bill establishes a new, alternative registration process for certain schedule I research.*	*Rep - H. Morgan Griffith* *Sen – Bill Cassidy*	*1/3/25: Introduced, Referred to the Committee on Energy and Commerce, Committee on the Judiciary* *See – H. Res. 93* *2/10/25: Received in the Senate and Read twice and referred to the Committee on the Judiciary* *3/3/25: Committee on the Judiciary. Reported by Senator Grassley with an amendment in the nature of a substitute. Without written report.* *3/14/25: Passed/agreed to in Senate: Passed Senate with an amendment by Yea-Nay Vote. 84 – 16* *3/18/25: Received in House* *6/11/2025: Debate in House, Postponed Proceedings* *6/12/2025: Considered Unfinished Business, On passage Passed by the Yeas and Nays: 321-104. Motion to reconsider laid on the table Agreed to without objection.* *7/8/25: Presented to President* *7/16/25: Signed by President. Became Public Law No: 119-26.*

BILLS & REGULATIONS PERTAINING TO SUD				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
	H. Res. 93	Providing for consideration of the bill (H.R. 27) to amend the Controlled Substances Act with respect to the scheduling of fentanyl-related substances, and for other purposes.	H. Morgan Griffith	2/4/25: Submitted in the House, reported in the House 2/5/25: Debate – proceeded with one hour of debate, postponed proceedings, considered as unfinished business, motion to reconsider laid on the table without objection
	HR 2383	**Protecting Kids from Fentanyl Act of 2025**: To amend the Public Health Service Act to authorize the use of Preventive Health and Health Services Block Grants to purchase life-saving opioid antagonists for schools and to provide related training and education to students and teachers	Joe Neguse	03/26/2025 - Referred to the House Committee on Energy and Commerce
	S 1132	**Families Care Act:** To amend the Older Americans Act of 1965 to include peer supports as a supportive service within the National Family Caregiver Support Program, to require States to consider the unique needs of caregivers whose families have been impacted by substance use disorder, including opioid use disorder, in providing services under such program	Ted Budd	03/26/2025 - Read twice and referred to the Committee on Health, Education, Labor, and Pensions
	HR 2935	**PREPARE Act of 2025**: To establish a Commission on the Federal Regulation of Cannabis to study a prompt and plausible pathway to the Federal regulation of cannabis.	David Joyce	04/17/2025 - Referred to the Committee on Energy and Commerce, and in addition to the Committees on the Judiciary, Ways and Means, Agriculture, and Financial Services
	HR 2483	***SUPPORT for Patients and Communities Reauthorization Act of 2025 (SUPPORT Act):*** *This bill reauthorizes and revises Department of Health and Human Services (HHS) programs that address substance use disorders, overdoses, and mental health.*	*Brett Guthrie*	*3/31/2025 – Introduced in the House, Referred to the Committees on Energy, and Commerce, Education and Workforce, Judiciary, and Financial Services.* *5/29/2025 – Placed on the Union Calendar* *6/4/2025 – General Debate. Passed in the House* *6/5/2025 – Received in the Senate, read twice, referred to the Committee on Health, Education, Labor, and Pensions* *9/18/2025 – Passed Senate with unanimous consent* *9/19/2025 – Message sent to House* *11/25/2025 – Presented to the President* *12/1/2025 – Signed by the President, Became Public Law No: 119-44.*
	HR 4607	**SEEK HELP Act:** To provide protections from prosecution for drug possession to individuals who seek medical assistance when witnessing or experiencing an overdose	Joe Neguse	07/22/2025 – Introduced, Referred to the Committee on the Judiciary, and in addition to the Committee on Energy and Commerce

BILLS & REGULATIONS PERTAINING TO SUD				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
	HR 4595	**Small and Homestead Independent Producers Act of 2025:** To provide authority for small cultivators of cannabis and small manufacturers of cannabis products to ship cannabis and cannabis products using the mail	Jared Huffman	07/22/2025 – Introduced, Referred to the Committee on Energy and Commerce, and in addition to the Committees on Agriculture, Oversight and Government Reform, and the Judiciary
	HR 1	**One Big Beautiful Bill Act:** This bill reduces taxes, reduces or increases spending for various federal programs, increases the statutory debt limit, and otherwise addresses agencies and programs throughout the federal government. It is known as a reconciliation bill and includes legislation submitted by several congressional committees pursuant to provisions in the FY2025 congressional budget resolution (H Con. Res. 14) that directed the committees to submit legislation to the House or Senate Budget Committee that will increase or decrease the deficit and increase the statutory debt limit by specified amounts. (Reconciliation bills are considered by Congress using expedited legislative procedures that prevent a filibuster and restrict amendments in the Senate.) **Proposed Federal Legislation Would Ban Virtually All Hemp-Based Cannabinoid Products | Shipman & Goodwin LLP** *The LRE is actively monitoring the repercussions of this new law, and the effects it will have on our system.	Jodey Arrington	5/20/2025 - The House Committee on the Budget reported an original measure 5/22/2025 - On passage Passed by the Yeas and Nays: 215 – 214 in the House 6/27/2025 – Received in the Senate 7/1/2025 - Passed Senate with an amendment by Yea-Nay Vote. 51 – 50 7/3/2025 - On motion that the House agree to the Senate amendment Agreed to by recorded vote: 218 – 214. Presented to President. 7/4/2025 - Signed by President. Became Public Law No: 119-21. H.R.1 Implementation Journey
	H.R 5630	To amend the Public Health Service Act to require additional information in State plans for Substance Use Prevention, Treatment, and Recovery Services block grants.	Erin Houchin	9/30/25 - Introduced, Referred to the Committee on Energy and Commerce
	H.R. 5415 S. 3076	To amend the Controlled Substances Act to permanently schedule the class of 2-benzylbenzimidazole-opioids known as nitazenes	Rep. Eugene Vindman Sen. David McCormick	09/16/2025 – (House) Introduced, Referred to the Committee on Energy and Commerce, and in addition to the Committee on the Judiciary 10/30/2025 – (Senate) Read twice and referred to the Committee on the Judiciary;
	H.R. 5844	To amend the Controlled Substances Act with respect to the registration of opioid treatment programs to increase stakeholder input from relevant communities and to ensure such programs are treating patients in need–the applicant will address community impacts;	Adriano Espaillat	10/28/2025 – Introduced, Referred to the Committee on Energy and Commerce, and in addition to the Committee on the Judiciary

BILLS & REGULATIONS PERTAINING TO SUD				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
	H.R. 5573	The Attorney General, acting through the Director of the Bureau of Justice Assistance, and in consultation with the Secretary of Health and Human Services, is authorized to award grants to State and local law enforcement agencies to assist such agencies in planning, designing, establishing, or operating locally based, proactive programs to combat the unlawful sale, marketing, or distribution of controlled substances using social media platforms	Gabe Evans	9/26/2025 – Introduced, Referred to the House Committee on the Judiciary
	S. 3522	**No Red Tape For Addiction Treatment Act:** A bill to amend title XIX of the Social Security Act to require that State Medicaid programs provide at least one formulation of each type of medication for the treatment of opioid use disorder without prior authorization or limitations on dosage, and for other purposes.	Margaret Wood Hassan	12/17/2025 – Introduced, Read Twice, Referred to Committee on Finance
	HR 7994	**HERO Act:** A bill to establish a grant program to provide schools with opioid overdose reversal drugs, to direct schools receiving Federal funds to report to certain Federal information systems any distribution of an opioid overdose reversal drug, and for other purposes.	Raul Ruiz	3/19/26 – Introduced, Referred to the Committee on Energy and Commerce, and in addition to the Committee on Education and Workforce
	S 3758	**End Veterans Overdose Act of 2026:** a bill to direct the Secretary of Veterans Affairs to make opioid overdose rescue medications available to veterans and their caregivers, and for other purposes.	Jeanne Shaheen	2/2/26 – Introduced, Read twice, referred to the Committee on Veterans' Affairs 3/18/26 - Committee on Veterans' Affairs. Ordered to be reported with an amendment in the nature of a substitute favorably.
	S 3588	**School Access to Naloxone Act of 2026:** a bill to amend the Public Health Service Act to provide funding for trained school personnel to administer drugs and devices for emergency treatment of known or suspected opioid overdose, and for other purposes.	Jeff Merkley	1/7/26 - Read twice and referred to the Committee on Health, Education, Labor, and Pensions. 3/19/26 - Committee on Health, Education, Labor, and Pensions. Hearings held.
	HR 8000	**END 7-OH Act:** a bill to amend the Controlled Substances Act to schedule synthetic 7-hydroxymitragynine as a Schedule I controlled substance.	Gus Bilirakis	3/19/26 – Introduced, Referred to the Committee on Energy and Commerce, and in addition to the Committee on the Judiciary
	S. 4257	**Resources To Prevent Youth Vaping Act:** A bill to apply user fees with respect to tobacco products deemed subject to the requirements of chapter IX of the Federal Food, Drug, and Cosmetic Act.	Jeanne Shaheen	3/26/26 – Introduced, Read twice and referred to the Committee on Health, Education, Labor, and Pensions.
	S. 4303	**ENDS Chinese Vapes Act of 2026:** A bill to amend the Tariff Act of 1930 to provide for escalating civil penalties for fraudulent or negligent importation of unauthorized electronic nicotine delivery systems.	Tom Cotton	4/15/26 – Introduced, Read twice, and referred to the Committee on Finance.

BILLS & REGULATIONS PERTAINING TO SUD				
Priority	**BILL #**	**SUMMARY**	**SPONSOR(s)**	**STATUS/ACTION DATE**
	HR 8192	**Nitazene Response Act:** To direct the Secretary of Health and Human Services to issue guidelines for the purpose of addressing the problem of nitazene overdoses, and for other purposes.	David J. Taylor	4/2/26 – Introduced, Referred to the House Committee on Energy and Commerce
	HR 7987	**CLIMB Act:** To prohibit Federal agencies from taking any adverse action against a person solely because the person provides business assistance to a cannabis-related legitimate business, to amend the Securities Exchange Act of 1934 to create a safe harbor for national securities exchanges to list the securities of issuers that are cannabis-related legitimate businesses	Guy Reschenthaler	3/18/26 – Introduced - Referred to the House Committee on Financial Services.
	H.R. 8766	**Deal Death, Face Death Act:** To amend the Controlled Substances Act to provide for the death penalty for anyone who knowingly deals fentanyl to a person who dies from the use of such fentanyl.	Chip Roy	5/12/26 – Introduced, Referred to the Committee on the Judiciary, and in addition to the Committee on Energy and Commerce

LEGISLATIVE CONCERNS

LOCAL THREATS AND CHALLENGES				
	ISSUE	**SUMMARY**	**COUNTY**	**ADDITIONAL INFORMATION/LINKS**
	FY 26 Appropriations Issues	See Attached Document		FY26 CMHA key budget issues.docx
	COVID Relief Funding Rescinded – ARPA Funds	As of March 24, HHS halted distribution of unspent COVID relief grant funds, this includes additional Community Mental Health Services Block Grant (MHBG) funding and Substance Use Prevention, Treatment and Recovery Services (SUPTRS) Block Grant funding. This additional funding was originally authorized in statute by a pair of COVID-19 relief bills passed by Congress in 2020 and 2021, the Coronavirus Preparedness and Response Supplemental Appropriations Act and American Rescue Act, which gave states until Sept. 30, 2025, to use the funds.		National perspective: Mental health and addiction funding on the federal chopping block : NPR State perspective: Nessel sues as Trump health cuts hit Michigan disease, addiction programs
	AG Order No. 6754-2026 from Department of	- DOJ and DEA immediately places all FDA approved products containing marijuana, and all marijuana products regulated by State Medical Marijuana programs as Schedule III.		Schedules of Controlled Substances: Rescheduling of Food and Drug Administration Approved Products Containing Marijuana From Schedule I to Schedule III; Corresponding Change to Permit Requirements

LOCAL THREATS AND CHALLENGES				
	ISSUE	**SUMMARY**	**COUNTY**	**ADDITIONAL INFORMATION/LINKS**
	Justice & Drug Enforcement Agency	- "provide immediate and long-term clarity to researchers, patients, and providers alike while still maintaining strict federal controls against dillicit drug trafficking." - Expedited hearing process, scheduled for June 26, regarding the complete rescheduling of marijuana		

MISCELLANEOUS UPDATES

	ISSUE	**SUMMARY**	**COUNTY**	**ADDITIONAL INFORMATION/LINKS**
	Presidential Drug Policy Priorities	The White House Office of National Drug Control Policy (ONDCP) has announced six key priority areas that it plans to focus on this year: Reduce the Number of Overdose Fatalities, with a Focus on Fentanyl; Secure the Global Supply Chain Against Drug Trafficking; Stop the Flow of Drugs Across our Borders and into Our Communities; Prevent Drug Use Before It Starts; Provide Treatment That Leads to Long-Term Recovery; Innovate in Research and Data to Support Drug Control Strategies		ONDCP Releases Trump Administration's Statement of Drug Policy Priorities – The White House 2025-Trump-Administration-Drug-Policy-Priorities.pdf
	Regional Opposition to HB 4255 & 4256	The LRE and MSHN both have sent letters to State Senators in opposition of HB 4255 and 4256. Please see the attached letter. This letter was emailed to Senators at the instruction of the Regional SUD Directors.		PDF 2025-5-2-HB4255-42 56 Opposition Letter.pdf
	H.R.1 Implementation	As states move to implement the Medicaid provisions of H.R. 1, behavioral health providers face both operational challenges and critical opportunities to shape the path forward. This journey map is designed to equip National Council for Mental Wellbeing members with clear, actionable guidance on the policy changes ahead, the roles of key stakeholders, and the opportunities that matter most for engagement. By proactively collaborating with state officials, leveraging community partnerships, and elevating the needs of people with mental health and substance use challenges, providers can help ensure implementation decisions preserve and strengthen access to care.		H.R.1 Implementation Journey
	SAMHSA Action Alert	**Congress must keep mental health a bipartisan priority in the FY 26 appropriations bill**		Funding Restored! Thank Congress & Encourage them to Keep Mental Health a Bipartisan Priority

	ISSUE	SUMMARY	COUNTY	ADDITIONAL INFORMATION/LINKS
	Gov. Whitmer's FY 27 Budget	Michigan Executive Office of the Governor announced Governor Whitmer's FY27 executive budget recommendation, presented on February 11, 2026, totaling $88.1 billion, with a focus on improving literacy, saving Michiganders money, protecting Medicaid, and fixing roads. The budget protects Medicaid access with $780.4 million in stabilization funding and proposes new revenue sources to offset federal cuts, while also funding programs to comply with new federal requirements (H.R. 1).		State Budget Office

Elected Officials

FEDERAL			
	NAME	**NATIONAL OFFICE CONTACT INFORMATION**	**LOCAL OFFICE CONTACT INFORMATION**
US Senate	Elissa Slotkin	825B Hart Senate Office Building Washington, D.C. 20510-2204 Phone: (202) 224-4822	315 W. Allegan St. Suite 207 Lansing, MI 48933
US Senate	Gary Peters	Hart Senate Office Building Suite 724 Washington, D.C. 20510 Phone: (202) 224-6221	110 Michigan Street NW Suite 720 Grand Rapids, MI 49503 Phone: (616) 233-9150
US Representative	Bill Huizenga	2232 Rayburn HOB Washington, D.C. 20515 Phone: (202) 225-4401	170 College Ave. Suite 160 Holland, MI 49423 Phone: (616) 251-6741
US Representative	Hillary Scholten	1317 Longworth House Office Building Washington, DC 20515 Phone: (202) 225-3831	110 Michigan Street NW Grand Rapids, MI 49503 Phone: (616) 451-8383
US Representative	John Moolenaar	246 Cannon House Office Building Washington, DC 20515 Phone: (202) 225-3561	8980 North Rodgers Court Suite H Caledonia, MI 49316 Phone: (616) 528-7100

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NATIONAL DRUG CONTROL STRATEGY

2026

THE WHITE HOUSE

WASHINGTON

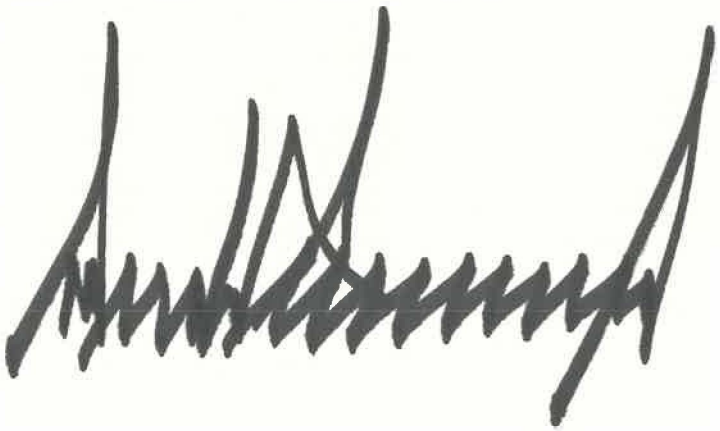
Drug addiction plagues families, leads to crime, and decays civil society. One of the gravest threats to American lives today is the fentanyl crisis, which has imposed tremendous heartbreak and unthinkable suffering upon untold numbers of our Nation's families.

From the moment I took office as the 47th President of the United States, my Administration has sent a clear signal to the cartels, narco-terrorists, drug traffickers, and lethal drug networks: The days of weak Presidents tolerating chemical assault against the United States are over.

To combat this vicious crime on the American people, I proudly signed into law the HALT Fentanyl Act, which classifies fentanyl-related compounds as Schedule I drugs. I designated cartels as foreign terrorist organizations and illicit fentanyl and its core precursor chemicals as weapons of mass destruction. And—with the passage of the One Big Beautiful Bill—we are expanding the wall along our southwest border and deporting violent drug traffickers who prey on our Nation's most vulnerable. At the same time, my Administration is expanding education resources to prevent drug use, and we are widening access to treatment so addiction recovery can start without delay. I will continue to do everything in my power to protect our children and communities.

The Office of National Drug Control Policy's *National Drug Control Strategy* report outlines a whole-of-government approach to end the fentanyl and drug crisis in the United States. We remain deeply committed to ending the scourge of drug addiction by preventing drug use before it starts, providing treatment at the earliest opportunity, and supporting those in recovery.

In the land of the free, every American deserves to live a drug-free life. We will never stop fighting to protect our children and families, break the grip of drug addiction, and keep lethal substances out of our communities and out of the hands of our citizens.



Letter from the Director of the Office of National Drug Control Policy

This *National Drug Control Strategy* is, first and foremost, a promise. It is a promise to the families who have an empty seat at their dinner table, to the communities scarred by loss, and to the memory of every American life stolen by the scourge of drug addiction and poisoning. The pages that follow are our unwavering commitment to honor their memory by reclaiming our nation's future from this crisis.

For years, I witnessed this crisis not from an office in Washington, but from the front lines, deep in cartel territory. I tracked the supply lines from the drug fields that funded the terrorists who nearly killed my husband, a U.S. Army veteran, to the battlegrounds in Mexico where criminal empires plotted the chemical assault on our country. This fight is deeply personal to me, the daughter of a proud Marine who fought in two wars and an immigrant mother who fled communist Cuba for the promise of a safe and free America. That is the same promise we are fighting for today.

As your new Director, my mission is built on a clear and urgent priority that animates every chapter of this plan: to fight and win this war on two equally important fronts.

First, we will take the fight to the enemy with a relentless offense. The era of containment has failed. This *Strategy* serves as our order of battle to hunt the cartels in their safe havens, dismantle their labs, seize their assets, and sever their supply lines. Using every instrument of American power, we will break the backs of the Transnational Criminal Organizations—especially those designated as Foreign Terrorist Organizations—that profit from killing our citizens.

Second, a true victory requires us to fortify our communities here at home. As we continue under President Donald Trump to attack the supply of these poisons abroad, we will work tirelessly to eradicate the demand for them in our country. We will build a culture of resilience where living drug-free is the norm. We will empower educators, faith leaders, and families to protect our children from this chemical assault. And we will ensure that compassionate, effective treatment and recovery support are available to every American who is courageously fighting to reclaim their life from addiction.

The poison pushed by these criminal empires does not care about our politics, and our response must be just as united. This cannot be a partisan issue; it must be an American mission. This document is more than a plan; it is our pledge to secure our homeland, bring these criminals to justice, and end this crisis. Our goal is not management. It is victory.

Sara Carter
DIRECTOR
Office of National Drug Control Policy

Table of Contents

Vision and Mission Statement

Vision Statement

To achieve a safe and healthy America, where a drug-free life is the prevailing norm.

Mission Statement

The mission of the Office of National Drug Control Policy is to advise the President of the United States on the development and implementation of the *National Drug Control Strategy* and lead the nation's whole-of-government approach to combat the scourge of illicit drugs.

Executive Summary

The Trump Administration is on a relentless offense against the drug crisis. For too long, reactive stances have failed our communities. This *National Drug Control Strategy,* hereinafter the *Strategy,* serves as our order of battle. The Administration will leverage accurate and timely drug data to provide actionable insights for policy, programmatic, and behavioral changes. We will fight and win this war on two equally important fronts: first, by attacking the enemy with a relentless offense that targets the sources and methods of drug distribution. Second, a true victory requires us to fortify our communities here at home. We will lead the way in preventing drug use before it starts and assisting those courageously fighting to reclaim their lives through treatment and recovery.

To counter current threats, this *Strategy* aims to disrupt the supply chain at every stage. This begins by securing the global supply chains currently being exploited by Foreign Terrorist Organizations (FTOs) and Transnational Criminal Organizations (TCOs). The Administration will hold countries accountable for their failure to regulate the chemical and pharmaceutical industries that facilitate the drug crisis. The Administration will also engage private industry, expanding voluntary compliance programs like the Customs-Trade Partnership Against Terrorism to incentivize chemical, pharmaceutical, and logistics companies to increase their security and screening standards. Furthermore, the *Strategy* will update and enforce regulations on drug-making equipment, such as tableting and encapsulating machines. Also, the Administration will impose significant costs, including financial sanctions and legal prosecutions, on any commercial entity or person, foreign or domestic, that facilitates the illicit drug trade.

The *Strategy* continues the United States' ongoing and relentless homeland offensive against the FTOs and TCOs attempting to smuggle drugs into our communities. Homeland Security Task Forces (HSTFs) will continue integrating our nation's combined efforts on this front into a seamless, layered approach. Under President Trump's leadership, the United States has, at long last, secured our nation's borders. This *Strategy* works to fortify this success through advanced inspection and detection systems and completing critical border infrastructure. Our nation's efforts will extend beyond our borders—the United States will attack foreign drug production at the source by supporting partner nations in dismantling clandestine labs. Domestic gangs operating as distributors for TCOs and FTOs will be targeted and dismantled through the combined efforts of federal, state, local, territorial, and tribal law enforcement.

Beyond our borders, the United States has adopted a whole-of-government approach to degrade and dismantle these FTOs and TCOs, recognizing that we must leverage every available tool in our arsenal to eliminate these cartels as a national security threat to the United States. President Trump has energized this whole-of-government approach with Executive Order (EO) 14367 Designating Fentanyl as a Weapon of Mass Destruction (WMD), demonstrating how every tool of American power will be brought to bear to identify, target, and dismantle cartels and foreign networks involved in the distribution and supply of illicit fentanyl and other illicit drugs.[1] The Administration will further use the full weight of the United States government to cripple TCO logistics, including maximizing criminal prosecutions for material support to terrorism pursuant to FTO designations, aggressively applying financial sanctions to block assets, dismantling online drug trafficking networks, disrupting the flow of firearms, and maximizing rewards programs to bring TCO leaders to justice.

The demand side of this *Strategy* begins with promoting the nation's social norm to that of a drug-free America. Preventing substance use before it begins is one of the most effective ways to protect public health, strengthen communities, and reduce the long-term social and economic costs of drug use. Federal

efforts will ensure access to prevention programs that are effective, evidence-based, and inclusive of programs that are faith-based. The *Strategy* also seeks to leverage modern media and digital platforms to promote consistent, science-driven prevention messaging, and advances drug-free workplace initiatives that support safety, productivity, and employee well-being. For the first time, the *Strategy* includes a Prevention Framework for federal and public guidance.

While prevention remains the ideal, millions of Americans currently suffer from addiction. As the President stated when issuing his Executive Order for the Great American Recovery Initiative, the disease of addiction touches every community and neighborhood in our Nation. To ensure treatment is more accessible than continued drug use, the Administration will emphasize early recognition and intervention of drug use. The *Strategy* further focuses on building capacity for treatment of addiction that is integrated into the broader healthcare system, while closely partnering with communities and faith-based organizations in its efforts. Testing and development of drugs to treat substance use disorders will be modernized to reflect the current drug environment. Finally, the Administration will prioritize consumer protections to ensure quality care and prevent fraud, particularly for those in their most vulnerable moments.

One of the most effective ways to promote recovery is to celebrate those who have already chosen to seek help. The Trump Administration celebrates and supports the 23.5 million Americans in recovery and is committed to increasing this number. To help more Americans achieve and sustain recovery, the Trump Administration will expand and enhance recovery support services and the peer support workforce across the nation. Addiction is a disease, and recovery is not only possible, but common. The *Strategy* acknowledges the science of recovery, and that it can come through many pathways, and embraces the power of faith in the process.

Through these lines of effort, the *Strategy* will turn the tide in our nation's war against illicit drug use. Over the past several decades, overdose deaths have continued to trend upwards, reaching over 100,000 in a single year for the first time in our nation's history during the previous Administration. This *Strategy* sets forth the ambitious goal of accelerating the downward trend that began in late 2023, marking a turning point in our nation's history.

While this trend does not mark a complete victory against illicit drugs, with over 72,000 drug overdose deaths predicted in the 12 months ending in September 2025, it does mark the beginning of a new era. For the first time in many years, the United States will see the dawn of a healthier tomorrow peeking over the horizon. And though our work will not yet be finished, we will know victory is within our grasp.

Footnote: Definitions of Key Threat Groups in this *Strategy*

Foreign Terrorist Organization (FTO): A foreign organization designated by the Secretary of State in accordance with Section 219 of the Immigration and Nationality Act (8 U.S.C. § 1189). Designation requires a finding that the foreign organization engages in terrorist activity or terrorism, or retains the capability and intent to engage in terrorist activity or terrorism, that threatens the security of U.S. nationals or U.S. national security. Executive Order 14157 (Jan. 20, 2025) set forth a process by which certain international cartels and other organizations would be considered for designation. Thereafter, the Secretary of State designated several cartels as FTOs, unlocking counter-terrorism authorities—including material support statutes (18 U.S.C. § 2339B) —to target criminal networks previously addressed solely through counter-narcotics action.

Transnational Criminal Organization (TCO): A self-perpetuating association operating transnationally to obtain power and monetary gains through a pattern of corruption or violence (21 U.S.C. § 2341(5); EO 13581). Distinct from other groups due to their extraterritorial command structures and diversified poly-criminal portfolios (e.g., human smuggling, weapons trafficking, money laundering), TCOs pose a broad national security threat beyond drug trafficking.

Drug Trafficking Organization (DTO): A complex organization with a defined command structure that produces, transports, or distributes illicit drugs (see DOJ/DEA National Drug Threat Assessment). Unlike the multi-crime TCO, a DTO is typically a regionally or locally based group within the United States whose criminal activity is overwhelmingly focused on the drug trade. DTOs frequently function as the domestic logistical arms for larger TCOs.

Introduction

Dedication

Over the past five years, nearly half a million Americans have been killed by drug overdose and poisoning; more than the combined American military losses of World War II, Korea, Vietnam, Iraq, and Afghanistan.[2,3,4] These lives are more than a statistic. They are our family members, friends, and neighbors. Countless other Americans, including law enforcement officers, have lost their lives due to drug-related violence. The pain and tragedy of the loss of these American lives must be recognized.

The lives lost, as well as the vast quantities of illicit drugs that have been allowed to enter the United States, are no accident. Rather, they are the result of Foreign Terrorist Organizations (FTOs) and Transnational Criminal Organizations (TCOs) exploiting our borders to traffic lethal substances, deliberately poisoning millions of Americans, while nation-states with the ability to stop these actions sit idly by. This Administration has taken, and will continue to take, decisive action against those waging this chemical war against the American people.

President Trump dedicates this *Strategy* to honor the lives lost to this crisis, and to pay tribute to the law enforcement officers, first responders, and service members who protect our communities from the threat of drugs and the violent organizations that traffic them. This dedication is made through not only our most ambitious plan to date, but the solemn promise to fight every day to take back our Nation from the scourge of drugs and those who intend to harm the United States. Through our bold actions today, we will build a brighter future in which our children, and generations to come, are free to live happy, healthy drug-free lives.

Save Lives and Protect America

The Trump Administration is focused on saving lives and protecting America from the drug crisis. During President Trump's first administration, significant progress was made in the fight to end the opioid crisis. This *Strategy* renews and expands these efforts to defeat the drug crisis with particular emphasis on illicit fentanyl and all evolving threats.

Tragically, the American death toll from illicit drugs is catastrophically high, but that is a relatively recent phenomenon. From 1980 to 1990, overdose deaths numbered 78,000, roughly 7,800 per year.[5] Beginning in 1999, the United States witnessed a substantial increase in overdose deaths starting with prescription opioids and illicit drugs like heroin and turning later to clandestinely made fentanyl beginning in 2013.[6] The subsequent flood of illicit fentanyl triggered an unprecedented escalation, pushing the annual number of drug overdose deaths for Americans to above 100,000 for three consecutive years from 2021 to 2023, reaching a devastating peak of 107,941 in 2022.[7] While recent provisional data show a decline to 72,836 deaths for the 12 months ending August 2025[8], this number still vastly exceeds any levels seen prior to the widespread availability of illicit fentanyl. This scale of loss continues to constitute a clear national security threat to the American people.

Therefore, solutions to this crisis require strong action on two fronts: reducing the drug supply and curbing demand. This Administration will continue delivering upon its promise to disrupt the flow of drugs into the United States, especially along the Southwest Border, by dismantling FTOs and TCOs responsible for drug trafficking. Already, tremendous progress has been made to secure the border—a night-and-day difference compared to the last administration. This Administration has further carried out numerous successful military strikes against sea-based drug smugglers. Every such strike, as well as many of the drug seizures along our borders, represents American lives saved.

To that end, Executive Order 14157 created a process to designate the most dangerous international drug cartels as FTOs, enabling the use of powerful investigative resources to bring them to justice.[9] Subsequently, the Administration made clear that domestic criminals cooperating with FTOs will be prosecuted to the furthest extent of the law.[10] Accountability will further extend to nation-states that enable the trafficking of drugs into the United States. This includes the governments that support TCOs and their drug trafficking activities. It also means making source and transit nations accountable for their lack of enforcement actions against chemical companies selling fentanyl and other synthetic drug precursors to FTOs and shipping them into the Western Hemisphere.[11]

Moreover, drug traffickers of domestically produced and marketed dangerous products will be brought to justice. Drugs with attractive packaging and marketing towards youth prey on young Americans and lead to devastating societal and economic impacts to the United States. Examples of such products include tianeptine (a.k.a. "gas station heroin"), kratom with high 7-hydroxymitragyine (7-OH) content, "legal psychedelics" or "mushroom edibles" made from *Amanita muscaria*, and psychoactive derivatives of hemp packaged as candies or vapes.[12]

The publication of this *Strategy* marks a turning point in which the United States will openly acknowledge and bring to justice those participating in the deliberate poisoning of tens of thousands of Americans each year. The United States re-asserts the fundamental right of the American people to live healthy lives. Those who infringe upon this right, be they foreign or domestic, will be held severely accountable for their actions.

Simultaneously, this Administration will seek to bring about a drug-free America as the new social norm. Unabated, open, illicit drug use is not normal and will no longer be acceptable. This Administration promotes health, working to prevent drug use before it starts and stopping the addiction pipeline. Compassionate care means accountability with appropriate deterrence and incentives. Intervention to prevent substance use initiation and supporting linkage to treatment at the earliest stages of addiction are most effective. Treatment for drug addictions should be easier to obtain than the drugs themselves. Even for those in the darkest depths of addiction, there is always hope and opportunity to find long-term recovery. Recovery should be celebrated and supported. To realize this vision, the Administration's *Strategy* recommits our nation to a drug-free America.

Both the supply and demand elements of the Administration's approach require timely and accurate data to assess the scope of the drug crisis and the effectiveness of solutions. The Administration will identify factors contributing to the drug crisis and continuously monitor and evaluate the effectiveness of drug control policies and programs. This *Strategy* will encourage and guide the development and implementation of advanced technology to turn bold ideas into decisive action, and decisive action into measurable results on behalf of the American people.

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Importance of Faith

The United States is, and will always be, one nation under God. Indeed, 83 percent of Americans believe in God or a spiritual force.[13] This fact is more than a sentiment —it is a reminder that our nation's faith is a powerful resource in the fight against illicit drug use.[14]

The power of God and faith is already central to drug treatment and recovery for many Americans.[15,16] Faith-based leaders are important advocates, who teach the value of living a drug-free life, protect the minds of our young people, and provide crucial support to those struggling with addiction. Living drug free should be a goal for all Americans. Secular education and treatment are important, but for those who have faith, adding God into the equation brings in a special power. Faith leaders are encouraged to use their influence and pulpit to promote the social norm of not using drugs and bringing hope and support to those who have the treatable condition of addiction.

National Drug Control Strategy Roadmap

The *Strategy* is a strategic road map for America to defeat the scourge of drugs and save lives. It is built upon two mutually reinforcing pillars: a relentless whole-of-government campaign to attack the illicit drug supply and a whole-of-society public health effort to reduce demand and consumption.

Defining the Threat (CHAPTER 1)

- **Chapter 1**: ***Defining Current and Emerging Drug Threats*** leads off the *Strategy*. It outlines the Administration's plan to build unified, agile processes that use modern data, surveillance, and technology to define the current drug crisis and proactively identify and communicate new dangers, from synthetic drugs and trafficking routes to domestic production and usage trends.

Supply Elimination (CHAPTERS 2–4)

These three chapters are organized to follow the logical flow of the illicit drug trade, from its source to its final distribution in our communities.

- **Chapter 2**: ***Securing the Global Supply Chain*** focuses on the source and the need to leverage private commercial entities to eliminate the supply of illicit drugs. It details the plan to stop the flow of precursor chemicals and tablet-making machinery from countries like China before they can ever be used to produce illicit drugs.
- **Chapter 3**: ***Stop the Flow of Illicit Drugs*** targets the pathway. This chapter builds on Chapter 2, outlining our multi-layered defense to interdict finished drugs as they move from foreign production hubs, across our borders, and into the United States.
- **Chapter 4**: ***Global Campaign Against Transnational Criminal Threats*** targets the enterprise. This chapter details law enforcement investigations and sanctions as the primary pathways of attack and dismantlement against TCOs' drug trafficking operations.

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Public Health (CHAPTERS 5–8)

These four chapters detail a comprehensive public health approach, following a full continuum of care—a spectrum of interventions designed to support Americans at every stage of their journey.[17]

- **Chapter 5**: ***Creating a Drug-Free America as a Social Norm*** focuses on primary prevention—stopping individuals, especially youth, from substance use initiation.
- **Chapter 6**: ***Bringing Help at All Stages of Addiction to the Mainstream*** provides a plan for those who are currently struggling with addiction. It focuses on treatment and early intervention, making it easier to receive life-saving help than to use drugs illicitly.
- **Chapter 7**: ***Celebrate and Support Recovery*** focuses on those who have entered recovery. It details our commitment to building the recovery support systems, such as peer networks and recovery-ready workplaces, that help Americans to achieve and sustain long-term well-being.
- **Chapter 8**: ***Rescue and Overdose Response*** addresses the most acute crisis—fatal overdose. This chapter is our life-saving plan to ensure overdose reversal medications, like naloxone, and immediate post-overdose care are available for anyone at immediate risk of a fatal overdose, at any point of drug use.

Appendices

Finally, the Strategy is supported by a collection of detailed Appendices. These supplemental documents provide readers with greater detail on specific implementation plans, the performance measurement system, a national drug data plan, and dedicated border security and public health strategies.

National Drug Control Strategy Notes

1. This *Strategy* outlines the strategic direction for the Nation's drug control efforts and does not include specific budgetary resource information. In accordance with 21 U.S.C. § 1703(c), the Office of National Drug Control Policy (ONDCP) separately oversees the National Drug Control Program agencies' counter-drug budgets. ONDCP meets these statutory requirements by reviewing and certifying agency budget requests and submitting a consolidated National Drug Control Budget to Congress, ensuring that federal resources are aligned with the goals and objectives of this *Strategy*.
2. ONDCP, established by the Anti-Drug Abuse Act of 1988, and reauthorized by the SUPPORT for Patients and Communities Act (Public Law 115-271), met the requirement to consult a wide array of experts, key stakeholders, and officials while developing the President's *Strategy*. ONDCP solicited the views of the following: National Drug Control Program agencies, ONDCP coordinators, Interdiction and Emerging Threats committees, appropriate Congressional committees, State, local and Tribal officials, law enforcement organizations, public health organizations, appropriate representatives of foreign governments, victim families, and private citizens.
3. The *National Southwest Border Counternarcotics Strategy* and the *National Northern Border Counternarcotics Strategy* are required by 21 U.S.C. § 1705(c) and 21 U.S.C. § 1701 note

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(Public Law 111-356), respectively. The *National Caribbean Border Counternarcotics Strategy* is included pursuant to direction in the House Committee on Appropriations report for the Financial Services and General Government Appropriations Act, 2025 (H. Rept. 118-556).

Chapter 1: Defining Current and Emerging Drug Threats

Introduction

To effectively execute the *Strategy*, we must first have a clear, precise, and unified understanding of the drug threats facing the United States. This requires a comprehensive evaluation of the current crisis as well as a forward-looking posture to identify emerging dangers. The primary, most lethal drug threat to our nation is the flood of synthetic drugs, principally fentanyl and methamphetamine, and TCOs. These criminal organizations purchase precursor chemicals from China and, to a lesser extent, India to produce these poisons on an industrial scale and traffic them across our borders.[18] This, combined with the persistent and increasing flow of cocaine from South America[19], forms the baseline of the crisis killing tens of thousands of Americans.

However, this baseline is not static. The TCOs are a well-resourced and dynamic enemy, and constantly adapt their products, production methods, and trafficking routes. The tragic lesson of the last decade was a national failure to anticipate the shift from prescription opioids to heroin and then to illicitly manufactured fentanyl. This resulted in a surge of fatal overdoses that government, at every level, was not prepared to prevent. Recognizing this existential threat, Executive Order 14367 formally designates fentanyl as a Weapon of Mass Destruction, mandating a national threat assessment posture commensurate with chemical, biological, and radiological dangers.[20] The Trump Administration is committed to ensuring America is prepared for the evolving drug landscape.

Therefore, this chapter outlines the Administration's plan to modernize the nation's research and surveillance systems. This is essential to mounting the strategic and targeted response necessary to combat both the crisis we face today and the drug crises of tomorrow. We will build a proactive and agile system to continuously define the current threat and identify and counter emerging threats by leveraging cutting-edge technologies and data sources. This system will empower federal, state, local, territorial, and tribal decisionmakers with actionable insights to better assess the scope of the current crisis, identify contributing factors, and evaluate interventions.

The drug threat is a dynamic landscape of both persistent and evolving challenges:

- New Synthetic Drugs: TCOs actively engineer new synthetic drugs and chemicals, such as potent nitazene analogues and designer precursors, to bypass international controls.[21]
- Adulterated Illicit Drugs: Existing drug threats are evolving to become far more dangerous. The adulteration of other illicit drugs with illicit fentanyl is a driver of overdoses, and more research is needed on the magnitude of this problem.[22]
- Opioid and Stimulant Co-use: Co-use of fentanyl/heroin with illicit stimulants is common, contributes to increased risk of overdose, and complicates treatment. It also makes

determining unintentional versus intentional exposure to fentanyl among stimulant users hard to accurately assess, which is a major challenge for overdose prevention and treatment.[23]

- Domestic Production: Domestic cultivation and production are a growing concern, often exploiting legal and regulatory loopholes. This includes high-potency marijuana grown by criminal groups, as well as unregulated psychoactive derivatives of hemp [such as delta-8 tetrahydrocannabinol (THC)] and other substances like kratom and "legal psychedelics."[24]
- Evolving Distribution: Drug distribution methods have evolved to include encrypted social media apps and online sales, bringing poison directly to the doorsteps of the American people, particularly our nation's youth.[25]

This dynamic landscape requires a unified and vigilant response, grounded in a deep understanding of current threats and a forward-looking posture. The Administration will fight to be steps ahead of the TCOs by applying advanced data science methods to a full range of modern data sources—including toxicology results, wastewater analysis, electronic health records, and law enforcement seizures. As the following principles and objectives detail, we will use every source of information to build a comprehensive system for defining current risks and providing early warning of new ones.

Further detail on the implementation of these data systems is available in Appendix C: *Strategy* Data Plan.

Victims of Another Opioid Threat – Nitazenes

The human cost of evolving drug threats is devastatingly real. On January 2025, Lucci-Reyes McCallister (left), a talented 22-year-old with a passion for cooking and a gift for mechanics, collapsed and died in League City, Texas, after taking a single pill he believed was Xanax. Despite multiple doses of naloxone, he could not be revived. The counterfeit pill contained N-pyrrolidino protonitazene, one of many nitazene analogues—synthetic opioids far more potent than fentanyl. Tragically, just three months later, in April, Lucci's friend, Hunter Clement (right), also died from a counterfeit pill containing a nitazene. These young men weren't seeking out a novel substance; they were poisoned by a hidden danger lurking within what looked like a familiar drug.

Lucci and Hunter's deaths highlight the complex and constantly shifting challenge we face. Criminal organizations, primarily sourcing chemicals from China, continuously alter the molecular structure of regulated drugs (like nitazenes) to create new, unregulated analogues when existing ones are banned. The DEA has already identified 19 distinct nitazenes circulating in the United States, each posing a unique challenge for detection, toxicology testing, and emergency response.

This constant chemical manipulation forces law enforcement and public health officials into an ongoing race to identify and warn about new threats. These tragic losses underscore the critical importance of a vigilant, agile early warning system capable of detecting these novel substances before they can claim more lives, reinforcing the stark reality that one pill can kill.

Text Box 1: Another Opioid Threat – Nitazenes[26]

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Key Principles

Strengthen Proactive Threats Identification by Leveraging Data Systems

We will leverage data and intelligence to continuously assess current threats and proactively identify, assess, and respond to emerging drug threats before they escalate at a national scale. Threats will be identified by monitoring patterns and trends in fatal and nonfatal overdoses, new substances, precursor chemicals, production trends, drug use behaviors, and trafficking methods. We will prioritize the continuous collection and analysis of drug data utilizing cutting-edge technologies.

Rapidly Disseminate Actionable Data and Public Warnings

We will make actionable drug data accessible to inform local and federal responses. This ensures all stakeholders—including federal, state, local, territorial, and tribal partners, as well as the public—are equipped with the timely information, clear public health warnings, and actionable intelligence needed to mitigate harm and effectively counter both current and new threats.

Ensure Legislative and Regulatory Agility to Counter Evolving Threats

To effectively counter the dynamic threats identified in this chapter, our national policy framework must be as agile as the threats we face. This requires the continuous evaluation and modernization of national legislation, regulations, and policies to ensure they remain relevant to the evolving drug landscape.

Objectives

Establish Standardized Processes to Define and Detect Drug Threats

The Trump Administration is committed to improving our nation's drug data systems to ensure the accurate and timely collection and reporting of data. We will integrate public safety and public health data to advance research and mount a coordinated response, breaking down information silos to provide a complete, real-time operational picture of the drug crisis.

Disseminate Accurate, Timely Data to Public and Private Sector Audiences

The Administration will analyze and disseminate data to all relevant partners. Information collected under Objective 1 will be tailored and rapidly delivered to the right mechanisms to be acted upon. This ensures public health officials, law enforcement, policymakers, and the public receive the specific, actionable intelligence they need to execute their respective missions—whether it is issuing public warnings, guiding policy decisions, informing law enforcement operations, or targeting public health interventions and clinical treatment guidelines.

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Action Items

Modernize and Integrate Public Safety and Public Health Data Collection

The Trump Administration will direct federal agencies to adopt modernized and standardized forensic toxicology testing that reflects current and evolving drug threats. Timeliness of data is a priority. We will encourage utilization of the Drug Enforcement Administration's Toxicology Testing Program (DEA/TOX) method of detecting new drug threats from emergency department data.[27] Federal data systems must track all drug control activities funded by federal dollars, including providing comprehensive, accurate, and timely estimates on the number of drug seizures, people receiving evidence-based substance use disorder treatment, and the distribution and use of opioid overdose reversal medications, such as naloxone. This includes developing protocols to adjudicate and deduplicate data from drug control efforts involving multi-agency collaborations or task forces. The Administration will continue to champion CDC's Drug Overdose Surveillance and Epidemiology (DOSE) system, which publishes near real-time counts and percentage change in suspected overdose emergency department visits, allowing participating states to alert clinicians and the public of local overdose spikes. CDC supports innovation through the Overdose Response Strategy, a national network of public health and public safety officers, such as law enforcement, fire and emergency medical services, in all 50 states, Washington, DC, Puerto Rico, and the U.S. Virgin Islands, working together to share information, disrupt the illicit drug supply, and prevent overdose. Further, agencies will work with nonprofit and private sector laboratories and international partners to identify best practices and techniques so that testing approaches can be regularly and reliably updated to better identify and track drug threats. We will also prioritize establishing new data systems to monitor drug consumption in real-time, through a national wastewater-based monitoring system and biosurveillance. These objective measures will provide timely, localized data on current drug use and trafficking patterns.

Leverage Advanced Technology and Artificial Intelligence (AI) to Analyze Current and Anticipate Future Threats

The Administration will accelerate the deployment of AI and machine learning tools to improve the operational efficiency of our response. We will develop use cases where these novel technologies can be applied to automate tasks, perform predictive analytics, and detect hidden patterns. Examples include utilizing AI to enhance the screening and detection of illicit drugs in cargo at ports of entry, applying predictive analytics to electronic health records to identify patients at high risk of overdose, using natural language processing in clinical settings to create search algorithms for detecting emerging threats, and improving the efficiency of forensic laboratories. This will allow the U.S. Government to proactively anticipate strategic shifts from the current baseline in the global and domestic drug supply.

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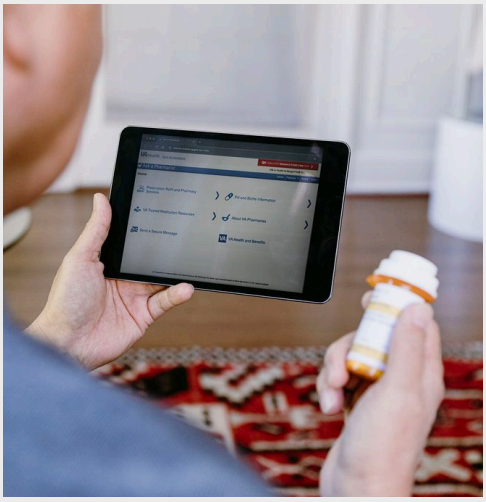
Using Artificial Intelligence to Improve Drug Treatment for America's Veterans

Opioid overdoses among veterans have risen significantly in the last decade. To address this issue, the Veterans Health Administration (VHA) utilized machine learning and artificial intelligence to develop clinical decision support tools to identify veterans at risk of suicide, overdose, and treatment discontinuation.



The Stratification Tool for Opioid Risk Mitigation (STORM) is a web-based clinical support system that providers can use to assess individual patient risk factors and adjust treatment plans as appropriate. STORM uses predictive analytics to determine the risk for opioid-related serious adverse events for each VHA patient with an opioid prescription and supports decisions based on best practice recommendations.

The next phase includes implementing a developed 2.0 version of STORM predictive model which will estimate risk of overdose and suicide-related health care events or deaths for all VA patients, with attention to risks related to opioid prescriptions and opioid discontinuation as well as substance use disorders.

Text Box 2: Using Artificial Intelligence to Improve Drug Treatment for America's Veterans[28]

Promote Cross-Cutting Research to Understand the Current and Evolving Drug Crisis

The Administration urges researchers to prioritize developing methodologies and conducting cross-cutting research examining the relationships between illicit drug supply, drug use, and the adverse consequences of drug use to inform policy. Research on nonfatal overdoses should differentiate people who overdosed on opioids due to intentional opioid use versus those poisoned by unintended opioid use to facilitate appropriate treatment responses. Hospitals' emergency departments are the canary in the coal mine of society's problems and currently show a crisis of people with drug intoxication and mental health crises being held for extreme lengths of stay. Research of this population would inform optimally needed community resources. Further research is needed to better understand the impact of law enforcement operations on the availability and use of illicit drugs in current markets. To facilitate this work, federal agencies must commit to making relevant datasets publicly available while protecting personal privacy and law enforcement investigations.

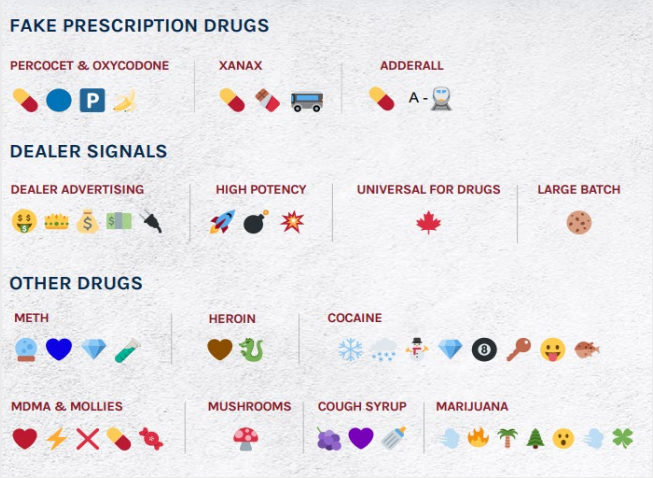
Rapidly Disseminate Actionable Warnings and Guidance

The government has a wealth of data, but this information must be translated into actionable intelligence, including early warnings, and delivered to the people who need it most. Federal agencies must prioritize improving the timeliness of reporting drug data so that it is available for use within six months of data collection, such as improvements made to CDC's State Unintentional Drug Overdose Reporting System (SUDORS), which now publishes preliminary six-month overdose death and circumstance data within weeks of completed data abstraction. The Trump Administration will lead federal agencies to develop innovative methods to make

drug data available as soon as possible, such as by publishing provisional data or developing methods to predict or impute data estimates based on reports that have already been received and processed. The Administration will prioritize communicating data and research findings to drive targeted policy and programmatic changes, through existing platforms like CDC's Health Action Network Alerts and novel dissemination mechanisms. This includes, but is not limited to, special communication briefs to professional groups and law enforcement, public use data tools for researchers, and targeted campaigns on social media to reach young adults, such as CDC's Free Mind Campaign. This will provide a statement on current and designated emerging drug threats with tailored messaging to public health, public safety, and the public at large.

Getting Drug Threat Information to Those Needing It Most

When a dangerous new drug hits the streets, or a familiar one becomes deadlier, getting the word out quickly can save lives. Right now, news reports and social media chatter often spread faster than official warnings, leaving frontline responders and the public without the reliable information they need. Existing systems, like the CDC's Health Alert Network (HAN) that warns clinicians and health departments, and HIDTA's Overdose Map (ODMAP) that flags overdose spikes in real-time are crucial, but don't always capture everything. No single source provides the full picture of the drug threat. To issue clear, actionable warnings, ONDCP will work to bring together for analysis law enforcement seizure information, health surveys, wastewater testing results, trends from hospital data, and mortality data.



This Administration is committed to making sure this vital information flows seamlessly, so everyone from emergency physicians to parents know exactly what threats are out there and how to respond.

Text Box 3: Getting Drug Threat Information to Those Needing It Most[29]

Chapter 2: Securing the Global Supply Chain from Foreign Terrorist and Transnational Criminal Organizations

Introduction

Over one billion low-value shipments, more than 90 percent of total shipments to the United States, entered the United States last year. The majority of these shipments contain legitimate commodities that are critical to the healthy flow of international commerce. However, illicit actors, including TCOs and FTOs, exploit the immense volume of these shipments along with existing global customs frameworks to hide their illicit activities.[30,31] This includes utilizing commercial shipping methods through air, land, and sea to transport illicit drugs and the materials used to make them.

Integral to the Trump Administration's *Strategy* to counter the exploitation of legitimate supply chains is to strengthen and fortify the security measures surrounding its governance. Already, the Administration took the bold and decisive step in Executive Order 14324, "Suspending Duty-Free De Minimis Treatment for All Countries," to close a significant enforcement gap through the suspension of the *de minimis* exemption on a global basis.[32] This action allows for improved customs information collection that furthers law enforcement's risk mitigation processes, weeding out illicit commodities within the voluminous flow of regular commerce. Building upon the President's Executive Order, the Administration is setting forth an innovative approach to counternarcotics by introducing a new incentive structure for private industry stakeholders to voluntarily invest in additional security measures, as well as continuing to impose legal consequences against those who facilitate illicit activities.

Private industry involvement is key because they have advanced access to information on the commodities that they sell, facilitate, or ship. The voluminous low-value commodities environment makes it difficult for governmental entities to inspect and examine every package and parcel.[33] Given governmental resource constraints, private companies and entities involved in transporting goods must, on their own accord, implement heightened security and risk mitigation measures that complement existing governmental customs export and import requirements. To effectuate this change, the Administration will expand trusted trade programs and increase the associated minimum-customs-security standards to include supply chain integrity principles developed by ONDCP and the interagency.

Supply Chain Integrity is analogous to a chain of custody. It demands accountability from the initial order through transit to final delivery. Applying this concept to a supply chain will help mitigate exploitation by illicit actors. The principles of Supply Chain Integrity include:

- *Transparency and Accountability Across the Supply Chain.* Supply Chain Integrity emphasizes the need to maintain a verifiable, chronological record of all entities involved in handling goods to ensure transparency and prevent illicit activities.

- *Due Diligence.* Companies take on the responsibility to reduce vulnerabilities in their supply chains through increased understanding of their business partners and their customers; risk analysis; and the implementation of mitigation measures.
- *Enhanced Data Collection, Standardization, and Verification.* Strengthening and standardizing data requirements, along with rigorous verification, ensures the legitimacy of transactions and narrows exploitable gaps in the supply chain.

The shipping industry already uses the Customs Trade Partnership Against Terrorism (CTPAT), a voluntary compliance program from Customs and Border Protection (CBP). CTPAT is a public-private partnership that strengthens international supply chains by inviting companies to voluntarily implement stringent security measures that lead to prioritized and expedited processing at ports of entry.[34] The Administration will expand the CTPAT program, enhancing data requirements to satisfy Supply Chain Integrity principles and setting engagement targets to bring in the shipping, chemical, pharmaceutical, laboratory equipment, and pill press manufacturing industries.

As well, the Administration will leverage its bilateral, regional, and multilateral engagements to demand that source and transit countries like China, India, Mexico, Canada, and Colombia expand similar and compatible incentive frameworks for shipping, chemical, pharmaceutical, and logistics companies. The Administration will also lead global scheduling and control efforts and require countries to take aggressive enforcement actions against entities and individuals that traffic illicit drugs, both cultivated and synthetic, along with their precursors, related substances, and equipment.

This *Strategy* aims to reduce the supply of deadly drugs entering the United States. We will achieve this by partnering with private industry and other governments on voluntary compliance programs. These programs will offer new market incentives to offset the costs of securing supply chains. This approach makes our global trade systems less vulnerable and prevents criminal organizations from exploiting them. It also ensures that the people, companies, and countries that enable these illegal activities are held accountable.

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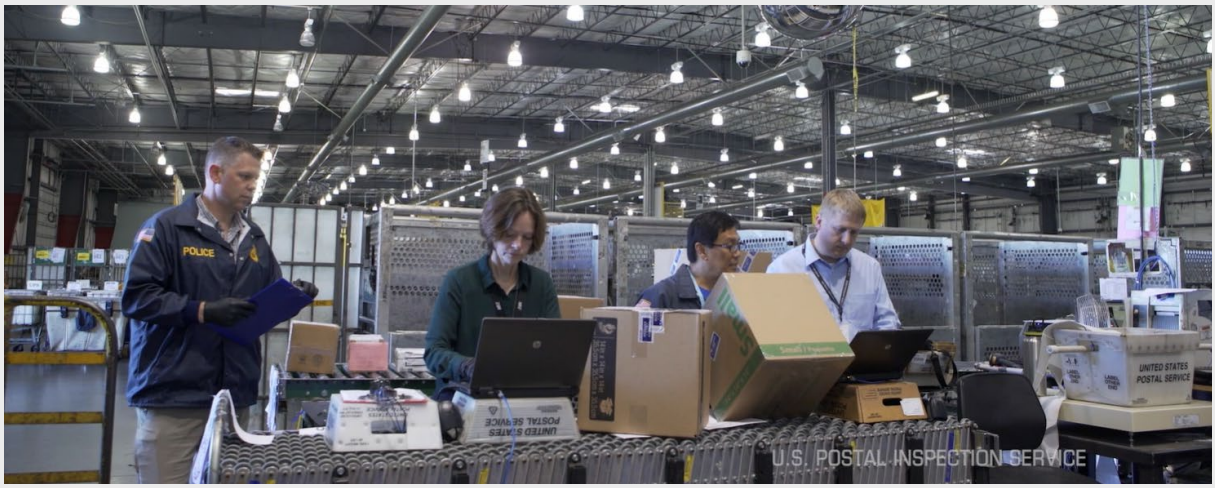
Ending the Exploitation of De Minimis



The de minimis rule allowed commercial shipments under $800 to enter the United States duty-free with minimal customs processing. The Trade Facilitation and Trade Enforcement Act (TFTEA) raised this limit in 2016 to $800 from $200, inadvertently creating a massive national security loophole. As a result, package volume exploded from 150 million in 2016 to over one billion annually.

This flood of low-data parcels provided ideal cover for transnational criminal organizations to ship extremely potent drugs directly to Americans. Fentanyl found in these parcels often exceeds 90% purity—far more lethal than the 10% average for seizures at the land border.

In response, President Trump issued an Executive Order on April 2, 2025, suspending the de minimis exemption for shipments from China or Hong Kong. A subsequent order on July 30, 2025, suspended the exemption for all nations to prevent traffickers from simply shifting shipping routes.

These orders are designed to shut down this trafficking pathway by forcing packages back into the formal customs entry process. This gives U.S. Customs and Border Protection (CBP) the data needed to target and intercept deadly drugs.

Text Box 4: Suspending Duty-Free De Minimis Treatment.[35,36,37,38,39,40]

Key Principles

Hold Countries Accountable for Enabling Drug Trafficking

For too long, engagement with source and transit countries that enable the flow of drugs into the United States has failed to hold countries accountable for their weak regulatory frameworks, lack of enforcement, and above all, the absence of political will to take decisive and urgent action to reduce the flow of drugs in the United States.[41] With the issuance of the "America First" Executive Order and the innovative drug-related Executive Orders that followed, President Trump introduced both a new lens by which to measure foreign policy objectives and a new approach to countering illicit drugs.[42] We will now use all tools available to ensure source countries take credible measures to stop the production and trafficking of drugs and related chemicals destined for the United States. Source countries will be held accountable and expected to take vigorous action to investigate, prosecute, and eliminate the illicit drug trade at its roots.

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Protect the Global Supply Chain from Drug Traffickers

Criminal organizations exploit legitimate global supply chains to move illicit drugs and precursor chemicals efficiently, capitalizing on entry processes that fail to illuminate a shipment's full chain of custody. To counter this, the Administration will enhance data collection, track at-risk packages, and expand interdiction capabilities. By denying criminals the advantages of licit commerce, we will disrupt their operations and reduce the availability of dangerous drugs in American communities.

Leverage Regional and Multilateral Fora to Stop the Flow of Drugs into the United States

The Administration will utilize international engagements in regional and multilateral fora to focus drug control efforts with maximum impact on reducing the flow of drugs into the United States.

Objective

Decrease the Movement of Finished Drugs, Precursors, Related Chemicals, and Equipment through Legitimate Shipping Modalities

Making it harder for TCOs to use the licit supply chain to move drugs, precursors, related chemicals, and equipment is an essential component of President Trump's *Strategy* to save American lives from drug overdoses, addiction, and abuse. The action items below represent pinch points within the complex system of international commerce that provide targeted opportunities to secure the licit global supply chain. Success requires constructive engagement with and commitment from the U.S. Congress, source and transit countries, and the private sector.

Action Items

Strategically Progress on Bilateral Counterdrug Initiatives

The Administration will fully empower federal departments and agencies to aggressively seek action on cooperative counterdrug mechanisms with countries that fuel or have the potential to fuel the drug trade, aimed at eliminating the flow of illicit drugs and precursor chemicals used to produce synthetic opioids, methamphetamine, and cocaine. China in particular has subsidized and otherwise incentivized its chemical companies to export fentanyl, precursors, and related chemicals.[43] Measurable progress to disrupt and degrade the illicit drug trade is critical to reducing American drug overdose poisonings and deaths.

We will prioritize lines of effort that drive China to stop the flow of precursor chemicals used to illicitly manufacture synthetic drugs; Canada to deepen actionable intelligence sharing to target TCO operations; Colombia to reduce coca cultivation and disrupt the criminal networks that thrive on cocaine production; Mexico to seize precursors and reduce production; Mexico to eliminate cartels' ability to threaten the territory, safety, and security of the United States through their extraterritorial command-and-control structures; and India to take further action to regulate

its pharmaceutical and chemical industries so that it does not supplant China as the preponderant source of chemicals for the production or manufacture of illicit drugs.

Expand Participation in Trusted Trade Programs

Federal agencies will actively seek to increase the number of pharmaceutical, chemical, and global logistics companies participating in Trusted Trade programs, such as CTPAT, to help secure the supply chain from the trafficking of drugs, precursors, related chemicals, and equipment.[44] The international community will also be encouraged to develop and incentivize participation in their domestic versions of trusted trade programs. Further, we will continue to prioritize engagement with foreign authorities to develop better oversight of legitimate industries and more effectively identify sources of diversion. We will also assess the utility of new enforcement tools, such as authorizing U.S. Customs and Border Protection (CBP) to sanction shippers who repeatedly fail to provide required data.

Partnering with Industry to Secure the Supply Chain
Customs Trade Partnership Against Terrorism

The Customs-Trade Partnership Against Terrorism (CTPAT) is a cornerstone of U.S. Customs and Border Protection's (CBP) layered cargo enforcement strategy. Launched in 2001, CTPAT is a voluntary public-private sector partnership program where CBP works collaboratively with members of the trade community—importers, carriers, manufacturers, brokers, and others—to strengthen international supply chains and improve U.S. border security.

Participants agree to implement specific security measures throughout their supply chains, documented in security profiles, in exchange for benefits, including expedited processing of their cargo.

By incentivizing companies to adopt higher security standards, CTPAT makes the legitimate supply chain a harder target for criminal organizations, including those trafficking illicit drugs and precursor chemicals.

Members implement measures like enhanced physical security at facilities, stricter personnel vetting, and improved tracking of conveyances. This commitment allows CBP to segment risk better, focusing inspection resources on unknown or higher-risk shipments while facilitating the flow of legitimate trade from trusted partners. This collaboration is vital for enhancing supply chain visibility and integrity, preventing the exploitation of commercial channels by TCOs.

Text Box 5: Partnering with Industry to Secure the Supply Chain[45,46]

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Update Regulations and Track Tableting and Encapsulating Machines and Essential Parts to Prevent Production of Illicit Drugs

The U.S. Government will facilitate the exchange of applicable data through CBP's Automated Commercial Environment (ACE) and Automated Export System (AES) processing for the exportation and importation of DEA-regulated controlled substances, listed chemicals, and tableting and encapsulating machines (i.e. "pill presses") along with their essential parts.[47] Concurrently, federal, state, local, and tribal law enforcement will rigorously enforce currently existing Controlled Substance Act registration and reporting requirements to identify and seize illicit machines. Further, we will update and develop as needed regulations for notifying DEA of transshipments, transfers, and the destruction of tableting and encapsulating machines; support legislation that better defines tableting and encapsulating machines along with their essential parts under the Controlled Substances Act; and update customer verification requirements for these regulated transactions.

Leverage Multilateral Fora to Advance U.S. Counterdrug Priorities

Federal departments and agencies will advance U.S. priorities utilizing targeted tools in regional and multilateral fora, such as the Commission on Narcotic Drugs (one of the governing bodies of the United Nations Office on Drugs and Crime), the International Narcotics Control Board, and the World Customs Organization. These are used to support the rapid scheduling of dangerous drugs and precursor chemicals, increase global security standards, and enhance real-time communication and information sharing between national authorities of pre-exportation of precursor chemicals and equipment used to manufacture illicit drugs and facilitate national authorities' incident response mechanisms. We will also continue to work with bilateral and multilateral partners to ensure chemical producers and distributors are held accountable for diversion into illicit drug manufacturing.

Impose Costs on Commercial Entities that Facilitate Illicit Drug Production and Trafficking

The U.S. Government will impose significant costs on any commercial entity, foreign or domestic, that fails to secure its supply chain from exploitation by TCOs. Taking a whole-of-government approach, the Department of the Treasury will, as appropriate, levy sanctions to deny these companies access to the U.S. financial system.[48] In parallel, the Department of Justice will pursue criminal prosecutions against companies and executives who knowingly or through willful blindness facilitate the illicit drug and precursor chemical trade.[49] These actions will complement federal efforts to target criminal organizations, those that enable them, and their profits from criminal activities.

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Case Study: Imposing Costs on Illicit Chemical Suppliers

The United States actively targets commercial entities that facilitate the illicit drug trade, demonstrating our commitment to securing the global supply chain. As an example, in September 2025, the U.S. Department of the Treasury's Office of Foreign Assets Control (OFAC) sanctioned Guangzhou Tengyue Chemical Co., Ltd., a PRC-based company, along with its key personnel. This action followed an investigation revealing Guangzhou Tengyue was manufacturing and selling synthetic opioids, such as nitazenes, and associated cutting agents like xylazine and medetomidine, directly to drug traffickers operating within the United States.

This case exemplifies how seemingly legitimate commercial operations can directly fuel our nation's drug crisis. The investigation uncovered a criminal network trafficking multi-kilogram quantity of fentanyl, methamphetamine, and cocaine using chemicals sourced from Guangzhou Tengyue to increase their drug yield and potency. By designating the company and its operators under counter-drug authorities, OFAC effectively severed their access to the U.S. financial system, freezing their assets and prohibiting U.S. persons from engaging with them. Such actions are a critical tool in holding commercial entities accountable and preventing the exploitation of legitimate trade for illicit profit.

Text Box 6: Case Study: Imposing Costs on Illicit Chemical Suppliers

Chapter 3: Stop the Flow of Illicit Drugs into American Communities

Introduction

The Trump Administration has launched a relentless, unified effort to strengthen national security and safeguard our communities by eliminating the criminal actors who traffic deadly illicit drugs into the United States. To operationalize this approach, the Homeland Security Task Force (HSTF) was conceived and implemented to drive a whole-of-government effort to degrade and dismantle the TCOs, including those designated as FTOs, responsible for the deaths of hundreds of thousands of our citizens. The HSTFs are achieving success by discarding the often-siloed initiatives of the past and instead deliberately and methodically braiding all federal efforts into a streamlined and unified whole. This chapter outlines this new strategy, which inextricably links drug trafficking to the related criminal activities that drive and empower TCOs and FTOs, including financial crimes, firearms trafficking, and human smuggling.[50,b]

This *Strategy* recognizes the interdiction of illicit drugs as a critical element in preventing American drug overdose deaths, but an approach that will only succeed when properly oriented as one part of a comprehensive effort designed to destroy the criminal organizations transporting illicit drugs. The Administration's swift move to seal the border with Mexico has challenged the TCOs and FTOs who had previously accounted for the interdiction of the drugs they transported as simple business losses. Now, in this more hostile operating environment, these criminal adversaries must seek alternative methods for smuggling drugs into the United States. Thus, the United States has succeeded in destabilizing the operations of these criminal organizations at precisely the moment that the HSTF stands poised to elevate discrete interdiction events into holistic investigations that ultimately degrade and dismantle the TCOs responsible. All law enforcement partners are unified as part of the HSTF, which leverages a unique and indispensable combination of legal authorities, specialized capabilities, and operational capacity that is vital to the success of the overall national effort. Through the HSTF National Coordination Center (NCC), this federal capacity is integrated with the vast and indispensable interdiction efforts of over 18,000 State, local, territorial, and Tribal police departments and law enforcement agencies across the country.[51] This entire national enterprise is underpinned by robust intelligence support that drives operations and strong international partnerships that extend our reach far beyond our borders. This chapter is directed at this dedicated workforce, building upon the authorities, capabilities, and professionalism they bring to the fight every day to keep Americans safe. Additional detail can be found in the White House's annually produced *National Interdiction Command and Control Plan*.

[b] The approach described here comports with the Administration's *Counter Cartel Strategy*, which is further discussed in the Classified Annex.

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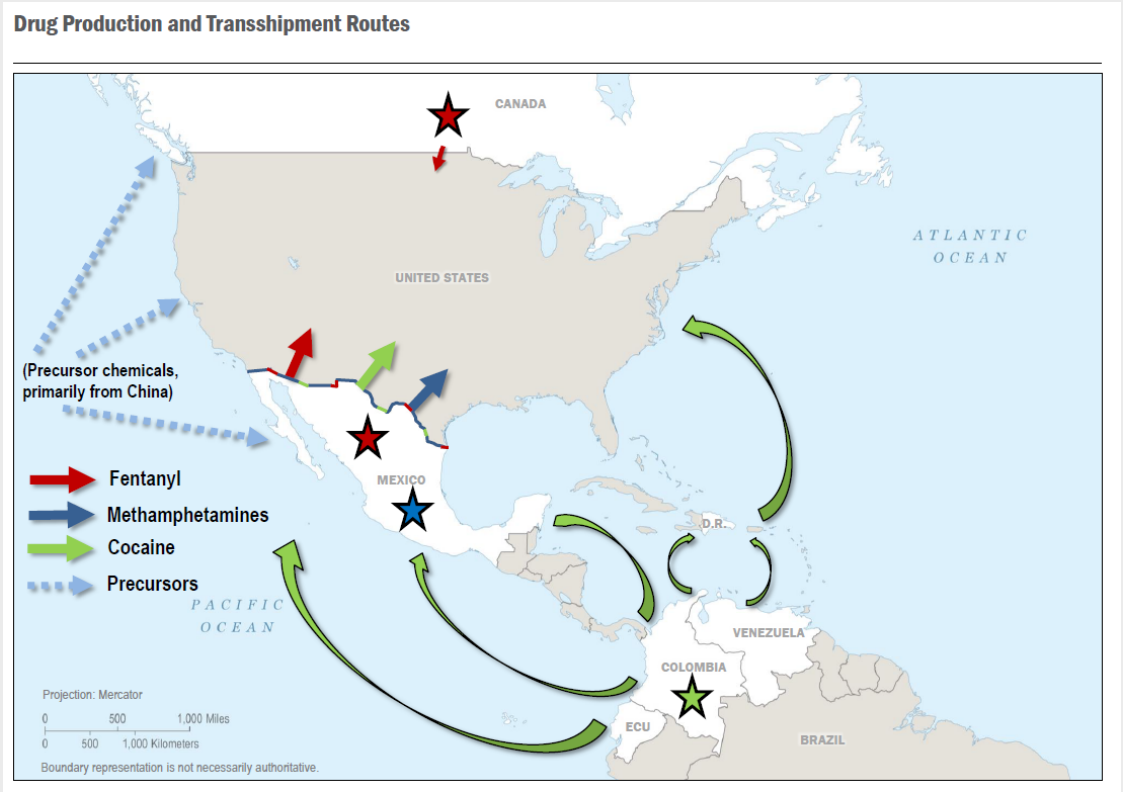
Vectors for Fentanyl, Methamphetamine, and Cocaine Production



Text Box 7: Map – Vectors for Fentanyl, Methamphetamine, and Cocaine Production[52]

Key Principles

Disrupt the Flow of Illicit Drugs Across a Unified Interdiction Continuum

The Administration will treat the trafficking of illicit drugs as a single, continuous threat vector that requires seamless, layered defense extending from the source zone, through the transit zone, to the homeland. This principle mandates the complete integration of international, border, and domestic law enforcement and interdiction efforts to ensure there are no gaps for traffickers to exploit. This creates a consistently hostile environment for traffickers, increasing their risks and costs at every step of their operation.

Drive Operations with Intelligence and Technology to Maximize Interdictions

Efforts to degrade and dismantle TCOs and FTOs often begin with effective interdictions, which are achieved by fusing actionable intelligence with advanced technology. This approach uses intelligence from sources like HSTF enterprise investigations and large-scale data analysis to precisely target high-risk traffic. Technologies like Artificial Intelligence (AI) and Non-Intrusive Inspection (NII) capabilities act as force multipliers in this process, while every seizure is exploited to generate new intelligence that hones future operations and maintains our decisive advantage.

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Honoring the Guardians of Our Communities

This *Strategy* is dedicated to the unwavering courage of the men and women who stand on the thin line between the safety of our communities and the chaos of the drug trade. Every day, federal, state, local, tribal, and territorial law enforcement officers, border security agents, first responders, and investigators face extraordinary dangers to protect the American people.

Their mission is fraught with risk. In the course of interdicting lethal narcotics, dismantling violent criminal networks, and securing our borders, these dedicated professionals are regularly injured and, tragically, some pay the ultimate price in the line of duty. Their sacrifice is measured not only in the risks they face but in the time they give—enduring long deployments, grueling hours, and countless missed birthdays and holidays away from their families to ensure that our families remain safe.

These Americans represent the very best of our nation. They are patriots and heroes who run toward danger when others flee. We recognize the profound weight of their service and the silent burdens borne by their loved ones. To those who serve: your sacrifice is not forgotten, your dedication is the foundation of our security, and your nation is eternally grateful.

Text Box 8: Honoring the Guardians of Our Communities

Objectives

Secure U.S. Borders and Approaches

We will leverage a formidable, multi-layered defense to prevent the entry of illicit drugs and related materials to the United States. We will strengthen inspection and interdiction capabilities at all ports of entry[c] and enhance our border security posture to detect, monitor, target, and maintain domain awareness in the air, land, and maritime transit zones approaching the United States. This includes completing infrastructure such as border walls, fences, and advanced systems to secure the border between ports of entry. It also includes maximizing whole-of-government operations to deny traffickers access to maritime and air routes into and approaching the United States.[d]

Disrupt Domestic Drug Distribution and Degrade TCO Logistics Inside the Border

This objective targets the final, and most dangerous, link in the drug supply chain: distribution within the United States. HSTFs will degrade and dismantle the TCO-affiliated cells and

[c] The term "ports of entry" is used comprehensively to encompass all locations designated under federal regulation where U.S. Customs and Border Protection (CBP) is authorized to clear international passengers and cargo. Strategically, this term includes not only the 328 official land, air, and sea ports, but also functionally equivalent locations where international arrivals are processed, such as International Mail Facilities (IMFs), express courier hubs, and user fee airports. In this context, a port of entry is any location where federal agencies—including but not limited to CBP, the U.S. Coast Guard, and the U.S. Postal Inspection Service—are authorized to interdict illicit drugs arriving from foreign countries.

[d] See Appendix D and the NICCP for additional discussion on the layered defense to secure the border.

domestic gangs that transport, store, and sell illicit drugs in American communities, including the interstate distribution of illicit marijuana from states with legal markets. This includes a focus on identifying and dismantling key logistical nodes, such as drug warehousing facilities and transportation networks that enable bulk storage and regional distribution. Further, this effort will adapt to modern trafficking methods by targeting the online marketplaces, unmanned and autonomous systems, social media platforms, and direct-to-consumer delivery models that bring poison directly to our doorsteps. Achieving this will require the seamless integration of federal, state, local, territorial, and tribal law enforcement.

Taking the Hide Out of Hide and Seek: Automated License Plate Readers

Automated License Plate Readers (ALPRs) are a critical technological tool for domestic drug interdiction, acting as a significant force multiplier for law enforcement on our nation's highways. By capturing license plate images and comparing them against law enforcement databases containing vehicles actively sought in criminal investigations, ALPR systems provide officers with real-time alerts on vehicles linked to ongoing criminal activity or known warrants.

This intelligence enables law enforcement to move beyond random stops and focus investigative resources on vehicles specifically identified as relevant to an active case, significantly increasing the probability of intercepting drug loads and apprehending traffickers, as demonstrated by numerous successful seizures documented by the National HIDTA Program.

ALPRs are a powerful tool, and law enforcement agencies are using them to successfully intercept drug traffickers while protecting the civil liberties of innocent Americans. By developing and adhering to clear policies that define the purpose, scope, and limitations of ALPR use, and ensuring alignment with jurisdictional laws and constitutional standards, law enforcement maximizes investigative gains while upholding the rights guaranteed to all citizens.

Text Box 9: Taking the Hide Out of Hide and Seek: Automated License Plate Readers[53]

Enhance Interdiction by Leveraging and Fusing Intelligence from Seizures

To maximize our impact, every enforcement action must be treated as an intelligence collection opportunity, thereby feeding the intelligence cycle. Information gathered from seizures—including from biometric data, digital devices, ledgers, and interviews—will be rapidly analyzed and fused with all other intelligence sources. This includes information and analysis provided by international, State, local, Tribal, and territorial partners, which is critical to understanding drug networks.[54] The HSTF NCC will ensure this information is shared to the widest extent possible, across U.S. agencies and levels of government, ensuring that a single interdiction can illuminate broader TCO networks and drive precision targeting against high-value individuals.

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Protecting America with Canines – From Local Communities to the Border

Across the United States, approximately 50,000 active police K9s serve as a vital force multiplier for federal, state, local, territorial, and tribal law enforcement. These highly trained canine units are indispensable in the fight against illicit drugs, safeguarding our borders, patrolling our nation's highways to intercept bulk shipments, screening millions of parcels at mail facilities, and executing search warrants in our communities. Their impact is immense; by detecting concealed threats that technology and human officers often miss, these teams save countless lives and disrupt the revenue streams of TCOs.

The U.S. Customs and Border Protection (CBP) Canine Program exemplifies this capability as the largest and most diverse federal law enforcement canine program, deploying over 1,500 teams. With academies in El Paso, Texas and Front Royal, Virginia, its primary mission is detecting terrorists and their weapons, while simultaneously serving as a critical defense against drug trafficking. Under the Office of Training and Development, the program maintains rigorous federal standards and its own breeding program for working breeds, ensuring a sustainable pipeline of elite detection dogs. Whether at the border or supporting local police requests, these canine teams remain one of the most effective tools for securing the homeland.

Text Box 10: Protecting America with Canines – From Local Communities to the Border[55]

Attack Foreign Drug Production at the Source

Our multi-layered defense begins far beyond our own borders, working with dedicated foreign government and law enforcement partners to attack the drug supply at its sources. This objective focuses on supporting efforts to eradicate the sources of plant-based drugs, such as coca plants destined for further processing into cocaine in Colombia, while dismantling the clandestine drug laboratories that produce synthetic drugs like fentanyl and methamphetamine in Mexico and Canada. A critical component of this effort is supporting our foreign partners as they target the essential drug-making equipment that enables these operations within their countries, from cocaine processing lab equipment to the pill presses and die molds used by cartels to produce deadly fentanyl tablets. Globally generated profits from drug production strengthen TCOs, allowing them to counter increased pressures at U.S. borders.

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Action Items

Expand Capacity for Detection of Illicit Drugs Using Technology

The Administration will accelerate the deployment of cutting-edge technology at all U.S. ports of entry. The Department of Homeland Security (DHS), through U.S. Customs and Border Protection (CBP), will expand the use of high-throughput Non-Intrusive Inspection (NII) hardware and other new technologies to scan a higher percentage of commercial cargo, passenger vehicles, and international and domestic mail.[56] This investment aligns with the standards required by EO 14367, treating the interdiction of synthetic opioids with the same urgency and technical sophistication as the counter-proliferation of Weapons of Mass Destruction (WMD) materials. This investment in physical hardware will be coupled with an equally aggressive expansion of advanced data processing and analytical platforms, including AI-driven automated vetting systems that analyze advance trade data to identify high-risk shipments and passenger data to identify suspect travelers. This dual investment in hardware and analytical software will be applied across all domains. Further, we will deploy improved technology to better detect illicit drugs in domestic mail and expand coordination with commercial package services to leverage their unique data and screening capabilities. When these vital partnerships identify potential drug or precursor shipments moving through their supply chains, the U.S. government will be postured to take swift enforcement action.

Vulnerability of the Domestic Supply Chain

Domestic mail and private parcel services are primary vectors for TCOs to distribute poisons—including Mexican-produced synthetic drugs and South American cocaine—throughout the United States. This *Strategy* turns modern logistics into weapons, allowing traffickers to send deadly drugs to any location with an airstrip or mailbox.

This threat is magnified in remote regions. The Alaska HIDTA reports Drug Trafficking Organizations in the lower 48 states use commercial air cargo and parcel delivery as their "primary methods" for this onward distribution. Administration officials have seen this vulnerability firsthand in discussions with Alaskan leaders. In remote Native Alaskan villages, often accessible only by air or water, a single package containing Mexican-produced fentanyl represents thousands of lethal doses. The arrival of such a shipment has a catastrophic and disproportionate impact, underscoring the critical need to secure all domestic supply pathways.

Text Box 11: Vulnerability of the Domestic Supply Chain[57,58]

Expand and Formalize Joint Operations Through the Homeland Security Task Force (HSTFs)

The Administration will fully resource and empower the HSTFs as the mechanism for conducting counter-TCO and FTO operations. Co-led by the Department of Justice and Department of Homeland Security, the HSTFs integrate personnel and resources from all relevant federal law enforcement agencies and intelligence entities, including HIDTA, under a single structure with state, local, territorial, and tribal law enforcement partners. The HSTFs will conduct sustained, multi-jurisdictional operations aimed at dismantling the domestic drug trafficking networks orchestrated by TCOs and FTOs.

Enhance Border Security through Department of War Support

The Department of War (DoW) is an indispensable partner in the nation's counter-drug mission. In line with the Administration's national priorities to secure the homeland, DoW significantly increased its border security missions to support federal law enforcement in 2025. DoW will continue to leverage these vital operations to enhance detection and monitoring capabilities along the Southwest Border and in the maritime approaches used for illicit drug trafficking from South America. DoW also will provide unique capabilities, including advanced surveillance, logistical support, engineering expertise, intelligence analysis, and specialized training to its federal law enforcement partners. By executing this critical mission, DoW acts as a powerful force multiplier, directly contributing to the U.S. government's ability to keep Americans safe.

Photo Source: Deputy Assistant Secretary of War for Public Affairs

Increase Intelligence-Driven Interdictions of Precursor Chemicals and Manufacturing Equipment

The Intelligence Community (IC), the Department of War, and federal law enforcement will intensify efforts to identify and track shipments of drugs, precursor chemicals, and drug manufacturing equipment. For U.S.-bound shipments, this intelligence will drive targeted interdiction operations to be carried out by the HSTF. For shipments among foreign chemical suppliers and drug production countries, this intelligence will assist our foreign partners in stopping these materials before they can be used to produce illicit synthetic drugs. More specific detail can be found in the Classified *Strategy* Annex.

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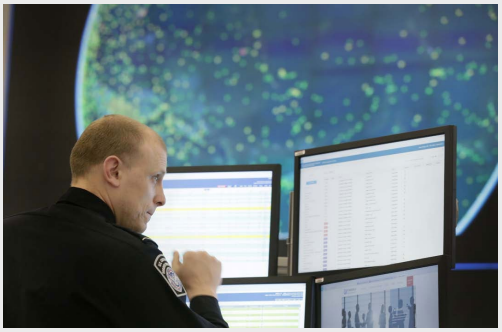
Technology as a Force Multiplier:
The Role of Data and AI in Drug Interdiction

U.S. Customs and Border Protection (CBP) operates a sophisticated, 24/7 screening process to identify high-risk passengers and cargo destined for the United States. CBP uses advanced analytics and intelligence to vet traveler and shipment data against law enforcement and intelligence databases before they arrive. This risk-based strategy, known as the Advanced Targeting System (ATS), analyzes vast amounts of data—such as shipping manifests, import/export records, and passenger information—to assign a risk score to each shipment or individual. This allows CBP officers at ports of entry to focus their inspection resources on the small percentage of traffic deemed most likely to be involved in illicit activities, including drug smuggling, rather than relying on random searches.



This data-driven approach extends to the international mail system, where CBP and the U.S. Postal Inspection Service (USPIS) collaborate to find contraband hidden among billions of parcels. A critical development in this fight has been the Administration's recent changes to the handling of *de minimis* shipments, a topic detailed in Chapter 2 of this *Strategy*.

This policy change now mandates the submission of Advance Electronic Data (AED) for millions of small value parcels that were previously exempt, dramatically expanding the dataset available for analysis. By applying sophisticated algorithms to this newly available data, CBP and USPIS can identify anomalies and patterns indicative of drug trafficking with far greater precision. Data points like declared value, weight, origin country, and shipping patterns are all scrutinized to flag suspicious shipments for examination, turning the tide in the fight against small parcels containing synthetic drugs.

Text Box 12: The Role of Data and AI in Drug Interdiction[59]

Increase Investigation and Prosecution of Domestically Distributed Illicit and Unregulated Substances

To fully dismantle domestic drug distribution networks, the HSTF and State, local, territorial, and Tribal partners, will intensify efforts to prosecute the illicit production and distribution of dangerous substances originating within the United States. This includes targeting retail operations, such as vape and smoke shops, that unlawfully market harmful products, particularly to minors. Enforcement will focus on substances falling outside regulatory frameworks or being sold illegally, such as non-FDA approved drugs, certain hemp-derived psychoactive products, illicitly produced psychedelics, and dangerous substances like 7-hydroxymitragynine (7-OH, an active component and potent opioid found in the kratom plant) when illegally marketed or adulterated. The Administration has been granted new legal authority to address certain psychoactive hemp-derived cannabidiol substances thanks to the “hemp loophole closure” passed as part of the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Act funding bill for fiscal year (FY) 2026. Shutting down these domestic sources of harmful substances is crucial to degrading the overall availability of illicit drugs within our communities.

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The Dangers Of Kratom Products: It's Neither Organic Nor Safe

In April 2022, in Cowlitz County, Washington, after mixing a powdered kratom supplement into his lemonade, Jordan McKibban collapsed in his bathroom and never woke up. He was an organic food distributer and thought he was taking a natural, healthy supplement. Jordan was planning on starting a family with his girlfriend, but will never get that chance. He was 37. Understandably and unfortunately, many people believe that since kratom is a natural product, it is safe for human consumption. However, drug sellers have turned the active component of this product into profits knowing its use can be both addictive and deadly.

The kratom sold in the United States today can include highly enriched levels of laboratory-made 7-hydroxymitragynine (7-OH), a chemical that binds strongly to opioid receptors. In July 2025, the Food and Drug Administration (FDA) announced that warning letters had been sent to seven companies for illegally marketing products containing 7-OH. This action reflects the HHS's growing concern around this opioid product being marketed to American consumers online, in smoke shops, gas stations, and corner stores.

The FDA's letters focus on concentrated 7-OH products such as tablets, gummies, drink mixes, and shots, all of which are dangerous and potentially deadly. The FDA has published educational materials to highlight the serious health risks posed by these products and HHS is recommending that 7-OH be classified as a Schedule I controlled substance under the Controlled Substances Act (CSA).

Photo source: Jordan McKibban family

Text Box 13: Kratom Victim: it's neither organic nor safe[60]

Chapter 4: Global Campaign Against Transnational Criminal and Foreign Terrorist Threats

Introduction

The chemical war being waged against the American people by predatory criminal empires requires a decisive and overwhelming response. This chapter outlines a comprehensive strategy for a global campaign against criminal organizations that produce and traffic illicit drugs, an effort that forms the spearhead of our nation's broader strategy to defeat TCOs and particularly those designated as FTOs. The approach described herein works to eliminate these organizations through HSTF-led investigations that attack the entirety of criminal enterprises, including drug trafficking, financial crimes, weapons offenses, and human trafficking.[61] This holistic assault degrades the criminal infrastructure that supports all their illicit activities.

The United States' capacity to investigate, prosecute, and dismantle complex, transnational drug trafficking networks is a core component of our national security. We will aggressively prosecute TCO and FTO members to the fullest extent of the law—not only for drug smuggling and violent crimes , but also for terrorism and the facilitation of terrorism charges as applicable. The HSTF brings a range of investigative authorities, advanced operational techniques, and global reach to this mission. These federal efforts are designed to complement and empower the critical investigative work performed daily by our international, State, local, territorial, and Tribal partners. Because the large-scale logistical and financial footprint of drug trafficking is a TCO's greatest vulnerability, drug investigations provide the most effective inroads for attacking, disrupting, and ultimately dismantling these powerful criminal organizations. This chapter is aimed at all law enforcement and intelligence professionals engaged in this complex and dangerous work, providing a strategic framework that builds upon their existing efforts and expertise.

The HSTF is the unifying framework for all counter-TCO operations. The HSTFs serve as the engine for integrating the unique authorities, intelligence capabilities, and investigative resources of all federal partners and will encourage joint operations with State, local, territorial, and Tribal agencies. The HSTF National Coordination Center (NCC) is the central mechanism for fusing this law enforcement information. For TCOs designated as FTOs, the HSTF NCC will ensure this information is passed to the National Counterterrorism Center (NCTC) to be integrated with terrorism-related intelligence, supporting the full spectrum of the U.S. counterterrorism mission. This structure breaks down agency silos and enables a whole-of-government approach to the execution of coordinated, long-term enterprise investigations designed to dismantle TCOs from the root to the branch. We will leverage all legally available U.S. Government capabilities including diplomatic, informational, military, and economic tools to cripple their logistics, block and seize their assets, and ensure there are no safe havens for those who poison our people for profit.

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HSTFs in Action

The fight against TCOs and FTOs has seen significant organizational and structural changes within the agencies, departments, and interagency working groups tasked with protecting the homeland. On January 20, 2025, Executive Order (EO) 14159 was issued with the purpose of streamlining the existing federal task forces into one, streamlined interagency working group aptly named the Homeland Security Task Force (HSTF) in order to better combat the criminal and terrorist organizations causing irreparable harm on the citizens of the United States. The foundation of the new task force was built upon sharing intelligence, resources, and capabilities among federal entities to bring to bear the weight of the federal government into the fight in a fully coordinated and executed strategy. One month later, the Department of State declared multiple cartels FTOs, which opened previously unused charging vehicles to be used by federal agencies.

Federal law enforcement leaders in El Paso, Texas, working at the United States – Mexico border, understanding the significance of EO 14159 and FTO designations, acted quickly to take advantage of the opportunity by forming the first functioning HSTF in country. Supervisors, agents, task force officers, and attorneys at the Western District of Texas quickly began reviewing cases to identify a HSTF proof of concept investigation to utilize the new FTO designation. The FBI nominated an investigation targeting the Jalisco New Generation Cartel (CJNG) that had been investigated in coordination with the ATF. The newly formed HSTF discovered multiple other federal agencies were in possession of additional information implicating leaders within the CJNG.

Agents and Task Force Officers utilized a multitude of sophisticated investigative techniques including pen orders, search warrants, undercover operations, and international wire intercepts. Domestic HSTF agents coordinated extensively with the U.S. Embassy in Mexico City, who enlisted the assistance of Mexican law enforcement partners. Tirelessly working to deliver affects against terrorist organizations, agents took advantage of the new HSTF model to bring down a powerful cell within the CJNG responsible for trafficking fentanyl, humans, and weapons on both sides of the border. On May 4, 2025, Maria Del Rosario Navarro Sanchez, charged with 18 U.S.C. § 2339B(a)(1) in the Western District of Texas, was arrested by the Government of Mexico.

The investigation and results highlight benefits of the new HSTF and the FTO designations. Investigative results to date include: one highly sophisticated tunnel connecting El Paso, Texas, and Ciudad Juarez, Mexico, identified and disabled; 24 arrests; and 87 kg cocaine 142 kg meth, 13 kg fentanyl, 9 kg heroin, $357,000 cash, and 74 weapons seized.

Text Box 14: HSTFs in Action[62]

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Key Principles

Enterprise-Focused Enforcement

Our enforcement efforts will be strategically aimed at dismantling entire criminal organizations by attacking their primary vulnerability: the drug trade. Unlike their other criminal activities, the sheer scale of TCO drug trafficking operations and drug distribution provides the largest and most exposed surface area for law enforcement to exploit. Drug investigations therefore serve as the primary avenue to map these complex criminal networks. By exploiting this vulnerability, we gain the intelligence and access needed to attack every other facet of these criminal enterprises, including their senior leadership, financial networks, transportation and logistics arms, and the corrupt officials who enable their operations.

Intelligence-Driven Investigations

Long-term, complex investigations will be driven by the fusion of all-source intelligence. The HSTF has unified federal, state, local, territorial, and tribal partners to work together, breaking down traditional agency silos to conduct coordinated, multi-year enterprise investigations against entire TCOs and designated FTOs.

Combat Illicit Drug Sales in All Domains

We will relentlessly pursue and dismantle drug trafficking networks wherever they operate. This includes attacking criminal exploitation of physical transit zones, commercial supply chains, and virtual spaces such as social media platforms, encrypted applications, digital payment platforms, and darknet marketplaces that bring poison directly to our doorsteps.

Employ All U.S. Government Capabilities to Cripple TCO Logistics

We will utilize every available authority to destroy the infrastructure that TCOs need to operate, in an effort to impact their overall ability to produce and transport illicit drugs. This includes leveraging FTO designations, rewards programs, information-sharing with the private sector, diplomatic engagement with partner nations, robust security assistance for committed partners, aggressive financial sanctions and similar measures that prompt private sector engagement and compliance, asset seizures and forfeitures, and prosecutions to isolate these criminal networks from the international financial system.

Objectives

Unify Law Enforcement and Intelligence Community Efforts Against Designated TCOs

The HSTF has created a seamless information-sharing environment between U.S. law enforcement at all levels, the Department of War, and the Intelligence Community to combat priority TCOs, particularly those designated as FTOs. Through the HSTF NCC, criminal investigative information will be systematically fused with all-source national intelligence, including intelligence residing in mandated counterterrorism holdings at NCTC, to produce a

unified intelligence picture, exposing critical vulnerabilities for precision targeting. Progress will be tracked by measuring law enforcement information on designated TCOs provided to the NCC.

Systematically Dismantle TCOs and FTOs

Leveraging the actionable intelligence developed under Objective One, this objective is to dismantle the entire enterprise and capabilities of priority TCOs and FTOs. Through coordinated operations, we will remove participants from leaders to low-level distributors, seize illicit assets, and destroy their logistical networks to degrade these enterprises until they are incapable of posing a strategic threat to the United States.

Sever TCO and FTO access to Firearms to Degrade Their Capacity for Violence and Control

TCOs and FTOs enforce control over trafficking routes and perpetrate violence against rivals, government forces, and innocent civilians.[63] Their actions destabilize communities, domestic and abroad, by limiting legitimate economic opportunity and encouraging all types of criminal activity. Their ability to project power and maintain their criminal empires is directly linked to their access to illegal weapons, many of which are illegally trafficked from the United States.[64] This objective is to systematically dismantle the firearms trafficking networks that arm these dangerous groups while protecting the Second Amendment rights of American citizens. By severing this critical supply line, we will degrade their ability to use violence and intimidation as tools of their trade, making their operations more vulnerable and directly contributing to their eventual dismantlement.

Sever TCOs from the Global Financial System to Attack Their Core Motivation: Profit

In coordination with HSTF investigations, the Department of the Treasury will aggressively apply targeted economic sanctions and other financial measures against foreign TCOs and their global network of financial and logistical facilitators. The designation of high priority TCOs as FTOs provides powerful new authorities to attack their financial viability. The U.S. government will leverage law enforcement authorities to seize and forfeit assets held by these organizations and their affiliates anywhere in the world. The Department of the Treasury will also take action, in partnership with foreign jurisdictions, when possible, against foreign financial institutions that facilitate the laundering of drug proceeds. The Department of the Treasury will leverage Bank Secrecy Act reporting from U.S. financial institutions and financial intelligence from international partners to identify financial transactions including related to TCO activity, share that information with government partners, and leverage special measures authorities to sever TCOs and those who facilitate their activities from the U.S. financial system. Treasury will also facilitate information sharing with and by U.S. and foreign financial institutions on the laundering of drug proceeds and consider other policy, enforcement, intelligence, and regulatory tools to identify, disrupt, and disable TCOs and associated threats to the United States.

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Action Items

Fully Resource and Empower HSTFs for Enterprise Investigations

The Trump Administration will ensure the HSTFs are fully resourced and empowered to serve as the nation's primary mechanism for conducting integrated, long-term enterprise investigations against TCOs. The HSTFs will bring together the necessary personnel, expertise, and legal authorities from across federal, state, local, territorial, and tribal agencies to target the command and control of TCOs and build the prosecutable cases needed to permanently dismantle them. In doing this, HSTF enterprise investigations will ensure that border and domestic drug interdictions are systematically linked to broader, intelligence-driven efforts to dismantle the entirety of these criminal enterprises, from their leadership and financial networks to their logistical and distribution cells. Within the United States, a key focus for HSTF enterprise investigations will be targeting the criminal organizations, including those with ties to China, that exploit state-level marijuana laws to establish large-scale illicit cultivation and interstate distribution networks.

Illegal Marijuana Grows Destroying American Land and Supporting Drug Cartels

The marijuana trade in the United States is no longer a scattered, low-level problem; it has been co-opted and industrialized by sophisticated, transnational criminal organizations, particularly those with ties to China. These groups systematically exploit states where marijuana has been legalized under state law, leveraging these markets and lax regulations to establish massive, unlicensed cultivation operations. A stark illustration of this is Oklahoma, where law enforcement estimates that Chinese criminal groups run more than 80% of the state's thousands of marijuana and hemp farms. The scale is staggering: in 2023, the state's marijuana production exceeded its entire licensed medical demand by at least 32 times, with an estimated 85.5 million plants unaccounted for. This massive overproduction is not for local consumption; it is clear evidence of a coordinated criminal enterprise dedicated to trafficking marijuana across state lines to supply the nation's black market. These operations are not just agricultural; they are hubs of poly-crime involving human trafficking of exploited laborers, sophisticated money laundering, and the use of dangerous, unregistered pesticides that threaten public health and the environment.

Text Box 15: Illegal Marijuana Grows Destroying American Land and Supporting Drug Cartels[65]

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Target and Dismantle Online Drug Trafficking

Federal agencies, operationalized through the HSTFs, will target and dismantle the virtual drug markets, payment mechanisms, and social media applications used by TCOs. This initiative will combine sophisticated cyber investigations with undercover operations to identify and arrest traffickers who operate online. The Administration will also pursue new policies and legislation to compel greater cooperation from social media and technology companies in identifying and removing accounts used by TCOs and FTOs for drug sales, recruitment, and communications.

A Victim of Social Media and Counterfeit Pills
Sammy Chapman, Forever 16

The death of 16-year-old Sammy Chapman in Santa Monica, California, tragically illustrates the dangers of online drug trafficking. In February 2021, a dealer contacted Sammy on Snapchat and delivered a pill that Sammy believed was a legitimate prescription drug directly to his home. The pill was, in fact, a counterfeit with a lethal dose of fentanyl. Sammy took it and never woke up, a heartbreaking example of how dealers now use social media to bring deadly poison directly into American homes, bypassing the watchful eyes of parents.

Sammy's death highlights one of the many dangerous shifts in the drug trade. According to the DEA, this is not an isolated incident; Mexican drug cartels are now harnessing social media platforms as the "perfect drug trafficking tool," directly linking online sales to overdose deaths across the nation. Risky, in-person street deals are being replaced by anonymous online sales through social media and encrypted apps. TCOs market counterfeit pills disguised as legitimate prescription medications, which can be delivered as easily as a pizza.

These fake tablets often contain lethal doses of fentanyl, and unsuspecting users are dying from these hidden poisons, even in their own bedrooms. This deadly deception is why the DEA warns that "One Pill Can Kill."

Text Box 16: A Victim of Social Media and Counterfeit Tablets - Sammy Chapman, forever 16[66]

Systematically Levy Financial Sanctions and Prosecute Money Launderers

A TCO that cannot move its money cannot survive. The Department of the Treasury will prioritize sanctions against TCO leadership, their global financial facilitators, and alternative revenue schemes, using intelligence from HSTF-led investigations to support these designations. Treasury will also leverage financial intelligence reported pursuant to Treasury authorities, including the Bank Secrecy Act, as well as impose "special measures" when appropriate to safeguard the U.S. financial system from threats stemming from TCO-related activities. Simultaneously, the Department of Justice (DOJ), working within the HSTF construct, will intensify the investigation and prosecution of sophisticated money laundering networks, specifically targeting Chinese Money Laundering Networks (CMLNs) that utilize huala-like informal value transfer systems to wash cartel proceeds. This effort will leverage interagency

expertise, including from DoW, to dismantle these shadow banking systems, enhancing its capacity to trace and seize illicit proceeds in cryptocurrencies, cash applications, and other emerging financial technologies.

Maximize the Use of Rewards Programs to Generate Intelligence

To generate critical intelligence on TCO leadership and bring high-value targets to justice, the Administration will maximize the use of U.S. Government rewards programs. The Department of State's Narcotics Rewards Program and Transnational Organized Crime Rewards Program, along with all other federal rewards programs, will be robustly promoted and utilized to encourage individuals to provide information leading to the arrest and conviction of TCO leaders and key associates. These programs are a cost-effective force multiplier that can dismantle organizations from the inside out and will be a key tool in our global campaign.

Disrupt Firearms Trafficking and Associated Violence through Crime Gun Intelligence

TCOs and FTOs rely on firearms illegally trafficked from the United States to enforce control over their drug trafficking routes and perpetrate violence in our communities.[67] To sever this critical source of their power, the HSTF leads a national effort to dismantle these illegal firearms trafficking networks. This will be accomplished by systematically utilizing Crime Gun Intelligence (CGI), a comprehensive approach that includes firearms trace data to identify and disrupt the flow of firearms to illegal commerce. A vital component of CGI is the Crime Gun Intelligence Centers, which along with the expanded use of the National Integrated Ballistic Information Network (NIBIN), allow investigators to link firearms used in multiple shooting incidents. By connecting otherwise unrelated crime scenes, NIBIN helps identify and target the violent offenders and networks that use gun violence to further their drug trafficking activities.

Leverage All-Source Intelligence to Destroy TCOs

The United States will use all available diplomatic, intelligence, military, and economic tools to dismantle the TCOs threatening our nation. The HSTF National Coordination Center (NCC) works directly with the IC to fuse all-source intelligence to create comprehensive network maps of TCO leadership. As the central repository for law enforcement information on these TCOs, the HSTF NCC will ensure that all information related to designated FTOs is passed to NCTC to be fused with terrorism intelligence and support the full spectrum of the U.S. counterterrorism mission. This detailed intelligence will be used to target key leaders and operational planners for investigation, arrest, extradition, and prosecution, with the ultimate goal to degrade their ability to operate as a cohesive global enterprise. The specific operational plans and targets are detailed further in the Classified Annex.

Chapter 5: Creating a Drug-Free America as a Social Norm

Introduction

The Trump Administration is working to reclaim our nation's future, and that fight begins by preventing drug use before it ever starts. The *Strategy* is not limited to dismantling the criminal and terrorist organizations poisoning our communities, but, instead, represents a broader effort to restore our nation from the scourge of illicit drug use. This begins by recognizing there is no more effective means of defeating addiction than promoting a drug-free America as the social norm.

Regrettably, in recent years, American society has become increasingly permissive of illicit drug use, even as overdose deaths continue at unfathomable levels. Despite the vast majority of Americans abstaining from drugs, tens of thousands of Americans are dying each year. Whether through film, music, or public usage, this normalization only serves to promote drug use, resulting in a societal death spiral.

America must embrace and bolster the social norm that most people do not use drugs. Data shows that most Americans understand the serious risks of drug use and make the choice to be drug free.[68]

Prevention science provides the tools for this fight. It is not merely a study; it is our order of battle for fortifying our communities. It draws upon disciplines such as epidemiology, psychology, medicine, and neuroscience, and identifies and applies evidence-based strategies that strengthen protective factors and reduce risk factors at the individual, family, and community levels.[69]

Prevention is essential for a healthy, safe, and thriving society, and foundational to achieving the Administration's Make America Healthy Again goals. Substance use and early risk behaviors that take root during childhood and thus, it is critical that we prevent substance use in the first place to prevent the progression of substance use and mental health challenges, and to prevent and reduce the health consequences associated with these conditions. Investing in primary prevention, before drug use starts, saves lives and resources. Studies have shown prevention education grounded in science resulted in decreased substance use, decreased violence, decreased suicide, and better academic achievement among youth who received it.[70] An analysis by the Substance Abuse and Mental Health Services Administration (SAMHSA) showed that effective school-based prevention programs can save up to $18 in future costs for every $1 invested.[71] Other studies estimate long-term savings of up to $64 per dollar invested, depending on the approach.[72] Yet, evidence suggests that many adolescents have limited exposure to substance use prevention efforts, and that evidence-based prevention curricula are not consistently implemented in schools. SAMHSA data indicate that approximately one quarter of adolescents reported no exposure to prevention messages through school.[73] Moreover, research shows that while many schools provide some prevention education, relatively few adopt evidence-based curricula, with widespread reliance on locally developed or non-evidence-based approaches and inconsistent implementation across settings.[74] Expanding access to evidence-

based school and community-based prevention programs is essential to strengthen families and communities while reducing future treatment and enforcement costs.

The Public Health Approach: A Strategy for the Whole Nation

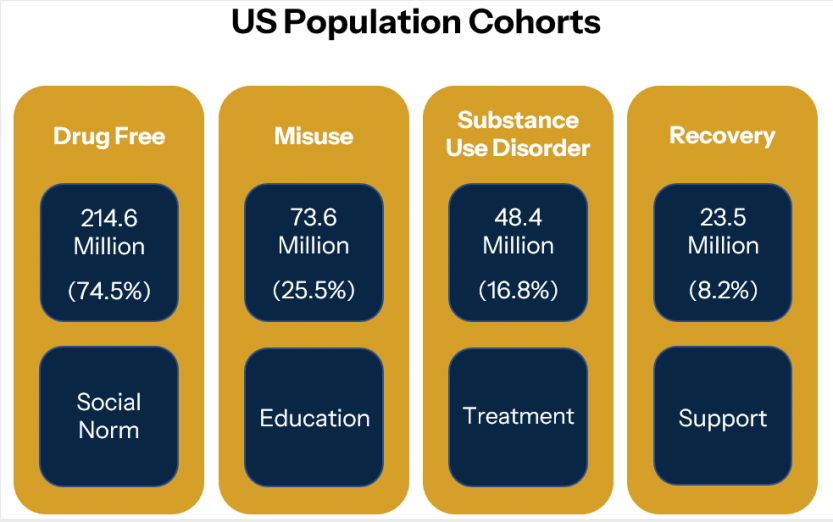
The public health section of this *Strategy*, which begins with this chapter and continues through Chapter 8, is organized to address the full spectrum of substance use and recovery. This organizational structure is intentional; it reflects the real-life status of millions of Americans and demonstrates why a comprehensive, multi-pronged approach is essential.

Different population cohorts require different policies. The largest group—214.6 million Americans (74.5%)—are not currently using illicit drugs. They embody the social norm, protecting their health and modeling a lifestyle this *Strategy* promotes. Chapter 5 is our plan to support them through robust, evidence-based prevention.

Millions of others, however, are at risk for, or are currently using drugs, misuse drugs or have an active substance use disorder. An estimated 73.6 million Americans have misused drugs in the past year, while 48.4 million (16.8%) have a substance use disorder. Chapter 6 details our intervention plan to provide these individuals with early support and compassionate, mainstream treatment. For those at immediate risk of a fatal overdose, Chapter 8 provides our critical rescue plan for overdose response.

Finally, 23.5 million American adults are living in recovery. They are a testament to hope and warrant our full support. Chapter 7 is our plan to help more Americans initiate and sustain recovery. Together, these chapters provide a unified strategy to meet Americans at every stage of the public health continuum.

President Trump's Great American Recovery initiative addresses prevention, treatment, and recovery of addiction at all population cohorts.



Text Box 17: The Public Health Approach: A Strategy for the Whole Nation[75,e]

[e] Notes: The denominator used for these calculations is 288.2 million people aged 12+. "Drug Free" represents people aged 12+ who did not use illicit drugs in the past year. "Misuse" represents people aged 12+ who used illicit drugs, including the misuse of prescription

The Administration will therefore support education-based prevention programs and sustain a campaign of coalition-building through the Drug-Free Communities (DFC) Program and other efforts to promote drug-free lifestyles throughout all facets of American culture. Groups with whom the Administration will engage include faith leaders, educators, healthcare professionals, media, and other influential individuals whose combined voices resonate throughout every American community. Indeed, our nation must challenge ourselves to set aside our differences and unite in promoting health and living drug free.

These coalitions, in turn, will assist in developing the messaging necessary to effectively communicate the dangers of illicit drug use and promote drug-free lifestyles at the local level. After messaging has been developed, it will then be amplified through mass communications in paid, social, broadcast, and print media. These messaging campaigns will serve to better inform the nation of the harms of illicit drug use to prevent addiction, as well as stories of recovery to encourage those currently suffering from addiction to seek treatment.

For the first time, this *Strategy* includes a Prevention Framework (Appendix G) that offers a unifying framework for action. It invites every reader to see how prevention can start anywhere—at home, in schools, and in workplaces—and how collective action can build healthier, drug-free communities.

Key Principles

Promote Non-Use as the Social Norm

The overwhelming majority of youth and adults do not use illicit drugs, and prevention strategies must reinforce and build upon that truth. Families, educators, coaches, and mentors play a critical role in modeling healthy behaviors. By equipping them with accessible tools and resources, prevention messaging normalizes healthy, drug-free lifestyles as the responsible and aspirational choice for young Americans.

psychotherapeutics, in the past year. "Substance Use Disorder" represents people aged 12+ who had an alcohol or drug use disorder in the past year; respondents who used alcohol or drugs in the past year were classified as having an SUD in that period if they met criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5). "Recovery" represents people aged 18+ who considered themselves to be in recovery from a substance use problem. Categories are not mutually exclusive and should not be added.

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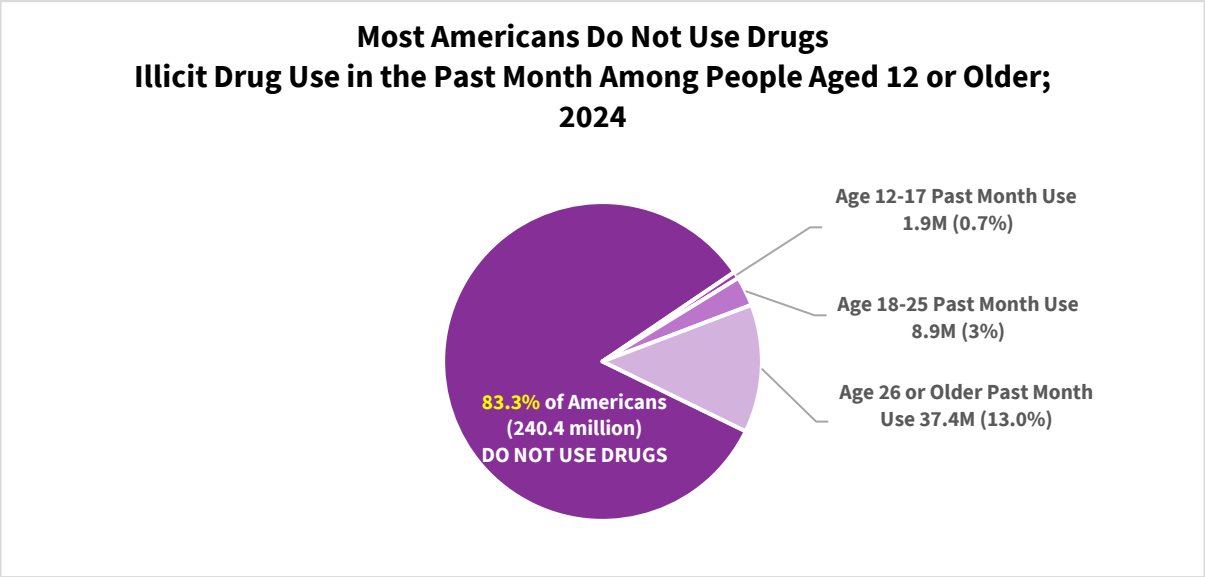
Promoting Being Drug-Free as the Social Norm



Most Americans are making the healthy choice to protect their brain, broader health, and well-being by not using drugs. According to the 2024 National Survey on Drug Use and Health, 83.3% of Americans do not use drugs, underscoring that non-use is the clear social norm. Of the 16.7% who use drugs, more than three quarters are over 25 years old. Illicit drugs include any use of marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamines, or misuse of prescription medications.

Text Box 18: Promoting Being Drug-Free as the Social Norm[76, f]

Ensure Access to Evidence-Based Prevention Programs

The Administration will seek to prevent drug use before it starts by expanding access to primary prevention programs that build resilience, teach coping and decision-making skills, and strengthen protective factors such as family engagement, community connections, and academic success. By supporting the implementation of these programs through schools, faith-based and civic organizations, local Drug-Free Communities (DFC) coalitions, and other youth-serving networks, we can reach young people where they live and learn. The Administration will also encourage states, localities, and Tribal governments to embed prevention into their existing health, education, and public safety systems, ensuring programs are implemented with fidelity and evaluated for results. Prevention must become a national standard, not an afterthought. When communities unite around prevention, they foster environments where every young person has the opportunity to live free from drugs and full of purpose.

[f] The denominator used for these calculations is 288.2 million people aged 12+.

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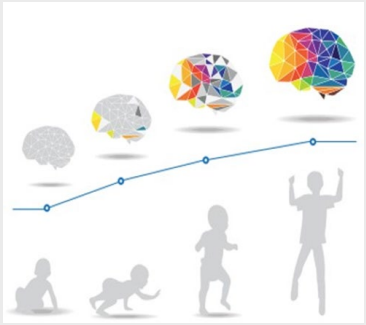
Substance Use and the Developing Brain

Brain development is characterized by rapid neural growth, heightened sensitivity to social influence, and ongoing maturation of cognitive and emotional control systems. The prefrontal cortex—the region of the brain responsible for decision-making, impulse regulation, and judgment—continues developing well into the mid-20s.[79]



During this stage, the brain's reward pathways are particularly active, increasing susceptibility to experimentation and risk-taking behaviors, including substance use.[80]

Science demonstrates the neurodevelopmental vulnerability of growing brains and underscores the need for prevention to focus on delaying initiation.

Comprehensive prevention strategies that combine accurate education, supportive adult relationships, and engagement in positive activities not only prevent early substance use but also enhance overall brain health, emotional regulation, and lifelong decision-making skills.

Text Box 19: Substance Use and the Growing Brain[77]

Leverage Media and Educational Digital Platforms for Prevention Messaging

A national prevention effort must reflect today's communication landscape. The Administration will expand prevention messaging by partnering with media outlets, creative industries, and digital platforms to promote the shared value of living drug-free. Through entertainment, sports, education, and community campaigns, prevention messaging will be delivered in ways that are relatable, aspirational, and grounded in American values. These efforts will draw from past public health successes while embracing modern communication tools to reach audiences of all ages. By coordinating across federal, state, and private partners, the Administration will promote a unified message that celebrates responsibility, family, and faith, making it clear that living drug-free is the American way of life.

Foster Drug-Free Workplaces

Primary prevention starts with youth but continues in the workforce, especially in safety sensitive positions. Substance use in the workplace can lead to decreased productivity and higher rates of injury, while also negatively affecting families and communities.[78] The Drug Free Workplace (DFW)[g] framework, established through federal law, is a foundational primary prevention approach for the workforce.[79] It provides the greatest incentive for living drug free that promotes both personal health and a safe work environment. The program creates a standard for drug testing, early detection of health concerns, and a strong incentive for entering treatment

[g] SAMHSA's Division of Workplace Programs (DWP) oversees programs to eliminate illicit drug use in federal workplaces and helps all workplaces become drug-free - https://www.samhsa.gov/substance-use/drug-free-workplace/about.

and recovery if necessary. The DFW and other Employee Assistance Programs are the standard for the federal workforce, as well as a model for the public, and should be supported, modernized, and enhanced.

Objectives

Increase the Percentage of Youth and Young Adults Who are Drug-Free

Most adults with addiction began using substances before age 18.[80] Importantly, addiction is up to seven times more likely if drugs are initiated while the brain is still developing.[81] This underscores the importance of targeting prevention at the earliest possible ages. This evidence aligns with the broader public health principle that prevention, when implemented early and while the brain is developing, yields exponentially greater public health and economic benefits than treatment after the fact.

Strengthen Drug-Free Workplace Initiatives

Workplaces are essential environments for advancing prevention, supporting early intervention, and building cultures of health and accountability. Workplace drug testing is an essential and effective prevention program that must be modernized, expanded, and aligned with Recovery-Ready Workplace Policies, which emphasize linking workers with a substance use disorder to treatment and providing services and support to ensure a successful return to the workplace. The Administration will promote initiatives that encourage employers to adopt approaches that support rehabilitation, retention, and comprehensive prevention policies, including employee education, wellness promotion, and confidential referral programs. These initiatives will reflect modern workforce realities while reinforcing the expectation that a drug-free environment contributes to productivity, safety, and the overall success of American businesses. The Drug Free Workplace (DFW) model, and the federal government, will lead by example, demonstrating how prevention contributes to both public health and workplace excellence.

Action Items

Strengthen the Evidence Base and Recommend Effective Primary Prevention Programs

There are hundreds of well-researched, evidence-based primary prevention programs that have demonstrated effectiveness in reducing drug use and improving academic achievement. There are even more promising education and other prevention programs that are new and innovative but have not been rigorously evaluated. The Trump Administration will work on an expedited short-term and long-term cost-effectiveness evaluation process to increase the number of effective primary prevention programs available across our Nation.

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Increase the Implementation of Evidence-Based Primary Prevention Strategies

The Trump Administration will prioritize expanding the implementation of evidence-based school and community-based prevention programs. This is essential to achieving population-level change. Federal agencies and grantees will be encouraged to integrate evidence-based prevention frameworks and data-driven practices into new and existing programs. Through enhanced coordination, technical assistance, and accountability mechanisms, this effort will ensure that federal prevention investments are aligned with the latest research and implemented with fidelity across sectors. Widening the reach of evidence-based prevention programs ensures that all youth, families, and communities benefit from evidence-based interventions. By scaling and sustaining these programs, the *Strategy* seeks to advance a public health model that embeds prevention in the everyday environments where young people live, learn, and grow.

Develop a National Media and Education Campaign That Reinforces a Drug Free America as the Social Norm

The Trump Administration will promote a unified, bold national media campaign that highlights living drug-free as the social norm in America. This campaign will use multiple media channels including television, radio, social media, and streaming platforms to promote messages that celebrate health, youth leadership, responsibility, and the future. By working with trusted messengers such as celebrities, athletes, educators, and community leaders, the campaign will connect with youth and families on the platforms they use every day. The campaign will not only raise awareness of the dangers of drug use, but also elevate the benefits of a healthy, drug-free life. This effort represents a full-scale cultural initiative to counter the false narrative that drug use is the norm in America. Every aspect of this campaign will have a strong evaluation component to measure engagement, commitment to behavior change, and other outcomes.

The Administration will advance a unified, whole-of-government approach to prevention that engages federal partners such as the Department of Health and Human Services (HHS), the Department of Education (ED), the Department of Labor (DOL), the Department of Justice (DOJ) and others to align resources and strategies to reinforce prevention messaging across national initiatives. Together, these actions will elevate prevention as a core American value, unifying the Nation around a shared goal: protecting the developing brain; promoting healthy decision-making; and building a stronger, drug-free future for everyone.

Establish New Partnerships with Organizations That Support Healthy Youth and Expand Primary Prevention

To ensure primary prevention remains a sustained national priority, the Administration will strengthen collaboration with leaders from public health, law enforcement, education, healthcare, faith-based communities, the private sector, and families affected by addiction. Through ongoing engagement and coordination across these sectors, the Administration will identify emerging trends, share innovative practices, and promote opportunities to strengthen prevention partnerships nationwide, while following the principles of prevention science and evaluation. Building on the success of the Drug-Free Communities Program and the coalition model comprised of 12 required sectors, these collaborative efforts will help extend prevention into organizations that shape youth development such as athletic leagues, after-school programs, and

educational institutions, ensuring that prevention messages reach Americans where they live, learn, and grow. Together, these partnerships will help unify the nation around a common goal: preventing drug use before it starts and protecting the next generation from its devastating effects.

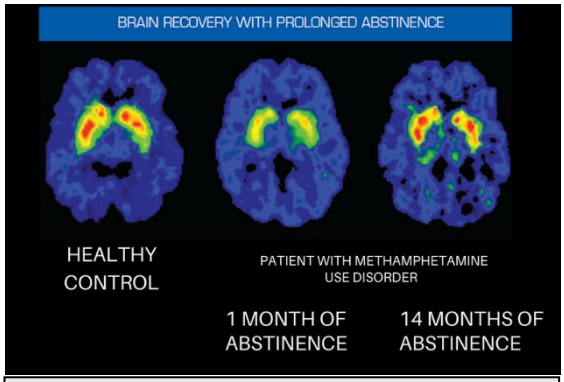
Support and Enhance the Federal Drug-Free Workplace Efforts as A Model for a Safe and Drug Free Work Environment

The federal Drug-Free Workplace Program (DFWP) will be strengthened and modernized to incorporate contemporary technologies, such as oral fluid and hair testing, and work to enable testing for evolving threats. Expanding testing panels will help employers and policymakers adapt to the changing drug environment. The Drug-Free Workplace Act of 1988 (41 U.S.C. § 81) should be enforced, especially for federally-funded programs. The Administration will ensure that prevention, education, treatment, and recovery support remain central to federal workforce policy. As a national model, the federal government will lead by example, expanding employee prevention education, offering voluntary well-being, counseling, and treatment resources, facilitating successful return to the workplace following treatment, and reinforcing accountability through clear policies and standards. The Administration will also explore approaches to recognize and encourage private employers who adopt strong drug-free and recovery-ready workplace practices as smart business sense. Together, these efforts will showcase how prevention contributes not only to health and safety but also economic growth, workforce reliability, and public trust. The Administration will also find innovative ways to sustain drug-free workplaces, such as by expanding and integrating recovery-ready workplace efforts in overall drug-free workplace practices. DOL's Office of Disability Employment Policy (ODEP) will continue to drive the President's innovative "Stay at Work/Return to Work" (SAW/RTW) initiatives. SAW/RTW initiatives will help prevent more Americans from ending up on benefits programs such as Social Security Disability Insurance (SSDI).

Chapter 6: Bringing Help at All Stages of Addiction to the Mainstream

Introduction

It is time to bring help for addiction to the forefront in America. It should be easier to access treatment than it is to buy illicit drugs, and this means that the general public should know how to detect signs of potential addiction, obtain screening and assessment, and access treatment when necessary. Addiction, also known as substance use disorder[82], is a chronic, relapsing disease of the brain[h] that is treatable. Like other chronic conditions, addiction emerges from a combination of genetic and environmental risk factors. Sadly, in the United States drugs are readily accessible, especially to young people, leading to 48.4 million, or 16.8% of Americans suffering a past-year substance use disorder.[83]



Dopamine receptors in brain can recover with drug abstinence. Each heatmap reflects the density of dopamine transporters (with yellow/orange/red representing an increase)

https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery.

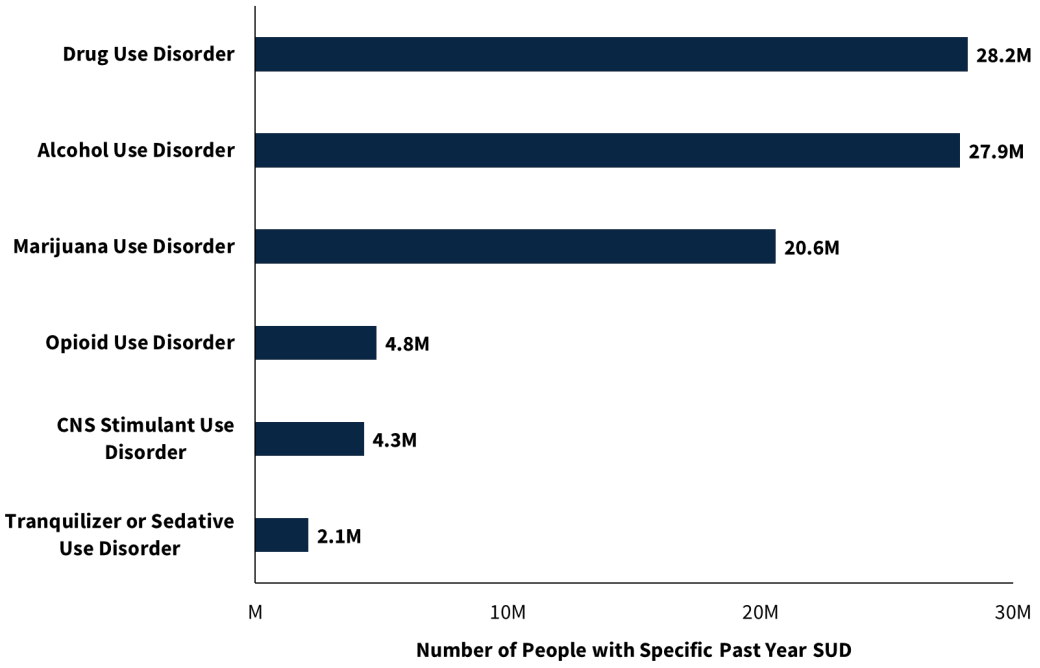
Tackling the addiction crisis requires a serious effort at multiple levels. It must begin with a clear understanding that drug use is risky and unhealthy. Next, there must be an emphasis on recognizing drug use and providing help early, before the development of severe addiction. While addiction is typically seen as an adult condition, it can also be a pediatric disease that can begin as early as middle school.[84] Like any other medical condition, early detection and intervention leads to much better outcomes and is less costly than treatment after the disease has progressed. And finally, treatment for addiction should be readily available and integrated into mainstream healthcare, while utilizing the various specialty treatment, peer support, and other community, justice-involved, and faith-based services that meet an individual's needs. Every nonfatal overdose is an opportunity for education and to link that individual to care for their substance use disorder. CDC SUDORS data show that, in 2024, 67.5% of decedents had at least one opportunity for intervention before their overdose became fatal.[85] And we know that connecting people to treatment saves lives. A study by HHS

[h] "All drugs that are taken in excess have in common the ability to directly activate the brain reward systems, which are involved in the reinforcement of behaviors and establishment of memories…. An important characteristic of substance use disorders is an underlying change in brain circuits that may persist beyond detoxification, particularly in individuals with severe disorders." American Psychiatric Association. (2022). *DSM-5-TR*, pp. 543-544. APA Publishing. https://www.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425787

researchers found that receiving treatment after a nonfatal overdose reduced the risk of dying from a fatal overdose in the following year by more than 50%.[86] Addiction affects the individual as well as the family, and comprehensive care must account for others affected by the disease.

Just as we do not wait until diabetes is fully established to monitor blood glucose levels, nor do we wait for a heart attack or stroke to screen for hypertension and high cholesterol, we must begin addressing addiction through early identification and intervention. This can be done by regular screening for drug use, early intervention, and linking individuals to treatment at every opportunity.

Bringing addiction care to the mainstream requires the integration of addiction care with other types of medical care. It also requires regular screening beginning in middle school, improved diagnosis and documentation, the increased use of peers and faith-based resources for those who need help, consumer protections from fraudulent services, and services of sufficient duration to allow for the restoration of brain function that has been hijacked by drugs. With the changing drug market, diagnoses should account for new drugs such as psychoactive derivatives of hemp or other high-THC products, kratom products with high 7-OH levels, and "legal psychedelics" or "mushroom edibles" made from *Amanita muscaria,* that can be consumed in multiple ways.



Note: The estimated numbers of people with SUDs are not mutually exclusive because people could have use disorders for more than one substance.

Figure 1: Past Year Substance Use Disorder by Select Substances: Among People Aged 12 or Older; 2024[87]

Addiction treatment should be individualized and comprehensive, providing behavioral, psychosocial, and pharmacological interventions tailored to the individual's evolving needs. Nearly half of all those who suffer from addiction also have a mental health disorder, and the intersection of mental health and addiction must be an integral part of any treatment solution.[88]

It is critically important to identify people who are experiencing psychosis for the first time, as it may be related to drug use. When patients understand that their acute psychiatric symptoms were related to drug use, they may be more likely to cease drug use and access treatment when necessary. Some providers may be reluctant to identify drug use as a potential driver of acute psychosis for fear of potentially missing an underlying genetic or other factor. Because many people with mental health issues use substances, and in people with psychosis, problematic drinking and use of illicit drugs occur more frequently than in the general population, the relationship between psychosis and substance misuse is complex, making it difficult for providers to distinguish between those underlying factors when patients present with psychosis.[89] One study found that over 30 percent of patients with a substance-induced psychosis later developed bipolar or schizophrenia-spectrum disorders, and nearly half of those with cannabis-induced psychosis (47.4 percent) developed bipolar disorder or schizophrenia.[90] Failing to identify and correctly treat substance-induced psychoses could represent a tragic lost opportunity. Additionally, convergent evidence from multiple sources suggests that cannabis exposure increases the risk of psychosis, and the prevention of marijuana use could serve to reduce the prevalence of psychosis, in addition to reducing cannabis use disorder and other consequences.[91]

Medications are an important tool in treating addiction to several substances, including tobacco and alcohol. There are medications approved by the Food and Drug Administration (FDA) for the treatment of opioid use disorder, also known as medications for opioid use disorder (MOUD), including buprenorphine, methadone, and naltrexone. These medications should be readily available to prevent withdrawal, treat addiction, and support sustained recovery. As long as it falls within their scope of practice, any physician or licensed prescriber can prescribe naltrexone, those with a DEA license for schedule III substances have the capability to prescribe buprenorphine, while methadone can currently only be provided for OUD by clinicians in federally-regulated opioid treatment programs.

While there are currently no medications approved for treatment of methamphetamine, cocaine, or marijuana addiction, pharmaceutical research in this domain should be accelerated. Until then, targeted non-pharmaceutical treatments must be readily available to meet this demand. Contingency management, a behavioral treatment, has been very successful in treating stimulant use disorder and cannabis use disorder, and is currently underutilized. The Administration will work to increase adoption of this evidence-based approach.[92]

According to the 2024 National Survey on Drug Use and Health (NSDUH), in 2024, for the first time ever, the number of Americans experiencing a drug use disorder surpassed the number experiencing an alcohol use disorder.[93] This shift has been driven principally by increasing rates of marijuana use and addiction.[94] We must ensure that we have the tools for Americans who want help with marijuana addiction and withdrawals.

Safe prescribing practices, such as those detailed in the 2022 Clinical Practice Guideline for Prescribing Opioids for Pain[i], and prevention of misuse of legal pharmaceuticals should continue to be a priority within the healthcare community. This includes screening for polypharmacy and

[i] https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm

receiving these medications from multiple providers, educating about drug interactions among prescription medications, the potential negative interactions between supplements and prescription drugs, and indicated drug testing.

Addiction is a chronic, relapsing, but treatable disease with a relapse rate similar to that of hypertension and asthma.[95] While it may be frustrating when someone with a chronic disease fails to follow medical advice and relapses to unhealthy habits and their consequences, often they are treated with compassion and helped back onto a path of wellness. Similarly, relapsing from addiction is frustrating and potentially dangerous, yet warrants the very same level of compassion and care as other chronic relapsing diseases without shame or judgement.

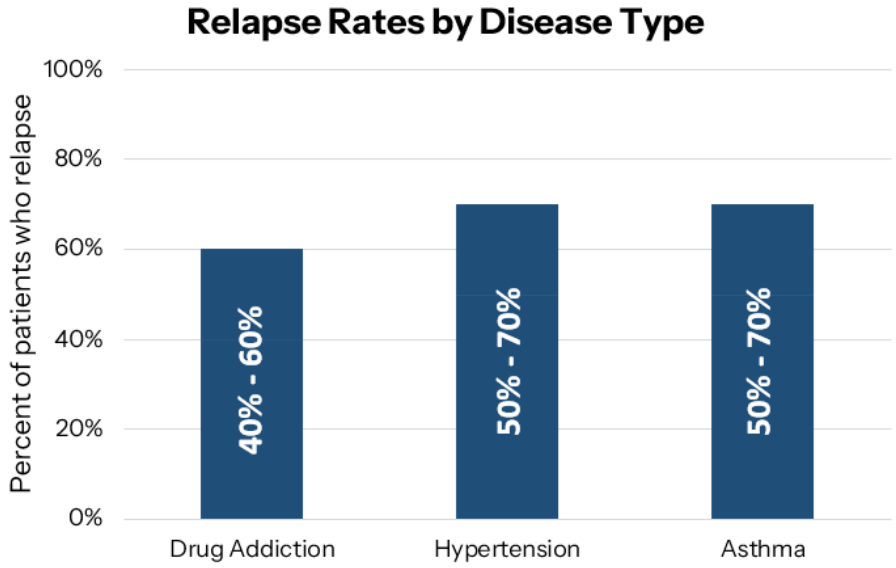


Figure 2: Comparison of Relapse Rates Between Substance Use Disorders and Other Chronic Illnesses[96]

Key Principles

Accurate, Timely Detection and Early Intervention

Drug use screening, like screening for other chronic health conditions, must be adopted, updated, and consistently conducted across the healthcare system and in other settings. Individuals who screen positive should receive education, resources, intervention, and linkage to specialty care as appropriate.

Expand Treatment Capacity, Availability, and Access

As we strive to make access to drug treatment easier than access to drugs, we must expand our capacity to provide evidence-based early intervention, treatment and related services. Additionally, parity, which requires health insurance to cover mental health and substance use disorder benefits on par with medical or surgical benefits; building capacity in outpatient and inpatient health care settings; sobering centers; recovery community centers; faith-based settings; and other outcome-based community resources is paramount.

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Patient Protection for Quality Rehabilitation Services, Quality Treatment, and Payment

Consistent addiction treatment, quality standards, and protection from fraudulent healthcare practices are necessary to ensure access to quality, evidence-based treatment for those who need it, and to prevent their exploitation by unscrupulous actors. Voluntary consensus standards can ensure quality and consistency among large and small treatment providers, public and private payers, and standards organizations. In accordance with Executive Order 14379, "The Great America Recovery Initiative", we should focus on addressing any provider workforce shortages that particularly impact the availability of mental health and substance use disorder treatment, especially in rural areas.

Objectives

Increase the Number of Screenings for Drug Use and Early Interventions

Early intervention for drug misuse at early-stage addiction results in better outcomes than waiting until substance use problems are severe and chronic. Therefore, there is a need to increase the number of screenings for drug use in healthcare settings, including drug testing in hospital emergency departments, screening in other community settings, and early intervention. Existing healthcare screening methodologies and reimbursement codes should be more fully utilized and improved to prevent and treat addiction early. New reimbursement and billing codes should be developed as needed.

Increase Access to Treatment for People with a Substance Use Disorder

Consistent with the vision that drug treatment should be easier to obtain than illicit drugs, more people should be connected with care that results in long-term recovery. There is no one-size-fits-all solution for addiction, and care should be available in healthcare, community, justice-involved, and faith-based settings.

Action Items

Enhance and Support Early Intervention Efforts, Education, and Awareness

In collaboration with federal partners and stakeholders, the Trump Administration will improve, update, and expand drug screening to match the current drug environment. It is important to incentivize early detection, intervention, and referral to care. This includes measures to improve the identification, diagnosis, testing, and documentation of drug use.

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Prioritize Robust Availability of Evidence-Based Treatment Across States, Localities, and Tribal Regions

The Trump Administration will prioritize increasing access to evidence-based substance use disorder care throughout the disease and recovery continuum; expanding and enhancing crisis intervention services; intervening at first episode of drug-associated psychosis; building co-occurring mental health disorder intervention and treatment capacity; expanding the addiction medicine and behavioral health professional workforce and training; and integrating peer support across a wide variety of health care, social service, child welfare, faith-based, and criminal justice settings.

Treatment First Policy for Homelessness

The Trump Administration is making historical changes in the way it serves homeless Americans. The "Treatment First" model focuses on wraparound services to address the root causes of homelessness and promote independent and self-sufficiency. It addresses the homeless root causes of drug addiction and mental health illness.

In 2024, the number of people experiencing homelessness reached record levels. Between 2023 and 2024, under the failed "Housing First" model, the number of people experiencing homelessness increased by 18%, with nearly 150,000 children experiencing homelessness, reflecting a 33% increase (32,618 more children) over 2023. The policy shift is about restoring dignity to vulnerable Americans. We need to greatly decrease homelessness and addiction and restore the ability to be self-sufficient and productive.

Implementing President Trump's Executive Order on Ending Crime and Disorder on America's Streets, the Department of Housing and Urban Development (HUD) "Treatment First" approach restores dignity and accountability by requiring individuals struggling with addiction to participate in treatment and recovery services as a condition of receiving taxpayer-funded housing. This policy is a critical demand-reduction tool. By redirecting the majority of the Continuum of Care grant program budget toward transitional housing and treatment-focused programs, the Administration is removing the enabling environment that allowed open-air drug use to fester in our cities.

ONDCP will work with HUD and SAMHSA to develop a best practice model for treatment focused programs for the homeless population.

Text Box 20: Treatment First Policy for Homelessness[97]

Ensure Access to Evidence-Based Treatment for All Substance Use Disorders

While continuing to emphasize treatment for opioid use disorder, the Trump Administration will encourage the expansion of Contingency Management for stimulant use disorder and cannabis use disorder, and address the challenges posed by rising rates of cannabis use disorder. Contingency Management is an effective tool to treat methamphetamine and cocaine use disorder, and barriers to increase utilization need to be removed. The Administration will also encourage expansion of effective behavioral treatments, such as motivational enhancement therapy (MET), cognitive-behavioral therapy (CBT), and contingency management while also developing new tools to treat marijuana withdrawal and addiction. This includes better fidelity in the diagnosis, documentation, and possible Current Procedural Terminology (CPT), billing, and reimbursement codes for the drugs involved and the specific substance use treatment provided.

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Increase Successful Outcomes and Reduce Recidivism for Those Arrested Who Have an Addiction

The Trump Administration will work across the federal, state, local, territorial, and tribal governments, and with key stakeholders, to develop addiction treatment for individuals involved in the juvenile and criminal justice systems. This includes first-responder deflection programs, drug courts, treatment courts, and treatment and recovery support services in carceral settings, to include state prisons, local jails, and community supervision.

Pursue National Consensus-Based Standards for Addiction Treatment

The Administration will encourage consumer protections for specialty addiction treatment and services that include quality, licensing, reimbursement, and care coordination to ensure the use of evidence-based approaches with improved long-term outcomes. The intensity, types, and length of treatment should be determined by a clinical assessment taking into account neurobiological and psychological considerations, rather than an arbitrary timeline.

Chapter 7: Celebrate and Support Recovery

Introduction

Addiction affects people of all ages, from all walks of life, and from every community. Fortunately, recovery is not only possible, it happens every day in communities across this country. Over 23.5 million Americans consider themselves in recovery from a substance use issue[98]; they are a living testament that recovery is possible.

In announcing his Executive Order on the Great American Recovery Initiative, the President spoke to fostering a culture that celebrates recovery. Recovery is a transformative process. It has been said that addiction is the only disease where individuals can end up with greater health, wellness and quality of life than before their substance use disorder began. In fact, research suggests that quality of life scores for people in long-term recovery from addiction may be higher than those of the general public[99], and some have referred to recovery as being "better than well."[100]

There are many pathways from addiction to recovery, and not all of them include clinical treatment. Recovery can be supported by medications but can also involve peer support, faith-based programs, mutual support, and other services. Recovery community organizations and similar community-based peer-led entities are critically important. These organizations help individuals find and follow a recovery pathway that works for them, whether it involves a 12-Step program, medications, SMART Recovery meetings, faith-based pathways, or a combination of these and other approaches. Recovery community organizations link people to treatment and other services, provide recovery coaching, support reentry from incarceration, provide access to a supportive community of recovering peers, and assist in finding housing or employment, in addition to other support services.

Local coalitions consisting of recovery community organizations, treatment providers, law enforcement officials, recovery residences, recovery-ready workplaces, recovery high schools, collegiate recovery programs, recovery ministries, recovery cafes, people in recovery, family members, and other stakeholders can help build recovery-ready communities by fostering collaboration and information sharing, educating the public, and helping people in recovery rejoin and contribute to their communities. The work needed to build this essential community-based organizational infrastructure must continue.

Addiction has devastating impacts on individuals and their families, but recovery can bring the development of new supportive social networks, the forging of a new identity as a person or family in recovery, service to others, and engagement in peer recovery support services (PRSS).[101,102,103,104,105,106] Moreover, individuals often benefit from participation in mutual support groups such as Narcotics Anonymous, Marijuana Anonymous, or SMART Recovery, and families often find support in Nar-Anon and Mar-Anon family groups.[107,108,109,110,111]

Addiction also affects communities and organizations. However, like individuals and families, communities and organizations can and do recover from the devastating impacts of drug use and addiction. Schools, businesses, other organizations, and entire communities can become "recovery-ready" by raising awareness of addiction and recovery; removing barriers to

treatment; providing recovery support, housing, employment, and education; and by forging formal and informal networks that help community members find and sustain recovery. The Trump Administration is committed to building our Nation's recovery support services infrastructure in order to help more Americans find the gift of recovery.

Key Principles

Expand and Enhance Community-Based Peer Recovery Support Services Infrastructure

The Administration will expand and enhance community-based peer recovery support services infrastructure consisting of recovery community organizations, recovery residences, recovery high schools, alternative peer groups, treatment court alumni associations, collegiate recovery programs, recovery cafes, recovery ministries, and similar entities that help build recovery capital at the individual, family, and community levels. The Administration will also work to promote the adoption of recovery-ready workplace policies nationally, as workplaces are a critical component of recovery ecosystems.

Build Resilient, Recovery-Supportive Communities

Leveraging a coalition approach involving public-private partnerships at the State, local, and Tribal levels can help in the development and implementation of voluntary recovery-ready certification initiatives for communities, employers, faith groups, families, schools, or other entities.

Make Recovery Visible and Valuable

We will celebrate recovery through education and awareness initiatives, and National Recovery Month activities in community, school, and workplace settings.

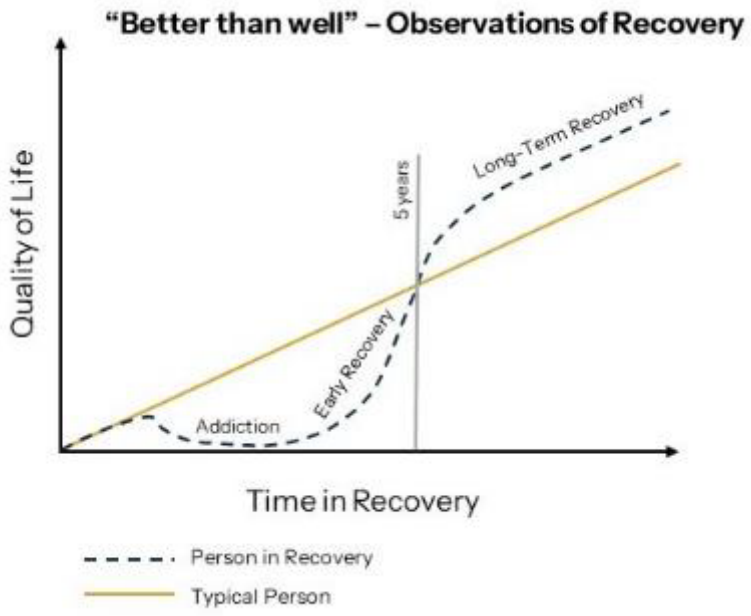

Figure 3: "Better Than Well" – Observations of Recovery[112,j]

Objectives

Increase The Number of People in Recovery

The National Survey on Drug Use and Health (NSDUH) asks respondents aged 18 and older whether they ever had an alcohol or drug use problem. Those who say they have ever had such a problem are then asked if they consider themselves to be in recovery or to have recovered from that problem. Historically, approximately 75 percent of individuals with a self-identified past alcohol or drug use problem indicate that they are in recovery or recovered.

Expand Recovery Friendly Workplaces

Addiction in the workforce is widespread. In 2024, nearly 30 million people with a substance use disorder were employed. Of these, nearly 80 percent worked full-time.[113] Drug use and untreated addiction undermine American productivity and are costly to businesses.[114] That is why it is critically important to increase the number of employers who are well-equipped to address substance use in the workforce and help employees achieve and sustain recovery. Fortunately, employers have natural allies in this effort: in 2024, over 14 million American workers were in recovery or had recovered from a substance use disorder.[115] Recovery-ready workplaces are an important part of a systematic national response to drug use and addiction. Because adopting recovery-ready workplace policies can result in savings, through reduced turnover and increased productivity, and because becoming certified as a recovery-ready workplace can generate

[j] Note: This chart does not reflect a specific study or dataset. Rather it conveys the idea of "better than well" and is generally reflective of research findings on quality of life in recovery.

positive publicity for employers, it is often said that adopting recovery-ready workplace policies is not simply the right thing to do, it makes good business sense as well.

Culturally Rooted Recovery for Native Americans

The pathways to recovery are diverse, deeply personal, and frequently rooted in community and culture. After growing up amid his parents' alcoholism, Don Coyhis, a member of the Mohican Nation, built a successful career in Colorado but nearly lost it to drinking. Though recovery meetings helped him get sober, he found they did not connect to his cultural or spiritual roots, and he saw few Native people attending the meetings, despite widespread addiction in Native communities.

Kateri and Don Coyhis

In 1998, to bridge this gap, Don founded a movement to bring culturally based healing and recovery to Indigenous Peoples, including American Indians and Alaska Natives. His vision was to address healing from alcohol and other drug use by reconnecting people to culture and traditional values.

Don has said that *"culture is prevention … a set of principles, laws, and values that is in harmony with the Earth. It can be Native teachings. It can be the Bible. Culture is going back to the principles, laws and values so that [substance use] isn't something you want to do, because your culture has ways to help you deal with the hurt."*

In 2000, Don invited his 16-year-old daughter, Kateri, to join him and others in completing the Journey of the Sacred Hoop: Wiping the Tears, a 3,800-mile walk to raise awareness of domestic violence in Native communities. That journey also marked the beginning of Kateri's own recovery. In 2020, she became Executive Director of the program, carrying forward her father's vision of healing through culture, community, and spirit.

Today, the Native American program offers culturally grounded programs for adult and youth treatment, prevention, family wellness, healing from grief and trauma, and reentry from incarceration. The program goes beyond sobriety—seeking emotional, mental, physical, and spiritual balance. Programs and resources are open to both Native and non-Native people.

Recovery programs shows how connection, support, shared wisdom, and spiritual guidance can open paths to hope and healing, reflecting the recovery principles highlighted in this chapter.

Text Box 21: The Wellbriety Movement[116]

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Action Items

Expand And Enhance the Nation's Peer Support Services Workforce and Organizational Infrastructure

The Administration will explore mechanisms for funding and otherwise supporting recovery community organizations, recovery community centers, and related peer-led organizations. In addition, the Administration will work to expand the number of recovery high schools, alternative peer groups, collegiate recovery programs, and recovery residences, while ensuring consistent standards and quality. The Administration will work with the Department of Health and Human Services, states, local governments, and non-governmental organizations to leverage the Substance Use Disorder Treatment and Recovery (STAR) Loan Repayment Program to help build a skilled peer support services workforce.

Increase The Number of State and Local Recovery-Ready Community/City Certification Initiatives, State Recovery-Ready Workplace Programs, and Nationally-Certified Recovery-Ready Workplaces

The Administration will partner with States, local governments, Tribal organizations, and other stakeholders to increase the number of recovery-ready community certification programs and state or local recovery-ready workplace programs. The Administration will promote the development of recovery-ready family and faith group initiatives and will build upon existing community certification initiatives to increase recovery ecosystems at the municipal and county levels.

Celebrate and Support Recovery

The Administration will support social media and educational campaigns with new and existing materials to increase public understanding of the process and promise of recovery. As part of these efforts, the Administration will highlight the contributions of people in recovery through national-level events that celebrate recovery.

Chapter 8: Rescue and Overdose Response

Introduction

An overdose, fatal or nonfatal, can occur at any stage of a person's substance use. In some cases, overdose may follow a long-term, severe substance use disorder, but in others, it can be a result of one-time or intermittent use, or accidental exposure. Rescue and overdose response is not just for those with a long-term addiction; it is a critical intervention for anyone at immediate risk of a fatal overdose, regardless of where they are in their substance use journey.

Potent and potentially deadly synthetic opioids, like fentanyl, have infected the entire illicit drug supply, from known illicit drugs to counterfeit tablets sold on the street or through fake online pharmacies. Because fentanyl has become a pervasive feature of the illicit drug landscape and acts as a chemical weapon against our population as recognized by EO 14367, it is critically important that the public be as familiar with overdose recognition and reversal as it is with CPR. Recently, kratom products with high 7-OH[k] content have caused breathing suppression and have been associated with overdose fatalities as well. In 2024, data from CDC's SUDORS identified 995 overdose deaths with kratom or mitragynine detected in toxicology reports.[117] Access to opioid overdose reversal medications, like naloxone, must be as common as having epinephrine to treat an allergic reaction.

An overdose is a critical event, marking a fine line between life and death. For those who are fortunate to survive, this can be a life-altering opportunity. For those without an addiction, who simply made the mistake of using a drug, the poisoning should be a wakeup call to seek a drug-free life. For those who struggle with addiction, the near-death experience can provide an opportunity to begin treatment.

Opioids bind to opioid receptors and decrease pain, but they are associated with decreased respiration, especially at high doses. When breathing stops, eventually the heart stops, leading to death. Opioid overdoses can be reversed by opioid overdose reversal medications, like naloxone, when administered within a narrow time period after the overdose. First approved by the Food and Drug Administration (FDA) in 1971[118], naloxone can rapidly reverse an opioid overdose by binding to opioid receptors in the brain and displacing opioids such as heroin, fentanyl, and morphine.[119] Naloxone can quickly restore normal breathing and save a life. The medication is available as a layperson-friendly, over-the-counter nasal spray and as an injectable. While there are currently no FDA-approved medications to reverse overdoses from other classes of drugs such as stimulants and hallucinogens, new drugs are under development.

In response to the epidemic of opioid overdoses, the federal government has increased support for opioid overdose reversal medications and its distribution. Federal programs allow for the purchase of overdose reversal medications to make them available at no cost.[120] Given the ongoing threat of fentanyl and other deadly opioids, continued education on recognizing and responding to overdoses, and continuing training on the use and the distribution of overdose reversal medications, are essential. For example, HHS has supported the development of campaigns like Free Mind to help prevent and reduce drug use and overdose among youth. HHS

[k] 7-OH (7-hydroxymitragynine) is a potent opioid found naturally in trace amounts in kratom.

has released an overdose prevention and response toolkit to provide information to various audiences on how to recognize and response to an overdose.

Saving a life from overdose is a critical step, but it must not be the final one. Every overdose carries a risk of repeat overdose, with one study showing almost a quarter of patients who survived an overdose suffering another within 30 days, and almost 4% dying of a subsequent overdose within a year.[121,122] Therefore, responding to an overdose is the first step in connecting victims to treatment and recovery. Further, each person who overdoses may very well have a circle of people that are also at risk of dying, especially if they use the same drug supply. Therefore, administration of an opioid overdose reversal medication should be considered the first step in connecting the overdose victim and others in that circle of risk to drug treatment leading to sustained recovery.

Clusters of multiple victims suffering similar overdoses or poisonings in a short period of time and in a relatively confined geographic area have affected communities across America, with a great variation in local responses. A common feature of the response to all of these mass casualty events is that they involve multiple agencies and professionals from medical intervention, to law enforcement investigation, to social support. A key lesson learned from other mass casualty events, such as active shooter incidents, is that a coordinated and standardized response yields the best results for all involved agencies in responding to the event, caring for its victims, and protecting the public at large. Overdose clusters can similarly benefit from well-coordinated and professionally executed efforts using standardized protocols to save lives, neutralize the immediate threat, protect other lives at risk, access and activate additional needed resources, and connect the survivors, their families, and at-risk individuals to the support and treatment they need. CDC Epi-aids provide rapid epidemiologic response support to communities to investigate urgent public health problems like spikes in overdoses and recommend practical solutions to control and prevent public health problems.

Addison Mott - Poisoned by Fentanyl at School

Addison Mott was 5 years old when she found a pill in her kindergarten classroom in California and almost died from a fentanyl poisoning. “I don’t know what I was thinking,” she said when interviewed at age 8.

“I was dizzy. When I would walk, I would start wobbling,” she said. “I wanted to go to sleep so bad ... My eyes were like, drifting off ... and then, everyone’s like, ‘No! Wake up! Stay up!’”

Naloxone was not available at the school. At the hospital, her condition was initially a mystery. A fentanyl lab test was not available, delaying her diagnosis and treatment.

Thankfully, today Addison is doing well with no visible side effects.

Text Box 22: Addison Mott - Poisoned by Fentanyl at School[123]

Key Principles

Save Lives During Overdose Emergencies

To prevent individuals from suffering fatal opioid overdoses, the Trump Administration will prioritize making opioid overdose reversal medications, like naloxone, more available, increase education on rescue interventions with naloxone, and work to decrease the price of these lifesaving medications. To help communities prepare for, and respond to, mass overdose events, the Administration will work with States to develop approaches and processes that maximize the capacity to save lives, anticipate potential overdose hotspots, apply lifesaving resources to those areas most at risk, and widely share post-event information so other communities are best postured to save lives and protect the public.

Educate Public Health, Public Safety, and the Public

Medical professionals, law enforcement, the mental health and social work communities, and the public at large need greater awareness of today's continually evolving synthetic drug supply, including which drugs are becoming increasingly available. In some cases, known drugs such as fentanyl and its analogues are showing up on America's streets in various forms, often requiring multiple administrations of naloxone. Carfetantanil and nitazenes are becoming more prevalent in the illicit market and are more potent and more deadly that fentanyl. In many cases polydrug use involving opioids mixed with xylazine, medetomidine, or benzodiazepines complicate overdose rescue and response efforts. Drugs sold legally and illegally in smoke shops can include kratom products with unnaturally high 7-OH levels, potent psychedelics, synthetic cathinones, and other various adulterants. Overdose response must adapt to match this changing environment, and the Administration will work to improve rapid drug testing in healthcare settings and toxicology labs, and to establish the mechanisms to better understand what drug the patient believed they ingested.

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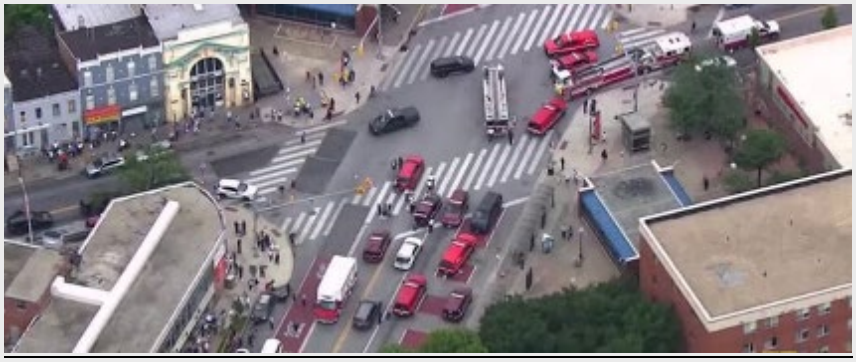
Mass Casualty Events from Drugs



Over an eight-day period in late March 2016, a total of eighteen patients presented to a California hospital with extreme opioid toxicity. All of the patients reported taking their "normal dose" of hydrocodone/acetaminophen tablets. However, their sedation and other overdose symptoms were much more pronounced than was typically encountered. One patient died, and eleven more required various levels of lifesaving intervention in the hospital, including prolonged infusions of naloxone lasting up to 39 hours. Toxicology testing and analysis performed on serum, urine, and surrendered tablets showed varying levels of fentanyl. This single overdose cluster placed enormous stress on the hospital and the community, and the continued presence of those counterfeit tablets placed the community in danger for an extended period of time.

In July 2025, a suspected “bad batch” of drugs sent at least 27 people in the Penn North neighborhood of West Baltimore to the hospital. When opioids are adulterated with non-opioid drugs that cause sedation, something that is increasingly common, normal lifesaving opioid overdose reversal medications, such as naloxone, can reverse the opioid overdose, but have no effect on the non-opioid adulterant. In this case, samples likely tied to the mass overdoses contained N-methylclonazepan, a benzodiazepine with powerful sedative effects, not previously known to law enforcement. Because of this compound, many patients remained unconscious even after the administration of naloxone.

Both of these mass casualty events, and scores of others like them across the country, drive home the need for communities to have pre-planned and standardized response protocols that go beyond simply saving lives at the scene. Established coordination mechanisms, the early identification of resource needs, notification procedures among agencies, and plans for post-event care for victims are all essential elements of ensuring that communities can respond to overdose clusters, quickly recover from these mass casualty events, and document and distribute lessons learned to improve our collective response to the disruptive and potentially deadly events.

Text Box 23: Mass Casualty Events from Drugs[124,125,126]

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Bridge From Nonfatal Overdose and Drug-Related Hospital Visits to Treatment and Recovery

The actions taken in the minutes and hours immediately after an overdose can help ensure that the reversal of that overdose is not just another event in a long and protracted struggle with addiction, but rather a step toward effective treatment and the path to sustained recovery.

No American should be subjected to painful opioid withdrawal immediately after having been saved from an overdose. Methadone and buprenorphine, two of the FDA-approved medications for opioid use disorder, can reduce the incidence of severe withdrawal and prevent the individual from immediately returning to the illicit drug market. Moving the patient from overdose directly into treatment beginning in the emergency department can provide critical linkage to services and begin the process of treatment and recovery.

Objective

Improve the Distribution of Naloxone

The Administration will improve its effort to place naloxone within reach of everyone who could use it to save a life. This includes updated clinical guidelines for using naloxone to match the changing drug environment, the strategic placement of naloxone in areas likely to have high numbers of overdoses, and efforts to make it affordable and available to everyone who may need it. New initiatives, such as making over-the-counter naloxone available, have significantly increased access to this lifesaving medication.

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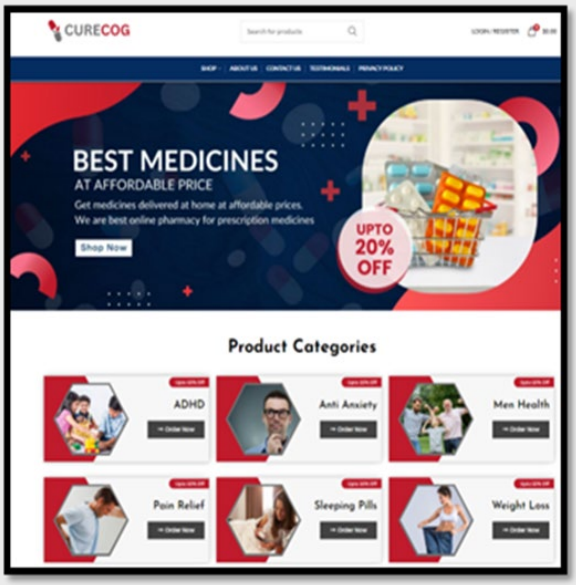
95% of Websites Selling Prescription Medicine Online are Unsafe and Unlicensed

The danger of overdose or poisoning can arrive directly at someone's doorstep, bypassing traditional street dealing entirely and underscoring the critical need for the widespread overdose rescue capabilities discussed in this chapter.



Illicit online pharmacies represent a significant and growing threat. Between August 2023 and June 2024, at least nine people died after purchasing fake pills from a network of illicit online pharmacies prosecuted in New York. The U.S. Drug Enforcement Administration (DEA) has seen an increase in illegal online pharmacies selling and shipping counterfeit pills made with illicit fentanyl and methamphetamine to unsuspecting customers in the United States who believe they are purchasing real prescription drugs, such as oxycodone, Adderall, Xanax and other drugs, from legitimate pharmacies.

Because these dangerous substances are delivered directly into homes, the risk of unexpected overdose is heightened, potentially occurring far from immediate medical help. According to the National Association of Boards of Pharmacy, 95% of websites selling prescription medicine online operate illegally and unsafely. The only safe prescription medications are those prescribed by a licensed medical provider and dispensed by a trusted pharmacy.

Text Box 24: 95% of Websites Selling Prescription Medicine Online are Unsafe and Unlicensed[127,128]

Action Items

Increase The Availability of Naloxone and Development of New Drug Overdose Reversal Medications

The Administration will continue the widespread distribution of naloxone, decrease the cost of the medication, and support innovation in reversal medicines for drug overdoses not reversed by naloxone. As fentanyl, nitazenes, 7-OH, and other potentially deadly synthetic opioids continue to be a threat, ensuring access to naloxone in terms of price, distribution, and location, remains a high priority. Naloxone must be available at every location where drugs may be used. Given the dynamic and ever-evolving drug threat, the Administration will also place a high priority on investing in other reversal therapeutics, such as sequestrants that quickly deactivate drugs in the body.

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Update Overdose Response and Rescue Training

The Administration will work across the federal government to update guidelines on overdose response to include the clinical implications of the drugs in the current illicit drug supply. In addition, we will work to increase the rate of connection to post-overdose treatment for both the victim and the victim's circle of people at risk. While the reversal of an overdose is a moment in time, it identifies a person at risk for recurring overdose and death. The rapidly changing drug landscape requires an equally rapid evolution in drug overdose response. The reversal of an overdose with naloxone most often results in the patient being awake and breathing with complete recovery. However, if the opioid was ingested with other drugs, such as a benzodiazepine or, a successful naloxone administration may result with the victim breathing but still sedated. Moreover, the dosing of naloxone may be different depending on the potency of the opioid ingested. For example, the dosing for fentanyl is greater than that for oxycodone or hydrocodone, but the dosing for more potent drugs such as those in the nitazene class, is even greater than that required for fentanyl.

Establish a Standardized Approach to Responding and Reporting on Mass Overdose Clusters

Lessons learned from mass casualty events have shown that a voluntary, standardized approach to response improves outcomes and provides the ability to quickly activate needed resources. The Administration will work to gather information from past overdose clusters, determine those aspects of the responses that most directly led to successfully saving lives, and establish guidelines and best practices for states, counties, and municipalities to employ. Moreover, the Administration will work to improve the sharing of information in the moment, as well as after the event, on all the critical aspects of the overdose clusters that will prove useful to other communities in the future.

Improve Drug Testing for Healthcare

Rapid drug testing in a clinical environment informs the provider, and in many cases the patient, of the drug or drugs that were ingested. This not only improves patient care, treatment recommendations, and outcomes, it can warn others at risk of overdose. While many hospitals have access to FDA-cleared rapid drug tests that screen urine samples for fentanyl, hospital drug tests are not as comprehensive as they could be. The currently utilized hospital tests do not detect nitazenes, psilocybin, or psychoactive hemp products such as delta-8 THC, and may not detect all fentanyl analogs. The Administration will work to improve drug testing in clinical settings.

Assess and Utilize Public Drug Checking Programs

The Administration will assess the value and availability of drug checking programs that use technologies like mass spectrometry, ensuring federally-funded initiatives report near real-time, de-identified data, to inform our understanding of and response to evolving and emerging drug threats. Laboratory testing of these samples also can help identify and then track the spread of emerging drugs into communities. Drug checking facilities benefiting from any federal funds should offer naloxone and connections to counseling or treatment services. Rapid test strips and

similar technologies that detect fentanyl and other drugs are an important tool that should be legal and not considered drug paraphernalia, but should come with the clear warning that they may give false negative results and will not detect substances that they are not designed to identify.

Epilogue: In Their Memory

This *Strategy* is dedicated to the loved ones we have lost.

Behind every statistic cited in this document is a human story, a stolen future, and a family left with unimaginable heartbreak. The preceding chapters have detailed our national plan—a plan to attack the supply chains, dismantle the criminal organizations, and rebuild our public health response. This plan is not an abstract policy exercise. It is our solemn promise to honor those we have lost with action.

All drug deaths, from any drug, should be preventable.

As we compiled this *Strategy*, we looked at the faces of those who were killed by drugs. Their faces tell the full, tragic story of this crisis.

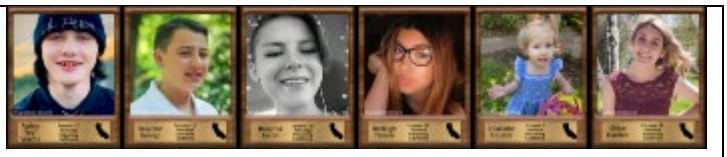
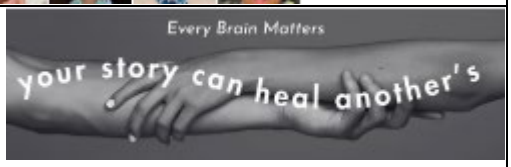
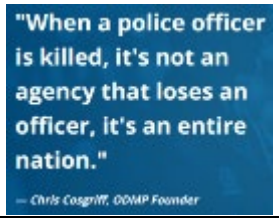
They are the teenagers poisoned by a single counterfeit tablet containing fentanyl. They are the young adults, bright with potential, whose futures were stolen by drug-induced psychosis and suicide linked to high-potency marijuana. They are the babies and small children—the ultimate innocents—killed by an environment saturated with these poisons.

And they are the heroes—the law enforcement officers, first responders, and service members—who gave their lives in the fight to keep our communities safe from the violence and chaos of the drug trade.

Their lives mattered.

May the memory of every person lost to this crisis be a blessing, and may it be a constant, solemn reminder that we must use the full force of the American government to save lives and protect our nation.

We are grateful to the families and memorial organizations who shared the photos and stories of their loved ones to give a voice to these victims, including:

Drug Memorial Wall	
Faces of Children Poisoned by Fentanyl	
Every Brain Matters	 
Officer Down Memorial Page	 

Appendix A: National Drug Control Strategy Implementation Process

The Office of National Drug Control Policy (ONDCP) leads, coordinates, and oversees the implementation of the *National Drug Control Strategy,* hereinafter the *Strategy,* in close collaboration with the Homeland Security Council (HSC), National Security Council (NSC), Domestic Policy Council (DPC), and other White House elements as appropriate. There are numerous facilitation mechanisms that the Director of the ONDCP uses to achieve the goals and objectives of the *Strategy*, including the specific functional coordinators discussed below.

ONDCP was established by the Anti-Drug Abuse Act of 1988 and reauthorized by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT ACT in 21 U.S.C. § 1705). ONDCP has met the requirement to consult a wide array of experts, key stakeholders, and officials while developing the President's *Strategy*. The ONDCP Director will work with the heads of the National Drug Control Program agencies; ONDCP's internal coordinators; The Interdiction Committee (TIC) and the Emerging Threats Committees; appropriate Congressional Committees; State, local and Tribal officials; private citizens and organizations, including community and faith-based organizations, with experience and expertise in drug demand reduction; private citizens and organizations with experience and expertise in supply reduction; and the appropriate representatives of foreign governments.

In addition, the Director, in conjunction with ONDCP's Office of Performance and Budget, will conduct a yearly evaluation of the effectiveness of the *Strategy* in light of the activities and accomplishments of the National Drug Control Program agencies.

Duration of Implementation

Implementation and reporting of results from the *Strategy* are divided into three time periods: near-term (zero to six months), medium-term (seven to 18 months), and long-term (19 months to 24 months).

Coordination Mechanisms

Emerging Drug Threats Coordinator: Chairs the Emerging Threats Committee that is responsible for monitoring and identifying emerging drug threats in the United States and recommending to the Director when such a declaration or termination needs to be made. The Coordinator and the Committee oversee the implementation of any plans to address designated emerging threats and disseminate data to inform the monitoring of emerging threats with federal, state, local, territorial, and tribal officials and other entities as determined by the Director. The Emerging Drug Threats Coordinator will coordinate the data activities (including data strategy, management, and analysis) to enable the real-time surveillance of drug control threats and assess the effectiveness of drug control policies and programs.

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Global Supply Reduction Coordinator: Guides and synchronizes internationally-focused interagency efforts to reduce the availability of illicit drugs, precursors, related chemicals, and tableting machines along with their parts. Coordinates law enforcement efforts with the Department of State and source country programs to reduce production and availability of illicit drugs and obtain accurate illicit drug production assessment and monitoring.

United States Interdiction Coordinator (USIC): Establishes the federal government's interdiction strategy, assesses the sufficiency of assets committed to illicit drug interdiction, and resolves issues related to the coordination, oversight, and integration of interdiction efforts. Coordinates domestic supply reduction, including through collaboration with federal partners; state, local, territorial, and tribal, law enforcement agencies, and HIDTAs.

State, Local, and Tribal Affairs Coordinator (SLTAC): Consults with and assists state, local, and tribal governments on the formulation and implementation of the *Strategy*. Secures commitments from state, local, and tribal officials for the implementation of the *Strategy*.

Demand Reduction Coordinator: Leads the interagency effort to plan, coordinate, and manage the public health responsibilities of the *Strategy*. This includes primary drug prevention, public education on the consequences of illicit drug use, increasing access to evidence-based treatment, including medication assisted treatment, and establishing and sustaining recovery support services. Collaborates and coordinates with other federal agencies; state, local, territorial, and tribal health officials; and health policy-related stakeholders to promote the development and implementation of these demand reduction functions.

Performance-Budget Coordinator: Responsible for ensuring the Director has sufficient information necessary to analyze the performance of each National Drug Control Program Agency and make informed policy decisions and to advise the Director on agency budgets, performance measures, and targets.

Coordination Process

Each ONDCP Coordinator will closely work with the HSC, NSC, DPC and the interagency to implement corresponding chapters within the *Strategy*. The interagency coordination process for sequencing and synchronizing activities will be accomplished through regularly scheduled meetings with executive departments and agencies to ensure the implementation of the *Strategy's* objectives, action items, and to address inquiries.

The National Drug Control Program agencies are the Departments of Agriculture, War, Education, Health and Human Services, Homeland Security, Housing and Urban Development, Interior, Justice, Labor, State, Transportation, Treasury, and Veterans Affairs, the Office of National Drug Control Policy, the United States Postal Inspection Service, AmeriCorps, the Appalachian Regional Commission, and the Court Services and Offender Supervision Agency for the District of Columbia.

National Drug Control Program Agency Responsibilities

The implementation of this *Strategy* requires a unified, whole-of-government approach that leverages the unique authorities, capabilities, and expertise of the entire federal government. While the Office of National Drug Control Policy (ONDCP) coordinates this national effort, the

statutory authority and operational capacity to execute these objectives reside within the National Drug Control Program Agencies (NDCPAs).

To ensure accountability and transparency, and to meet statutory requirements, the following table delineates the primary responsibilities of each NDCPA. While many objectives require broad interagency support, this matrix identifies the specific agencies charged with leading or significantly supporting the Objectives and Action Items outlined in the *Strategy*. These assignments ensure that every aspect of the *Strategy*—from supply reduction and interdiction to prevention, treatment, and recovery—is backed by dedicated federal resources and leadership.

National Drug Control Program Agency	Agency Sub-Components	Description of *Strategy* Support	Assigned Objectives and Action Items
Department of Agriculture	U.S. Forest Service; USDA Rural Development	Combats illicit drug use, manufacturing, trafficking, and smuggling on National Forest System lands to protect public safety and the environment. Supports rural communities impacted by the drug crisis through prevention, treatment, and recovery housing programs.	Ch 3, Obj 2; Ch 3, AI 5; Ch 4, AI 1; Ch 5, AI 4; Ch 6, Obj 2; Ch 6, AI 2; Ch 7, Obj 1
AmeriCorps		Strengthens communities by deploying members to support substance use prevention, education, and recovery services, and by building capacity for local organizations addressing the drug crisis.	Ch 5, Obj 1; Ch 5, AI 1; Ch 5, AI 2; Ch 5, AI 4; Ch 7, AI 1
Appalachian Regional Commission		Promotes economic development and funds initiatives to address the substance use crisis in the Appalachian region, focusing on recovery ecosystems and workforce re-entry.	Ch 6, AI 2; Ch 7, Obj1; Ch 7, Obj 2; Ch 7, AI 1; Ch 8, Obj 1
Court Services and Offender Supervision Agency		Supervises convicted criminals on probation, parole, and supervised release in the District of Columbia, providing close supervision and connecting offenders to substance use treatment and recovery support to reduce recidivism.	Ch 6, Obj 2; Ch 6, AI 3; Ch 6, AI 4; Ch 5 for drug testing;

National Drug Control Program Agency	Agency Sub-Components	Description of *Strategy* Support	Assigned Objectives and Action Items
Department of Education	Office of Elementary and Secondary Education	Promotes safe and drug-free learning environments. Supports school-based prevention programs and provides resources to help schools address student substance use and mental health.	Ch 1, AI 4; Ch 5, AI 1; Ch 5, AI 2; Ch 5, AI 3
Department of Health and Human Services	Administration for Children and Families; Centers for Disease Control and Prevention; Centers for Medicare & Medicaid Services; Food and Drug Administration; Health Resources and Service Administration; Indian Health Service; National Institutes of Health - NIDA/NIAAA; Substance Abuse and Mental Health Services Administration	Leads the Nation's public health response to the drug crisis through research, data surveillance; the regulation of food and drugs; the administration of grants to expand prevention, treatment, and recovery services; and the enforcement of parity laws.	Ch 1, Obj 1; Ch 1, Obj 2; Ch 1, AI 1; Ch 1, AI 2; Ch 1, AI 3; Ch 1, AI 4; Ch 2, Obj 1; Ch 3, AI 1; Ch 3; AI 4; Ch 3, AI 5; Ch 5, Obj 1; Ch 5, Obj 2; Ch 5, AI 1; Ch 5, AI 2; Ch 5, AI 3; Ch 6, Obj 1; Ch 6, Obj 2; Ch 6, AI 1; Ch 6, AI 2; Ch 6, AI 3; Ch 6, AI 5; Ch 7, Obj 2; Ch 7, AI 1; Ch 7, AI 2; Ch 7, AI 3; Ch 8, Obj 1; Ch 8, AI 1; Ch 8, AI 2; Ch 8, AI 3; Ch 8, AI 4; Ch 8, AI 5

National Drug Control Program Agency	Agency Sub-Components	Description of *Strategy* Support	Assigned Objectives and Action Items
Department of Housing and Urban Development	Office of Community Planning and Development	Addresses the intersection of homelessness and substance use disorder. Supports recovery housing and programs that provide stable housing environments essential for effective treatment and long-term recovery.	Ch 6, AI 2; Ch 7; Obj 1; Ch 7, AI 1
Department of Homeland Security	Customs and Border Protection; Federal Emergency Management Agency; Federal Law Enforcement Training Center; Immigration and Customs Enforcement; United States Coast Guard; Science and Technology Directorate	Secures the Nation's air, land, and maritime borders against the flow of illicit drugs. Conducts transnational criminal investigations and leverages technology to detect and interdict contraband in the supply chain.	Ch 1, Obj 1; Ch 1, AI 1; Ch 1, AI 2; Ch 2, AI 2; Ch 3, Obj 1; Ch 3, AI 1; Ch 3, AI 2; Ch 4, Obj 1; Ch 4, AI 1; Ch 8, AI 3
Department of the Interior	Bureau of Indian Affairs; Bureau of Land Management; National Park Service	Combats illicit drug production and trafficking on public lands and provides law enforcement and substance use resources to Tribal communities to enhance public safety and health.	Ch 3, Obj 1; Ch 3, Obj 2; Ch 3, AI 5; Ch 4; Obj 1; Ch 4, AI 1

National Drug Control Program Agency	Agency Sub-Components	Description of *Strategy* Support	Assigned Objectives and Action Items
Department of Justice	Asset Forfeiture Fund; Bureau of Prisons; Criminal Division; Drug Enforcement Administration; Organized Crime Drug Enforcement Task Forces; Office of Justice Programs; U.S. Attorneys; U.S. Marshals Service; Federal Bureau of Investigation; Bureau of Alcohol, Tobacco, Firearms and Explosives	Enforces federal drug laws, investigates and prosecutes TCOs and FTOs, dismantles firearms trafficking networks, manages federal prisons, and provides grants for state and local justice initiatives.	Ch 1; Obj 1; Ch 1; Obj 2; Ch 1, AI 1; Ch 1, AI 4; Ch 2; Obj1; Ch 2, AI 3; Ch 2, AI 5; Ch 3; Obj 1; Ch 3, AI 2; Ch 3, AI 4; Ch 3, AI 5; Ch 4; Obj 1; Ch 4, Obj 2; Ch 4, Obj 3; Ch 4, AI 1; Ch 4, AI 2; Ch 4, AI 3; Ch 4, AI 5; Ch 4, AI 6; Ch 5; Obj 1; Ch 5, AI 3; Ch 6, Obj 2; Ch 6, AI 3; Ch 6, AI 4; Ch 6, AI 5; Ch 7, Obj 1; Ch 7, AI 2; Ch 7, AI 3; Ch 8, Obj 1; Ch 8, AI 1; Ch 8, AAI 2; Ch 8; AI 3; Ch 8; AI 5

National Drug Control Program Agency	Agency Sub-Components	Description of *Strategy* Support	Assigned Objectives and Action Items
Department of Labor	Employment and Training Administration; Employee Benefits Security Administration; Office of Inspector General; Office of Workers' Compensation Programs	Promotes drug-free workplaces and recovery-ready workplace policies. Enforces mental health and substance use disorder parity laws in employer-sponsored health plans and supports workforce development for people in recovery.	Ch 3, Obj 3; Ch 5, Obj 2; Ch 5, AI 5; Ch 6, Obj 2; Ch 6, AI 2; Ch 6, AI 3; Ch 7, Obj 2; Ch 7, AI 2; Ch 7, AI 3
Office of National Drug Control Policy	(Agency Leadership and Coordination Components)	Advises the President on drug control issues, coordinates the Nation's drug control activities and budget, and evaluates the effectiveness of the *Strategy*.	Coordination and oversight of all *Strategy* Objectives and Action Items
Department of State	Bureau of International Narcotics and Law Enforcement Affairs; United States Agency for International Development	Leads international drug control diplomacy and capacity building. Works with source and transit countries to reduce illicit drug production, disrupt trafficking, and strengthen foreign judicial and law enforcement systems.	Ch 2, Obj 1; Ch 2, AI 1; Ch 2, AI 4; Ch 3, Obj 4; Ch 4, Obj 2; Ch 4, AI 4
Department of Transportation	National Highway Traffic Safety Administration; Federal Aviation Administration	Ensures safety in the nation's transportation systems by regulating drug testing for safety-sensitive employees and implementing programs to prevent impaired driving.	Ch 1, Obj 1; Ch 1, Obj 2; Ch 1, AI 1; Ch 3, Obj 1; Ch 3; Obj 2; Ch 5, Obj 2; Ch 7, AI 2; Ch 7, AI 3; Ch 8, AI 3; Ch 8, AI 4

National Drug Control Program Agency	Agency Sub-Components	Description of *Strategy* Support	Assigned Objectives and Action Items
Department of the Treasury	Internal Revenue Service; Financial Crimes Enforcement Network; Office of Foreign Assets Control	Combats the financial networks of TCOs through economic sanctions, financial intelligence, and anti-money laundering enforcement. Protects the U.S. financial system from illicit abuse.	Ch 2, AI 5; Ch 3; Obj 2A; Ch 4; Obj 2; Ch 4, Obj 4; Ch 4, AI 3
U.S. Postal Service	U.S. Postal Inspection Service	Secures the nation's mail system against the trafficking of illicit drugs. Conducts investigations into the use of the mail to distribute narcotics and collaborates with federal partners to interdict packages.	Ch 3, AI 1; Ch 7, AI 2; Ch 7, AI 3
Department of Veterans Affairs	Veterans' Health Administration	Provides comprehensive substance use treatment, including evidence-based medications and recovery support, to Veterans. Addresses co-occurring mental health conditions and chronic pain management.	Ch.1 AI 2; Ch 6, AI 1; Ch 6, AI 2; Ch 6, AI 3; Ch 7, Obj 1; Ch 7, AI 1; Ch 7, AI 3; Ch 8, Obj 1; Ch 8, AI 4
Department of War	USW (Policy)/DASW (CN&SP); USW (Policy)/Defense Security Cooperation Agency; USW (Personnel and Readiness)/Defense Health	Serves as the lead federal agency for the detection and monitoring of aerial and maritime transit of illegal drugs toward the U.S. Provides intelligence, analysis, and partner nation capacity building to support law enforcement interdiction.	Ch 1, Obj 2; Ch 1, AI 1; Ch 1, AI 2; Ch 2, AI 1; Ch 3, Obj 1; Ch 3, Obj 4; Ch 3, AI 3; Ch 3, AI 4; Ch 4, Obj 1; Ch 4; AI 6; Ch 5, Obj 1; Ch 5; Obj 2; Ch 5; AI 1; Ch 5; AI 2; Ch 5; AI 5; Ch 6; Obj 2; Ch 6; AI 3; Ch 6, AI 5

Appendix B: Strategy Goals and Objectives / Performance Review System (PRS)

Introduction

The Performance Review System (PRS) provides a detailed framework for assessing our effectiveness in meeting the goals and objectives of the *Strategy*. It directly links the *Strategy*'s single, overarching goal—to reduce fatal drug overdoses and save American lives—and the objectives laid out in each of the eight chapters, with specific measures and data sources. The PRS will leverage the most accurate, timely, and relevant data to efficiently and effectively track our progress toward the successful completion of the *Strategy*'s goal and objectives, identify areas where more efforts are needed, and celebrate milestones achieved toward our goal of saving lives.

The PRS closely aligns with the *Strategy*. The objectives listed here are identical to those in the *Strategy* chapters. While the chapters present the Action Items needed to address the resource, policy, or capability gaps to achieve the objectives, the PRS provides additional details on the measures and data sources we will use to track our progress in meeting the objectives.

The comprehensive framework presented here, which includes measures related to the *Strategy*'s Objectives and Action Items that drive them, is designed to meet all statutory requirements for performance measurement. It establishes specific performance measures for the Nation and sets 2- and 5-year targets for each of those measures, ensuring a rigorous and accountable system for tracking our whole-of-government effort. The PRS complements the *National Drug Control Assessment*, which tracks each National Drug Control Agency's (NDCA) efforts to achieve the *Strategy*, and the *Budget Summary*, which reports the NDCAs' activities and funding aligned to support the implementation of the *Strategy*.

This document is designed to guide federal agencies on their responsibilities to combat the drug crisis and to inform the public of the Trump Administration's proactive and ambitious plans to protect every citizen from the serious threat illicit drugs pose to the United States.

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Methods

A target setting approach was adapted from Healthy People 2030 to develop 2- and 5-year targets for the *Strategy*'s PRS.[129] ONDCP used five target setting approaches based on existing national goals, data availability, and historical trends. These target setting approaches are described below and summarized in Figure 1:

1. Maintain Consistency with Existing National Programs, Policies, Regulations or Laws: ONDCP reviewed strategic documents published by federal agencies to identify existing long-term goals for drug control measures that were consistent with *Strategy's* priorities. When possible, PRS targets were aligned with these goals following consultation with subject matter experts.

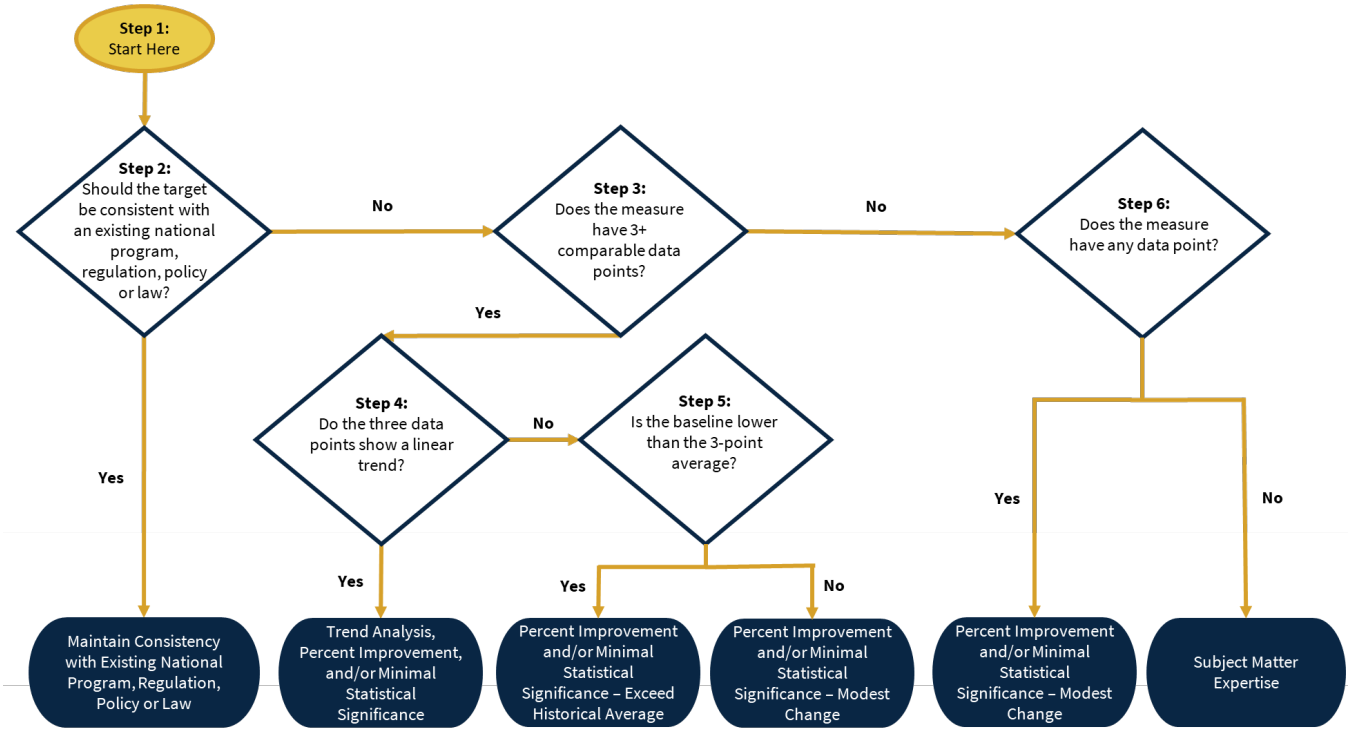
2. Trend Analysis: When a PRS measure had three or more years of comparable, historical data points, a trend analysis was performed using an ordinary least squares linear regression model. If the historical data followed a linear trend in the desired direction, this approach was used to project 2- and 5-year targets.

3. Percent or Percentage Point Improvement: This approach consists of adding or subtracting from the baseline a specified percentage (when the baseline is a number) or value (when the baseline is a percentage – this value is determined by Cohen's effect size). Percentages or values were informed by historical data (when available), and/or subject matter expertise. The percent or percentage point improvement target setting approach was the most frequently used approach for this PRS. If historical data did not follow a linear trend in the desired direction (e.g., fluctuating), targets were established using a percent or percentage point improvement target setting approach. If the baseline estimate was below the 3-year historical average, targets were established to exceed the 3-year historical average. If the baseline estimate was above the 3-year historical average, targets were established with a modest percent change. ONDCP also used a percent or percentage point improvement target setting approach for PRS measures where no historical data were available beyond a baseline estimate.

4. Minimal Statistical Significance: For PRS measures derived from national surveys, a 95% confidence interval was calculated to ensure that 2- and 5-year targets represented a statistically significant difference from the baseline estimate.

5. Subject Matter Expertise: For new initiatives with no baseline estimate nor historical data, ONDCP consulted subject matter experts to develop 2- and 5-year targets.

Figure 1: Framework for Selecting PRS Target Setting Approaches.



Note: Adapted from Healthy People 2030 framework.

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Strategy Goal: Save American Lives by Reducing Fatal Overdoses from All Drugs

Overarching Measure: Reduce the Number of Drug Overdose Deaths

Data Source: Centers for Disease Control and Prevention (CDC), National Vital Statistics System (NVSS)

Measure Description: The number of drug overdose deaths comes from final, year-end estimates. Drug overdose deaths were identified using the International Classification of Diseases, 10th Revision (ICD-10) underlying cause-of-death codes for drug overdose deaths involving any/all drug types with unintentional (X40–X44), suicide (X60–X64), homicide (X85), and undetermined (Y10–Y14) intents.

Historical Trends: Drug overdose deaths were below 20,000 annually from 1980 to 2000. Throughout the 2000s, drug overdose deaths began to increase due to the prescription opioid and heroin epidemics, leading to more than 50,000 Americans losing their life in 2015 alone. As illicitly manufactured fentanyl emerged, drug overdose deaths began to accelerate with an exponential doubling from 2015 to 2021, and nearly 107,000 Americans dying from a drug overdose in 2021. After three years with drug overdoses eclipsing 100,000 annually, estimates from 2024 have begun to show a glimmer of hope with fatal overdoses decreasing to 79,384, but this number is still far too high.

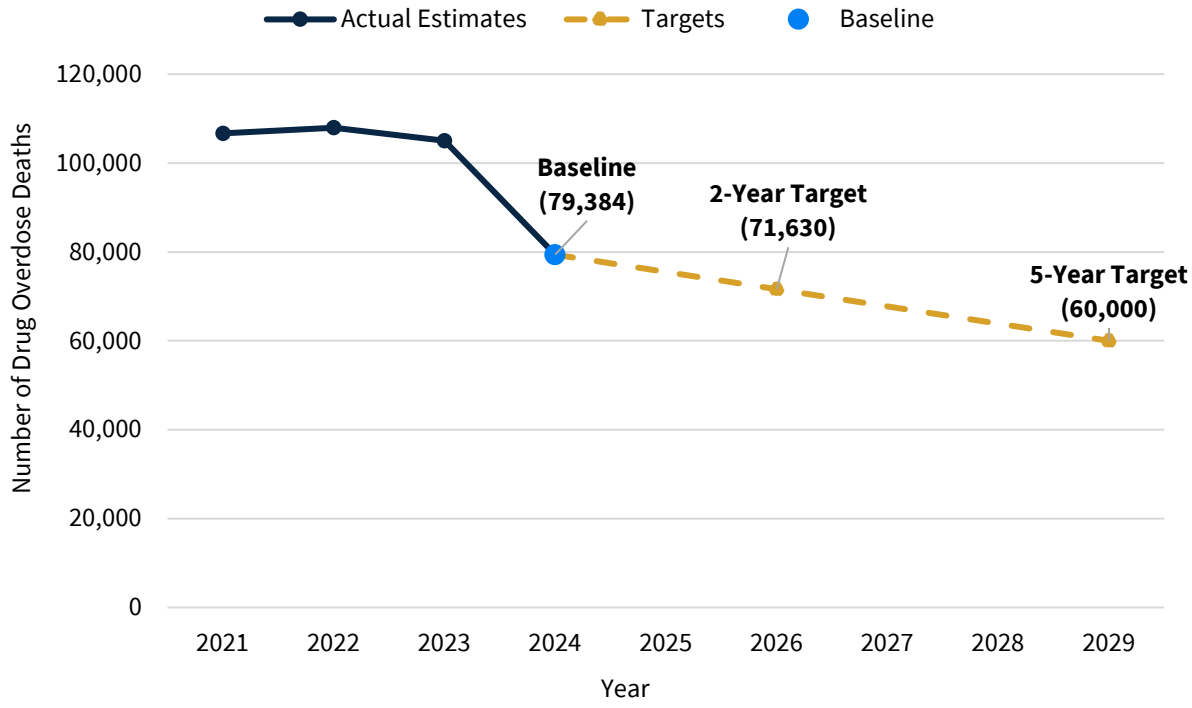
2024 Baseline: 79,384 drug overdose deaths

Targets: 71,630 drug overdose deaths in 2026; 60,000 drug overdose deaths in 2029

Target Setting Approach: Trend Analysis and Consistency with Other Targets

Rationale: To fully assess the human toll of America's overdose crisis, and to accurately measure progress toward saving American lives, ONDCP used a trend analysis target setting method using an ordinary least squares linear regression from the years 2021 to 2024 to project 2- and 5-year targets. This target was also informed by the U.S. Department of Health and Human Service's Healthy People 2030 objective for reducing drug overdoses. Each life lost to overdose is one life too many, and ONDCP will work tirelessly with partners across the federal government to save lives.

Overarching Figure: Number of drug overdose deaths, United States, 2021-2029.



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Chapter 1: Defining Current and Emerging Drug Threats

Objective 1.1: Establish Standardized Processes to Define and Detect Drug Threats

Measure 1.1.1: Increase the number of jurisdictions meeting all reporting requirements for the CDC's State Unintentional Drug Overdose Reporting System.

Data Source: Centers for Disease Control and Prevention (CDC), State Unintentional Drug Overdose Reporting System (SUDORS)

Measure Description: The CDC's State Unintentional Drug Overdose Reporting System (SUDORS) provides comprehensive data on unintentional and undetermined intent drug overdose deaths through expanded data collection from death certificates, coroner/medical reports (including scene evidence, witness reports, and autopsy reports), and postmortem toxicology reports. SUDORS captures information on specific drugs rather than drug classes and is flexible, allowing for new emerging drugs to be captured in real-time. This measure captures the number of jurisdictions meeting all reporting requirements so they can be included in the SUDORS dashboard. These requirements include the reporting of all overdose deaths in the jurisdiction for the selected year, including information on circumstances surrounding overdose deaths (e.g., from a medical examiner/coroner report) for at least 75% of deaths in that year.

Historical Trends: The number of jurisdictions meeting all reporting requirements for SUDORS has increased from 33 in 2021 to 43 in 2024.

2024 Baseline: 43 jurisdictions

Targets: 47 jurisdictions by 2026; 50 jurisdictions by 2029

Target Setting Approach: Trend Analysis and Subject Matter Expertise

Rationale: Currently, 49 states and the District of Columbia receive funding to participate in SUDORS (with North Dakota being the only state not currently receiving funding). For the 5-year target, we are proposing that all 50 jurisdictions currently participating in SUDORS meet the reporting requirements to be included on the SUDORS dashboard.

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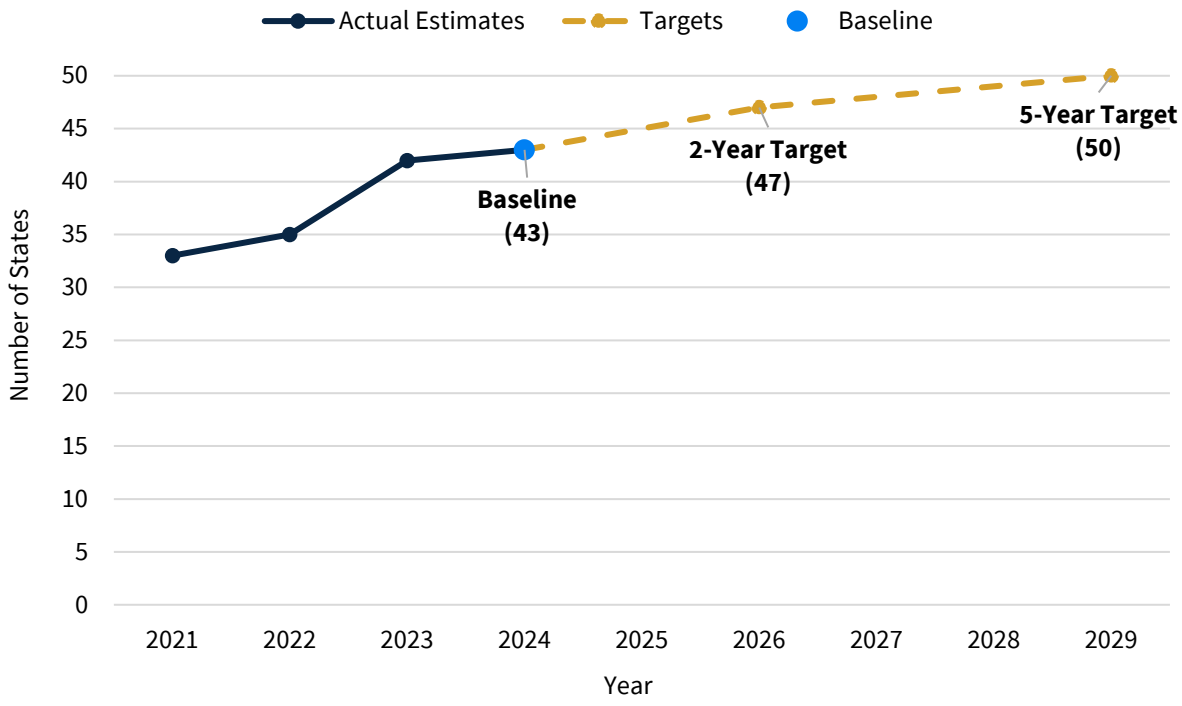
Figure 1.1.1: Cumulative number of jurisdictions meeting all reporting requirements for CDC's State Unintentional Drug Overdose Reporting System, United States, 2021-2029.



Objective 1.2: Disseminate Accurate, Timely Data to Public and Private Sector Audiences

Measure 1.2.1: Increase the number of core drug data sources that have at least 80% of data completed, processed, and available for use within six months of collection.

Data Source: Office of National Drug Control Policy (ONDCP), Plan for Collecting, Using, and Acquiring Data to Facilitate the Use of Evidence in Drug Control Policymaking (Data Plan)

Measure Description: Table 1 in Appendix C provides a list of 17 core federal data systems to inform the *Strategy*. These data systems are: EPIC's National Seizure System, DEA's National Forensic Laboratory Information System, CBP's Drug Seizure Statistics*, DOW's Consolidated Counterdrug Database*, ATF's Firearms Trace Data*, CBP's Weapons and Ammunition Seizures*, Treasury's Sanctions List Service*, HIDTA's Performance Management Process System*, HSTF's Management Information System, SAMHSA's National Survey on Drug Use and Health, the Monitoring the Future Study*, funded by NIDA, SAMHSA's Treatment Episode Data Set, CMS' Transformed Medicaid Statistical Information System, NHTSA's National Emergency Medical Services Information System Drug Overdose Surveillance Dashboard*, CDC's Nonfatal Drug Overdose Surveillance and Epidemiology System*, CDC's National Vital Statistics System*, and CDC's State Unintentional Drug Overdose Reporting System. These data

systems collect or provide information on a wide variety of indicators for drug surveillance, such as drug use, substance use disorder, seizures (whether drugs or firearms), arrests, or sanctions.

Data sources with an asterisk represent those currently meeting the criteria for this measure.

Historical Trends: No historical trends available

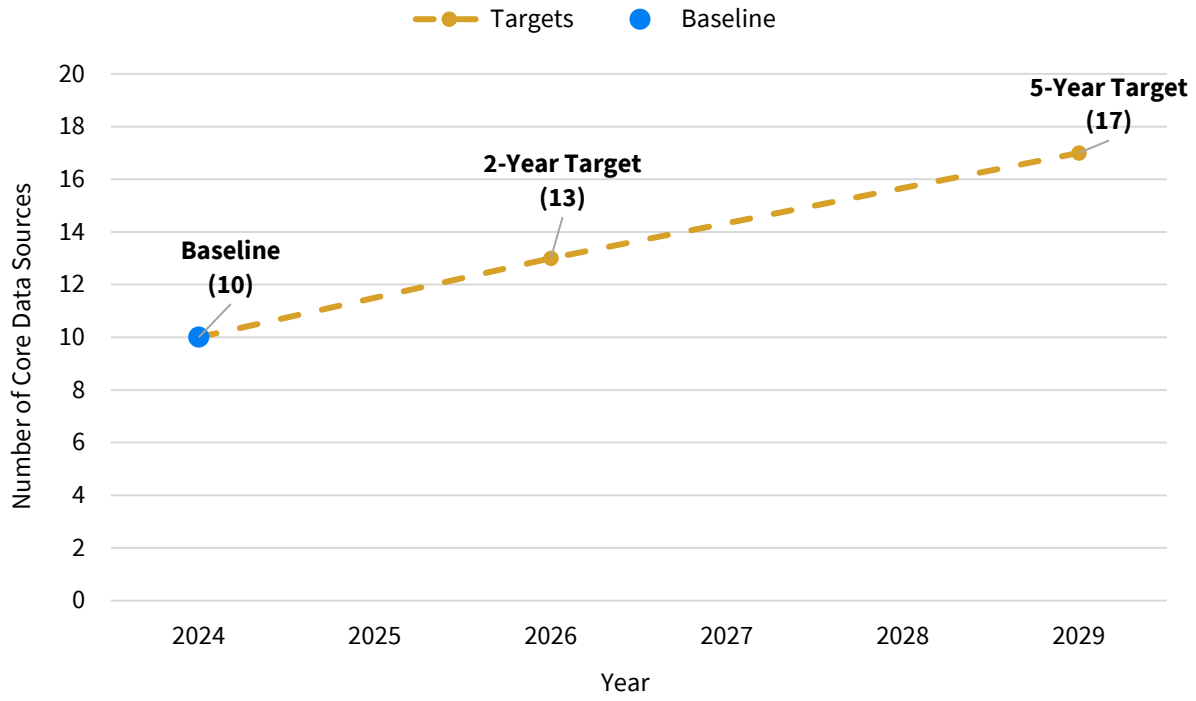
2024 Baseline: 10 core data sources

Targets: 13 core data sources by 2026; 17 core data sources by 2029

Target Setting Approach: Subject Matter Expertise

Rationale: Each of these data sources is critical to track progress in implementing the *Strategy*. Therefore, we propose that each of these data sources have at least 80% of data completed, processed, and available for use within six months of collection by the year 2029.

Figure 1.2.1: Number of core drug data sources that have at least 80% of data completed, processed, and available for use within six months of collection, 2024-2029.



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Measure 1.2.2: Increase the number of peer-reviewed scientific publications that examine the intersection between the drug supply and drug overdose.

Data Source: National Library of Medicine (NLM), PubMed

Measure Description: Articles published in PubMed are indexed using a standard vocabulary curated by the National Library of Medicine called Medical Subject Headings (MeSH). Peer-reviewed scientific publications examining the intersection between the drug supply and drug overdose were identified using the MeSH terms ("Drug Overdose"[Mesh]) AND (("Drug Trafficking"[Mesh]) OR ("Law Enforcement"[Mesh])). Commentaries, editorials, and articles published outside of the United States were excluded.

Historical Trends: The number of peer-reviewed scientific articles examining the intersection between the drug supply and drug overdose has fluctuated between 7 and 10 articles since 2021.

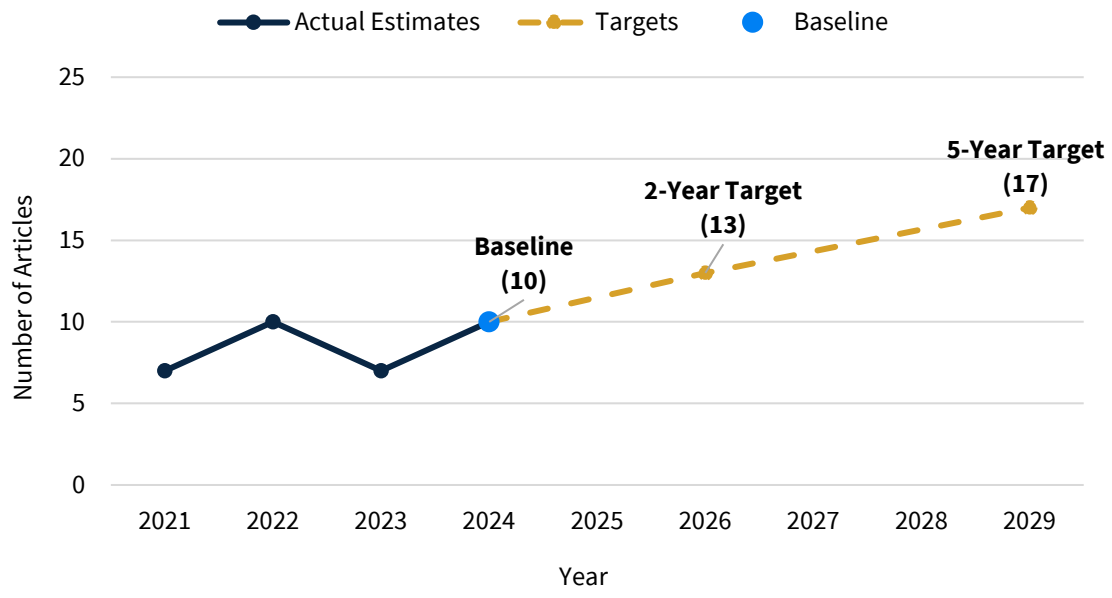
2024 Baseline: 10 new peer-reviewed research articles

Targets: 13 new peer-reviewed publications in 2026; 17 new peer-reviewed publications in 2029

Target Setting Approach: Trend Analysis, Percent Improvement, and Subject Matter Expertise

Rationale: Between 2021 and 2024, an average of 8.5 peer-reviewed scientific publications were published per year that examined the intersection of the drug supply and drug overdose. Given this low number, we believe it is possible to increase the number of publications by 70% through increased access to timely data on the supply and demand of illicit drugs.

Figure 1.2.2: Number of new peer-reviewed scientific publications that examine the intersection between the drug supply and drug overdose, United States, 2021-2029.



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Chapter 2: Securing the Global Supply Chain from Foreign Terrorist and Transnational Criminal Organizations

Objective 2.1: Decrease the Movement of Precursor Chemicals and Finished Drugs through Legitimate Shipping Modalities

Measure 2.1.1: Increase the number of chemical and pharmaceutical companies participating in the Customs Trade Partnership Against Terrorism program.

Data Source: U.S. Customs and Border Protection (CBP), Customs Trade Partnership Against Terrorism (CTPAT) Program

Measure Description: This measure reflects the cumulative number of chemical and pharmaceutical companies participating in the Customs Trade Partnership Against Terrorism (CTPAT) program.

Historical Trends: No historical data were available

2024 Baseline: 428 total participating companies

Targets: 445 total participating companies by 2026; 471 total participating companies by 2029

Target Setting Approach: Percent Improvement

Rationale: Given that no historical data were available, we propose a modest 10% increase over five years.

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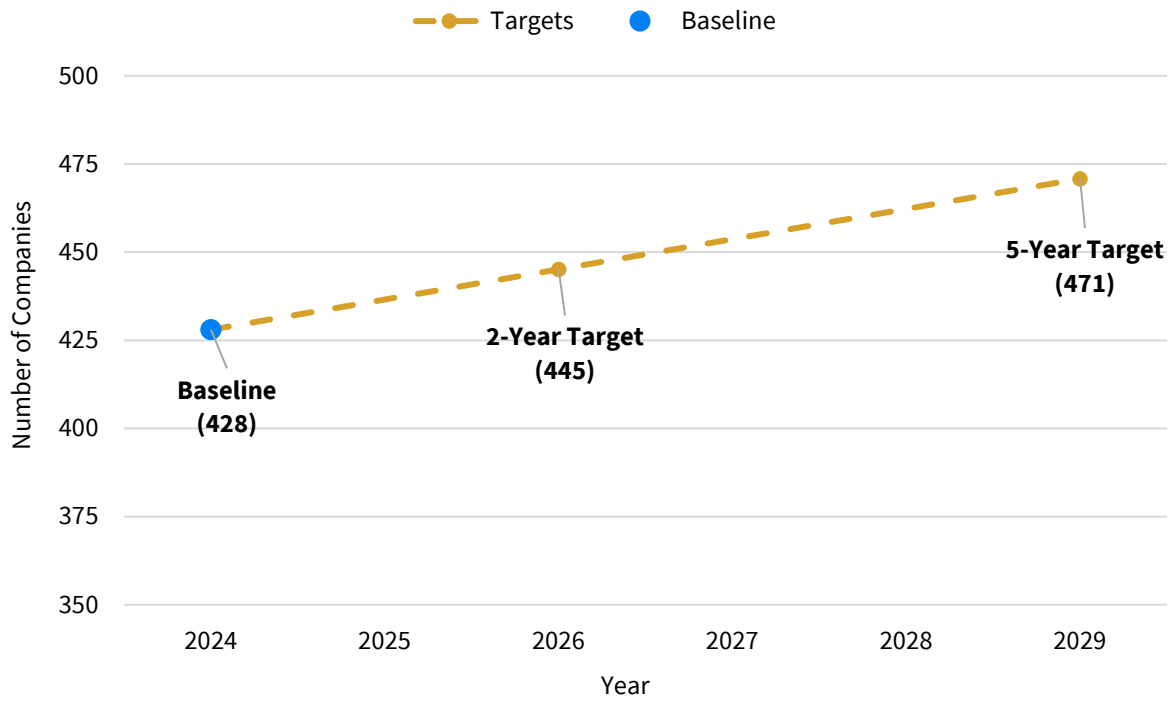
Figure 2.1.1: Cumulative number of chemical and pharmaceutical companies participating in the Customs Trade Partnership Against Terrorism program, United States, 2024-2029.



Measure 2.1.2: Increase the number of freight forwarders (i.e., consolidators) participating in Customs Trade Partnership Against Terrorism program.

Data Source: U.S. Customs and Border Protection (CBP), Customs Trade Partnership Against Terrorism (CTPAT) Program

Measure Description: This measure reflects the cumulative number of freight forwarders (i.e., consolidators) participating in the Customs Trader Partnership Against Terrorism (CTPAT) program.

Historical Trends: No historical data were available

2024 Baseline: 769 total participating freight forwarders

Targets: 800 total participating freight forwarders by 2026; 846 total participating freight forwarders by 2029

Target Setting Approach: Percent Improvement

Rationale: Given that no historical data were available, we propose a modest 10% increase over five years.

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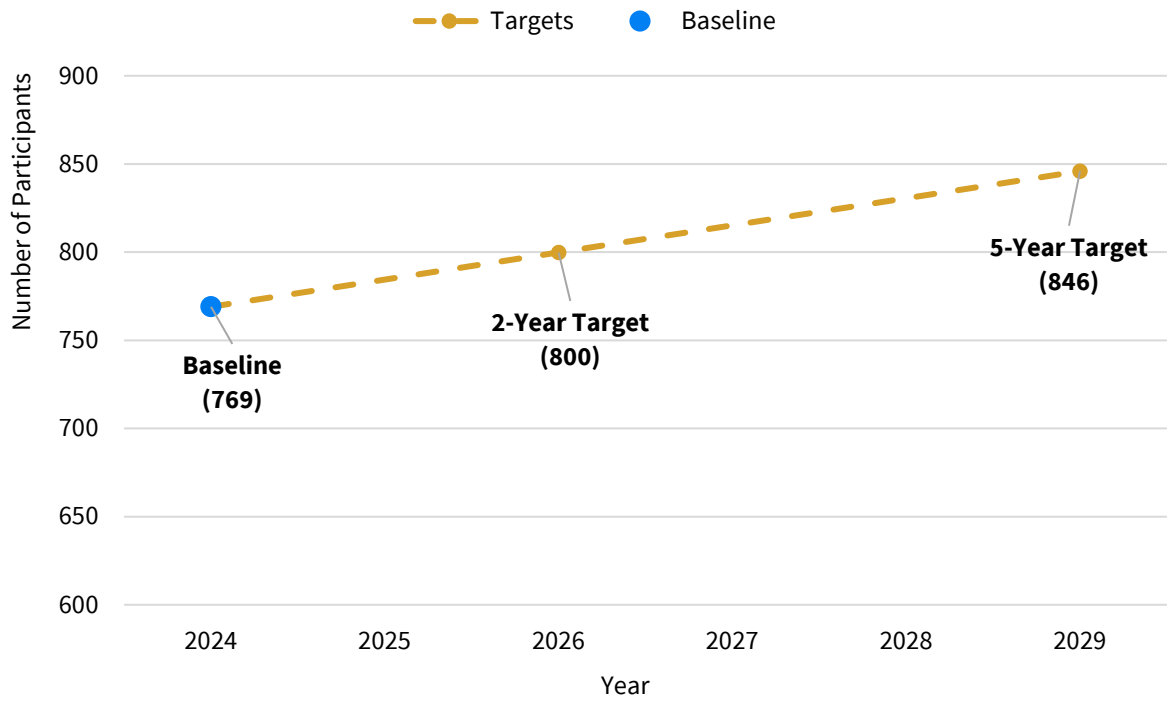
Figure 2.1.2: Cumulative number of freight forwarders (i.e., consolidators) participating in the Customs Trade Partnership Against Terrorism program, United States, 2024-2029.



Measure 2.1.3: Increase the cumulative number of companies participating in international trusted trader programs that have Mutual Recognition Agreements (MRAs) with Customs and Border Protection.

Data Source: U.S. Customs and Border Protection (CBP), Customs Trade Partnership Against Terrorism (CTPAT) - Mutual Recognition

Measure Description: MRAs allow CBP to recognize the security standards of foreign Authorized Economic Operator (AEO) programs as equivalent to CTPAT. This measure tracks the cumulative number of companies participating in these mutual recognition arrangements. Increasing this number expands the global network of trusted trade partners, hardening the supply chain against TCO exploitation while facilitating legitimate commerce.

Historical Trends: No historical data were available

2024 Baseline: 23,142 companies within foreign AEO programs

Targets: 24,068 companies within foreign AEO programs by 2026; 25,465 companies within foreign AEO programs by 2029

Target Setting Approach: Percent Improvement

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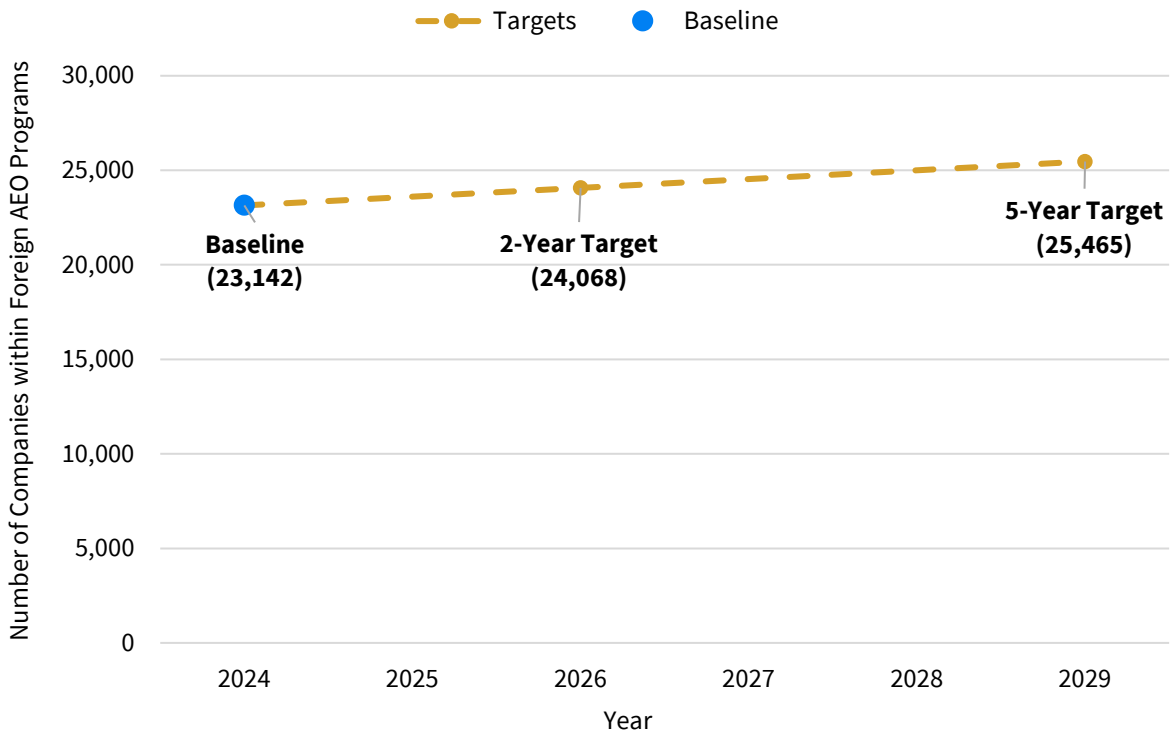
Rationale: We propose a steady 10% increase over five years, driven by the finalization of pending MRAs, and increased outreach to encourage companies to adopt these higher security standards.

Figure 2.1.3: Cumulative number of companies participating in international trusted trader programs that have Mutual Recognition Agreements (MRAs) with Customs and Border Protection, United States, 2024-2029.



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Chapter 3: Stop the Flow of Illicit Drugs into American Communities

Objective 3.1: Attack Foreign Drug Production at the Source

Measure 3.1.1: Increase the annual combined number of incidents of precursor and related chemicals, along with related equipment seizures reported in the Precursor Incident Communication System by China, Colombia, India, and Mexico.

Data Source: International Narcotics Control Board (INCB), Precursors Incident Communication System (PICS)

Measure Description: The Precursors Incident Communications System (PICS) is used by authorized national authorities to enter details about incidents, including seizures of precursors chemicals, stopped shipments, diversion attempts, and discovered illicit drug labs. This is information is used by U.S. law enforcement to investigate the illicit production, manufacture, and trafficking of dangerous drugs and can help relevant national and international authorities to better secure the chemical industry supply chain. This measure reflects the combined number of incident uploads in a calendar year by China, Colombia, India, and Mexico. Uploads include investigations or shipments of precursors, related chemicals, and equipment used to manufacture illicit drugs. Limitations may include laws impeding divulging information on ongoing cases and/or turnover of staff.

Historical Trends: The number of incidents reported annually by these four countries increased from 30 in 2021 to 46 in 2022 before decreasing to 11 in 2024.

2024 Baseline: 11 new incidents combined

Targets: 48 new incidents combined (12 submissions per country) in 2026; 208 new incidents combined (52 submissions per country) in 2029

Target Setting Approach: Subject Matter Expertise

Rationale: The combined number of PICS submissions by China, Colombia, India, and Mexico has been decreasing since 2022. These four nations have reported higher numbers of incidents in the past. Increased and consistent reporting from these countries in particular will help U.S. counternarcotic efforts. The 2-year target assumes each country will report one incident per month, while the 5-year target assumes each country will report one incident per week.

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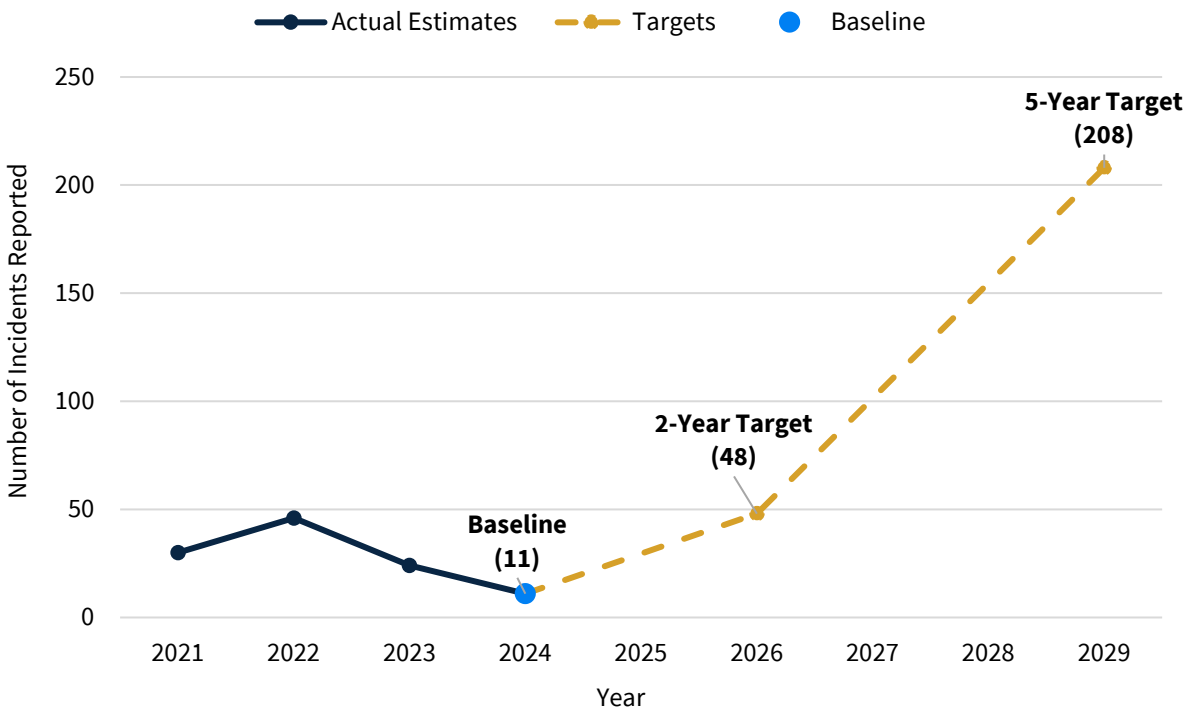
Figure 3.1.1: Annual combined number of incidents of precursor and related chemicals, along with related equipment seizures reported in the Precursor Incident Communication System by China, Colombia, India, and Mexico, 2021-2029.



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Objective 3.2: Secure U.S. Borders and Approaches

Measure 3.2.1: Increase the weight (in metric tons) of cocaine destined for the United States that is removed by the Coast Guard.

Data Source: U.S. Coast Guard, Performance Report

Measure Description: This measure is the actual metric tons of cocaine removed by the Coast Guard annually and includes cocaine seized or jettisoned, scuttled, or destroyed by smugglers as a result of Coast Guard law enforcement actions.

Historical Trends: The weight of cocaine removed by the Coast Guard decreased from 173.4 metric tons in 2021 to 96.2 metric tons in 2023, before increasing to 106.3 metric tons in 2024.

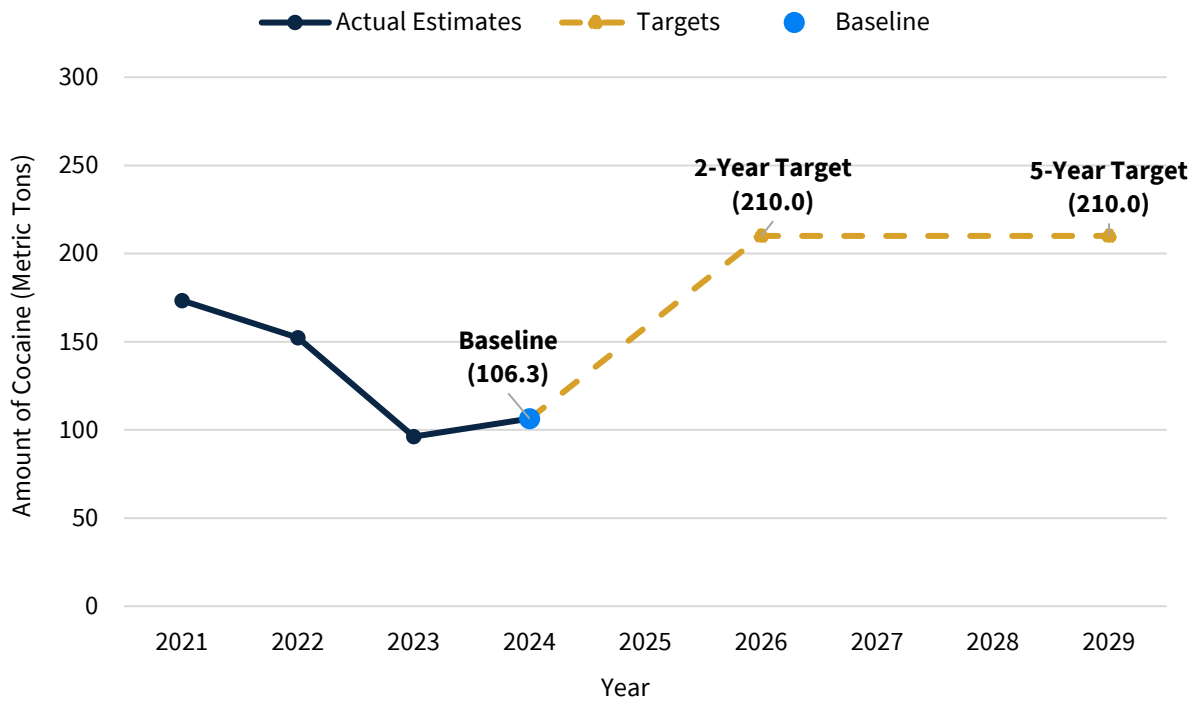
2024 Baseline: 106.3 metric tons

Targets: 210 metric tons in 2026; maintain 210 metric tons in 2029

Target Setting Approach: Maintain Consistency with Existing National Programs, Policies, Regulations or Laws

Rationale: The U.S. Coast Guard has a goal of removing 210 metric tons in FY 2027. We propose maintaining consistency with this national goal for our 2- and 5-year targets.

Figure 3.2.1: Weight (in metric tons) of cocaine destined for the United States that is removed by the Coast Guard, 2021-2029.



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Measure 3.2.2: Increase the weight (in pounds) of illicit drug seizures destined for the United States at ports of entry and between ports of entry via land, sea, and air by U.S. Customs and Border Protection.

Data Source: U.S. Customs and Border Protection (CBP), Drug Seizure Statistics and CBP, Air and Marine Operation Statistics

Measure Description: Interdicting illicit drugs at the border will reduce the supply available in the United States. This measure includes the weight (in pounds) of all annual illicit drug seizures by U.S. Customs and Border Protection (CBP) Office of Field Operations, Air and Marine Operations, and U.S. Border Patrol, including those where CBP assisted another agency.

Historical Trends: The weight of illicit drug seizures by CBP decreased from 926,414 pounds in 2022 to 807,131 pounds in 2024.

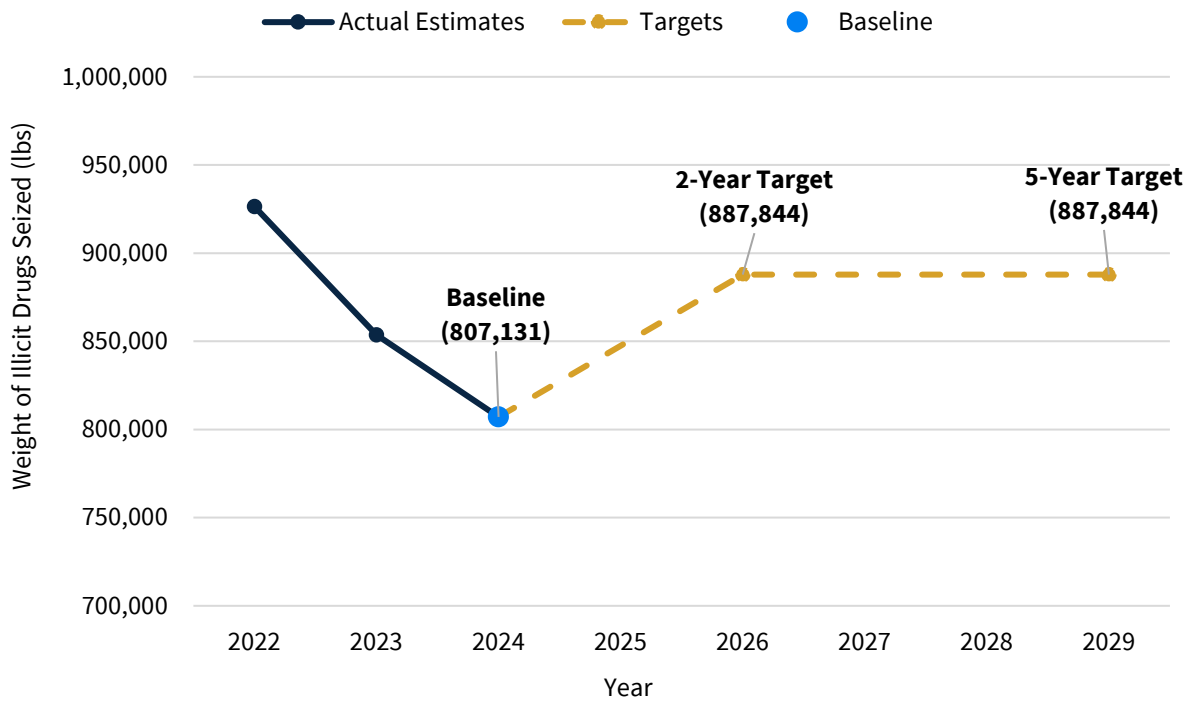
2024 Baseline: 807,131 pounds

Targets: 887,844 total pounds in 2026; maintain 887,844 total pounds in 2029

Target Setting Approach: Percent Improvement

Rationale: Given that the weight of illicit drug seizures by CBP has been decreasing since 2022, we propose a modest 10% increase in 2026 and to maintain that amount through 2029.

Figure 3.2.2: Weight (in pounds) of illicit drug seizures destined for the United States at ports of entry and between ports of entry via land, sea, and air, 2022-2029.



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Objective 3.3: Disrupt Domestic Drug Distribution and Degrade Transnational Criminal Organization Logistics Inside the Border

Measure 3.3.1: Increase the number of drug trafficking and money laundering organizations disrupted or dismantled by High Intensity Drug Trafficking Area task forces.

Data Source: High Intensity Drug Trafficking Areas (HIDTA) Program, Annual Summary Reports

Measure Description: High Intensity Drug Trafficking Area (HIDTA) investigations of drug trafficking organizations (DTOs) and money laundering organizations (MLOs) that were successfully disrupted or dismantled annually.

Historical Trends: The number of DTOs and MLOs disrupted or dismantled by HIDTAs decreased from 3,126 in 2021 to 3,038 in 2023 before increasing to 3,209 in 2024.

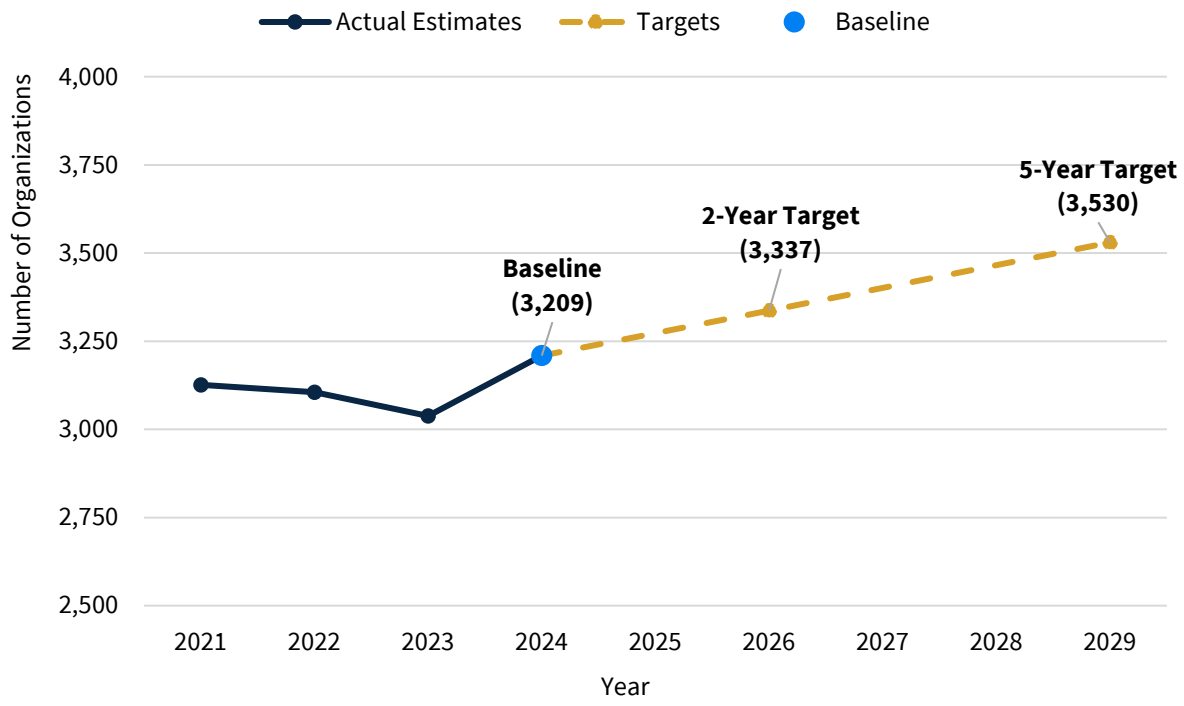
2024 Baseline: 3,209 new organizations disrupted or dismantled

Targets: 3,337 new organizations disrupted or dismantled in 2026; 3,530 new organizations disrupted or dismantled in 2029

Target Setting Approach: Percent Improvement

Rationale: The number of DTOs and MLOs disrupted or dismantled by HIDTAs has increased slightly since 2021, therefore, we propose a modest 10% increase over five years.

Figure 3.3.1: Number of new drug trafficking and money laundering organizations disrupted or dismantled by High Intensity Drug Trafficking Area task forces, 2021-2029.



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Measure 3.3.2: Increase the number of Food and Drug Administration Warning Letters sent to companies selling unauthorized products containing Delta-8 THC, Kratom/7-OH, and other opioids.

Data Source: U.S. Food and Drug Administration (FDA), Office of Business Informatics and Solutions Management

Measure Description: The number of FDA Warning Letters sent to companies selling unauthorized products containing Delta-8 THC, Kratom/7-OH, and other opioids.

Historical Trends: The number of FDA Warning Letters sent to companies selling unauthorized products containing Delta-8 THC, Kratom/7-OH, and other opioids has fluctuated between 9 and 17 from 2022 to 2024.

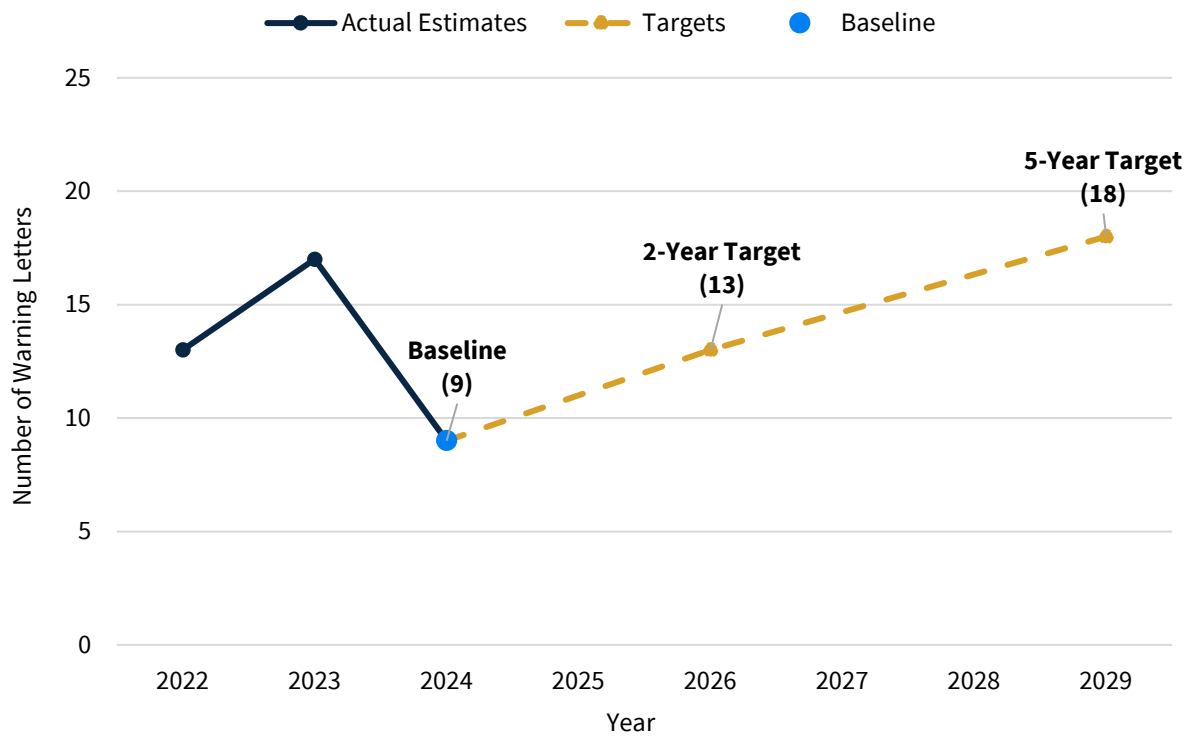
2024 Baseline: 9 FDA Warning Letters

Targets: 13 new FDA Warning Letters in 2026; 18 new FDA Warning Letters in 2029

Target Setting Approach: Subject Matter Expertise

Rationale: The number of FDA Warning Letters sent to companies selling unauthorized products containing Delta-8 THC, Kratom/7-OH, and other opioids has fluctuated between 9 and 17 since 2022. We are proposing a 5-year target of 18 new FDA Warning Letters in 2029 to demonstrate a consistent and renewed focus on companies selling these unauthorized products that are harming Americans.

Figure 3.3.2: Number of FDA Warning Letters sent to companies selling unauthorized products containing Delta-8 THC, Kratom/7-OH, and other opioids, 2022-2029.



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Objective 3.4: Enhance Interdiction by Exploiting and Fusing Intelligence from Seizures

Measure 3.4.1: Increase the number of electronic devices seized during drug operations from which data is extracted and uploaded into intelligence platforms and digital forensic tools.

Data Source: U.S. Coast Guard, Digital Evidence Search and Seizure Program

Measure Description: The U.S. Coast Guard's Digital Evidence Search and Seizure (DESS) program enables trained DESS operators and boarding officers to conduct imaging and at-sea searches of certain electronic devices for intelligence. Analysis of these extractions helps provide information about Drug Trafficking Organizations (DTO) networks and drug smuggling routes to determine where best to place resources for operational needs (such as interdictions and arrests). This measure includes the total number of digital extractions by the U.S. Coast Guard annually from maritime interdictions.

Historical Trends: The number of digital extractions by the U.S. Coast Guard has decreased from 56 in 2021 to 28 in 2023 before increasing to 39 in 2024.

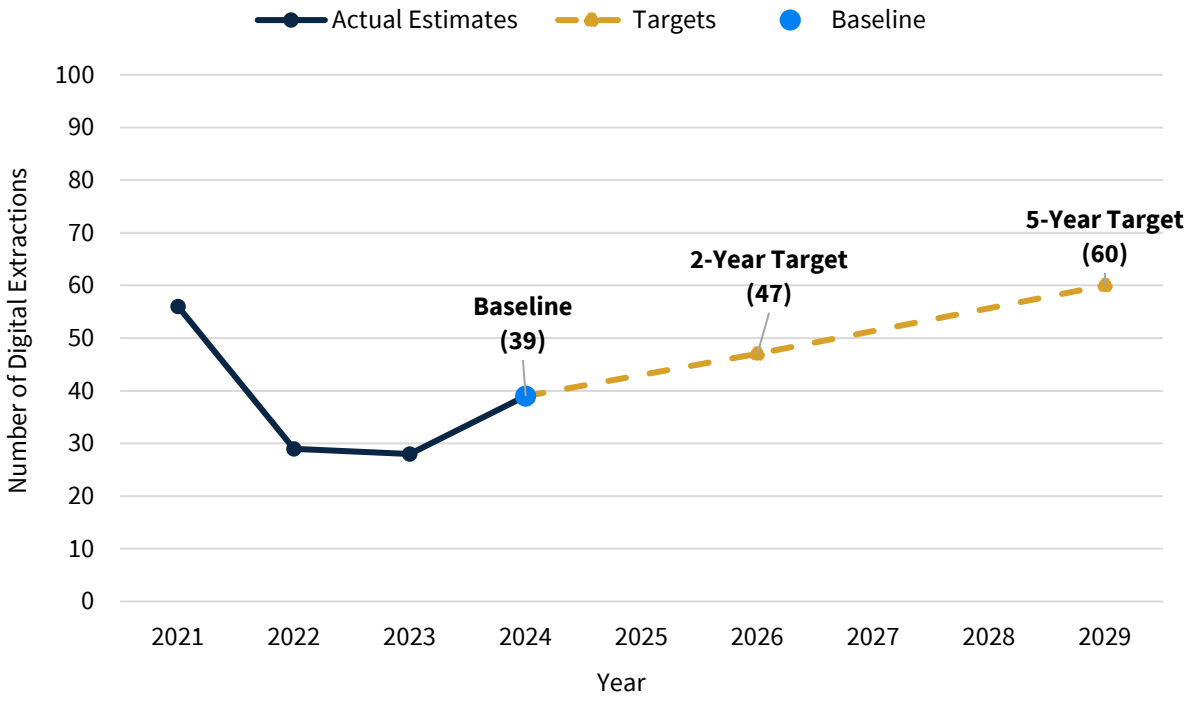
2024 Baseline: 39 digital extractions

Targets: 47 new digital extractions in 2026; 60 new digital extractions in 2029

Target Setting Approach: Percent Improvement and Subject Matter Expertise

Rationale: The number of DESS extractions has fluctuated over the past three years. Based on subject matter expertise, we expect this number to increase, therefore we have proposed to increase this number to 60 per year by 2029.

Figure 3.4.1: Number of Digital Evidence Search and Seizure extractions from maritime interdictions, 2021-2029.



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Chapter 4: Global Campaign Against Transnational Criminal and Foreign Terrorist Threats

Objective 4.1: Unify Law Enforcement and Intelligence Community Efforts Against Designated Transnational Criminal Organizations

Measure 4.1.1: Increase the percentage of requests for information submitted by Homeland Security Task Forces that were responded to by the intelligence community.

Data Source: Homeland Security Task Force, National Coordination Center

Measure Description: Improving intelligence sharing between the HSTFs and the intelligence community will provide agents assigned to HSTFs with increased access to information about designated Transnational Criminal Organization (TCO) targets. This measure will calculate the percentage of all requests for information by HSTFs that are responded to by the intelligence community.

Historical Trends: This is a new initiative; therefore, no historical data are available.

2024 Baseline: Not available

Targets: 90% of requests for information responded to by the intelligence community in 2026; 95% of requests for information responded to by the intelligence community in 2029

Target Setting Approach: Subject Matter Expertise

Rationale: Given that this is a new initiative, no historical data are available. Based on subject matter expertise, we propose that 95% of all requests for information by HSTFs are responded to by the intelligence community within the next five years.

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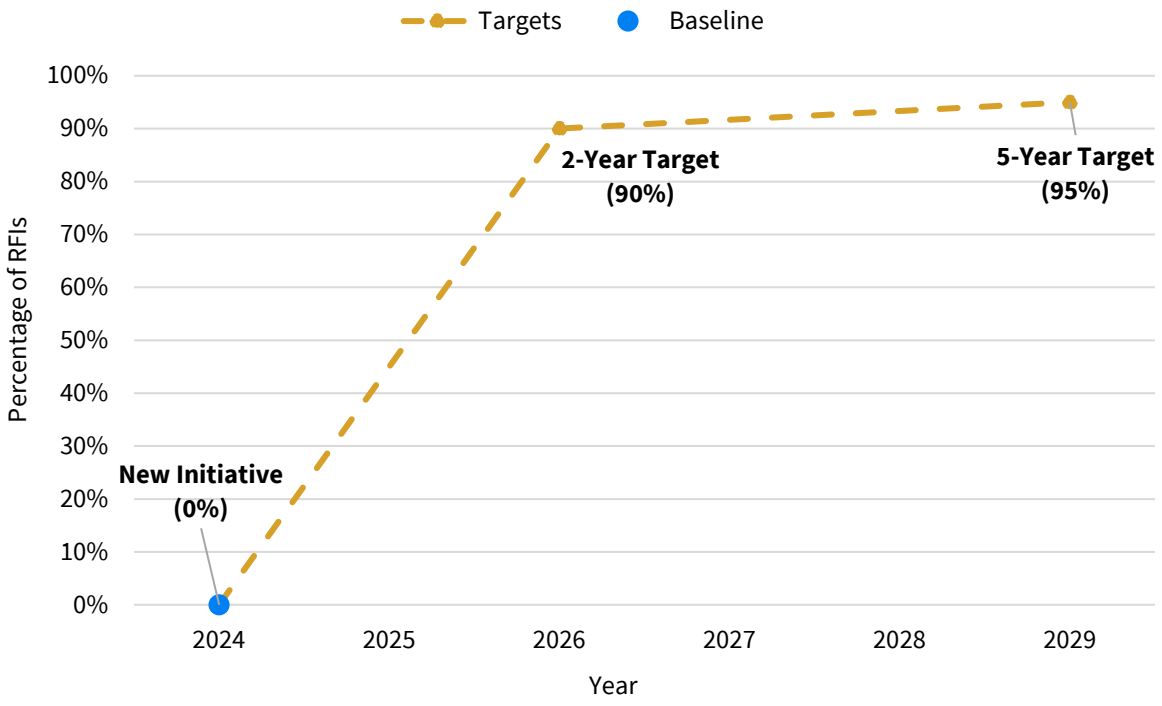
Figure 4.1.1: Percentage of requests for information submitted by Homeland Security Task Forces that were responded to by the intelligence community, 2024-2029.



Objective 4.2: Systematically Dismantle Transnational Criminal Organizations and Foreign Terrorist Organization Command and Control

Measure 4.2.1: Increase the number of individuals arrested on the Consolidated Priority Organization Target List.

Data Source: Homeland Security Task Force, National Coordination Center

Measure Description: The Consolidated Priority Organization Target (CPOT) List is made up of Foreign Terrorist Organizations (FTO)/Drug Trafficking Organizations (DTO) leadership. Arresting these individuals will disrupt the drug market and reduce the supply of drugs entering the United States. This measure includes the total number of individuals arrested annually on the CPOT List.

Historical Trends: The number of new individuals arrested on the CPOT list decreased from 24 in 2021 to 5 in 2023 before increasing to 7 in 2024.

2024 Baseline: 7 new individuals arrested

Targets: 9 new individuals arrested in 2026; 12 new individuals arrested in 2029

Target Setting Approach: Percent Improvement

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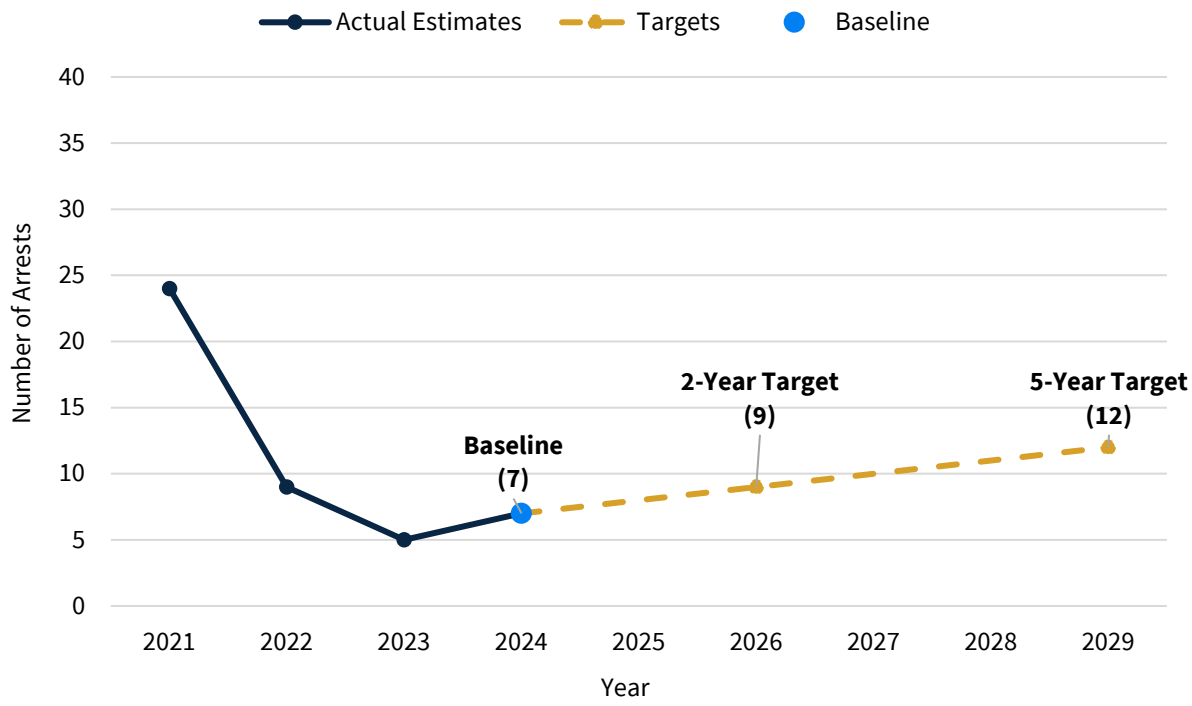
Rationale: Given that our baseline estimate is below the 3-year historical average, we propose establishing a 5-year target to get back above this average by arresting at least 12 new individuals from the CPOT List in 2029.

Figure 4.2.1: Number of individuals arrested on the Consolidated Priority Organization Target List, 2021-2029.



Measure 4.2.2: Increase the number of arrests by law enforcement agencies for the sale or manufacturing of illicit drugs.

Data Source: Federal Bureau of Investigation Crime Data Explorer

Measure Description: This measure includes the total number of arrests by law enforcement agencies for the sale or manufacturing of opium, cocaine, synthetic narcotics, and other dangerous drugs in a calendar year. These estimates do not reflect the total number of individuals arrested because a person may be arrested multiple times in a given year.

Historical Trends: The number of arrests by law enforcement agencies for the sale or manufacturing of opium, cocaine, synthetic narcotics, and other dangerous drugs increased from 69,569 in 2021 to 83,935 in 2023 before decreasing to 78,367 in 2024.

2024 Baseline: 78,367 arrests for the sale or manufacturing of illicit drugs

Targets: 81,502 arrests for the sale or manufacturing of illicit drugs in 2026; 86,204 arrests for the sale or manufacturing of illicit drugs in 2029

Target Setting Approach: Trend Analysis and Percent Improvement

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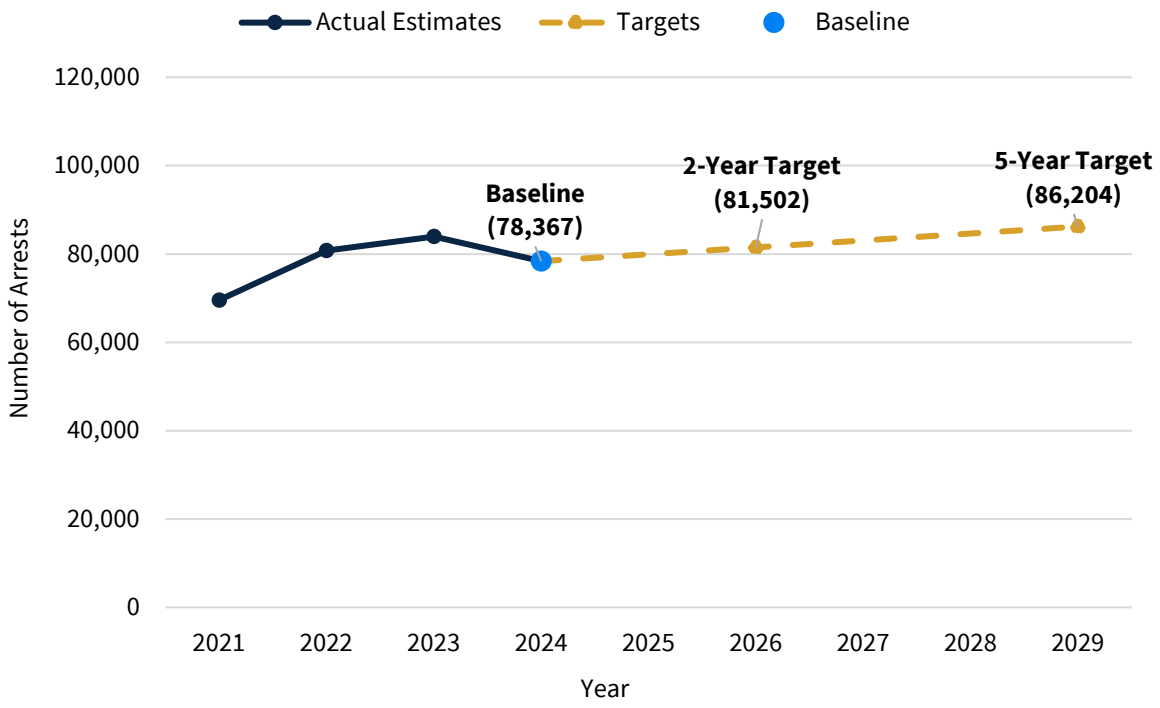
Rationale: Given that the number of arrests by law enforcement agencies for the sale or manufacturing of illicit drugs has fluctuated since 2021, we propose a modest 10% increase by 2029.

Figure 4.2.2: Number of arrests by law enforcement agencies for the sale or manufacturing of illicit drugs, United States, 2021-2029.



Objective 4.3: Sever Transnational Criminal Organizations and Foreign Terrorist Organizations' Access to Firearms to Degrade Their Capacity for Violence and Control

Measure 4.3.1: Increase the number of firearms seized that were destined Southbound.

Data Source: Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF), Crime Gun Intelligence Analysis, and the U.S. Customs and Border Protection's (CBP), Weapons and Ammunitions Seizures

Measure Description: Illegally obtained firearms from the United States in the hands of criminals appear in violence between Drug Trafficking Organizations (DTOs), as well as between DTOs and government forces. Reducing the number of firearms illegally flowing south will reduce the Foreign Terrorist Organizations (FTO)/DTOs' ability to protect their drug supplies and expand their territory through violence. This measure includes the total number of illegally obtained firearms seized annually by ATF and CBP that were destined south of the U.S. border.

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Historical Trends: The number of firearms seized by ATF and CBP that were destined Southbound has increased from 1,036 in 2021 to 3,917 in 2024.

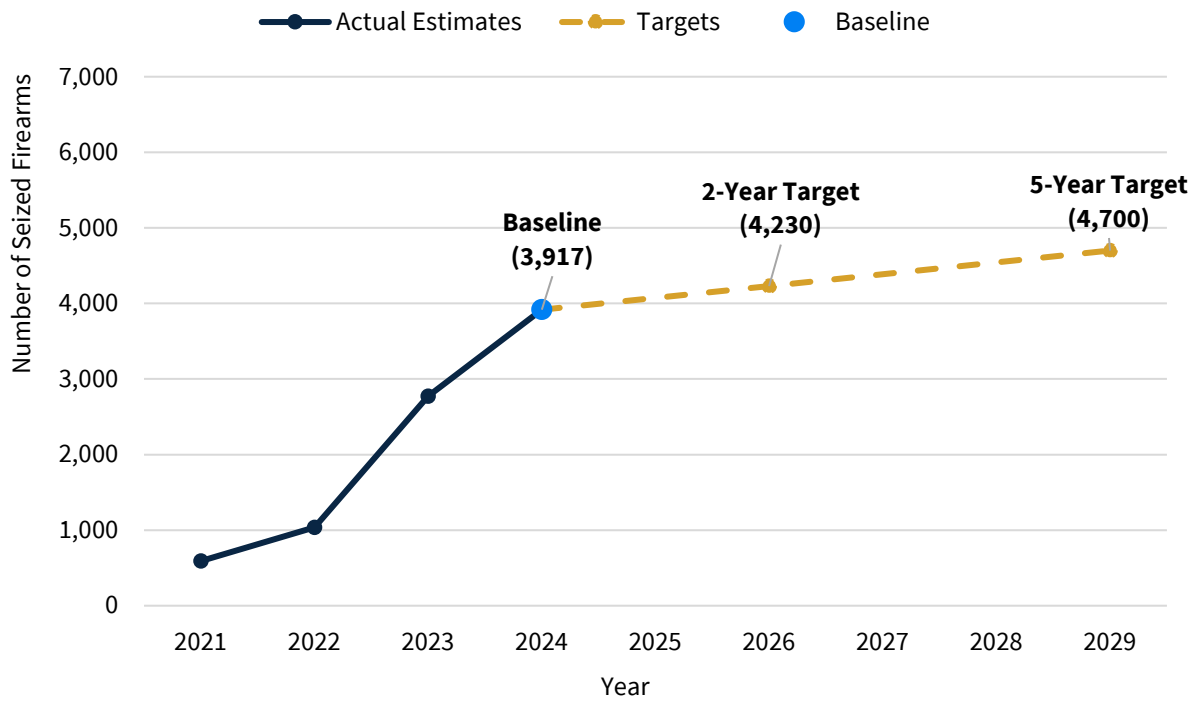
2024 Baseline: 3,917 new firearms seized

Targets: 4,230 new firearms seized in 2026; 4,700 new firearms seized in 2029

Target Setting Approach: Trend Analysis and Percent Improvement

Rationale: Given the rapid rate of increase in firearms seized by ATF and CBP that were destined south of the U.S. border, we propose a more substantial 20% increase in seizures for the year 2029.

Figure 4.3.1: Number of firearms seized that were destined Southbound, 2021-2029.



Measure 4.3.2: Increase the number of firearms recovered in the Western Hemisphere and submitted to the Bureau of Alcohol, Tobacco, Firearms and Explosives for tracing.

Data Source: Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF), Firearms Trace Data

Measure Description: Increasing the number of firearms tracing requests will feed information and intelligence to ATF investigations, resulting in the targeting and dismantling of illegal arms trafficking networks inside the United States. This measure includes the number of firearms seized by foreign law enforcement and submitted to ATF for tracing annually by foreign partners in illicit drug source and transit countries.

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Historical Trends: The total number of firearms recovered in the Western Hemisphere and submitted to ATF for tracing has decreased from 37,204 in 2021 to 36,557 in 2022 before increasing to 38,763 in 2024.

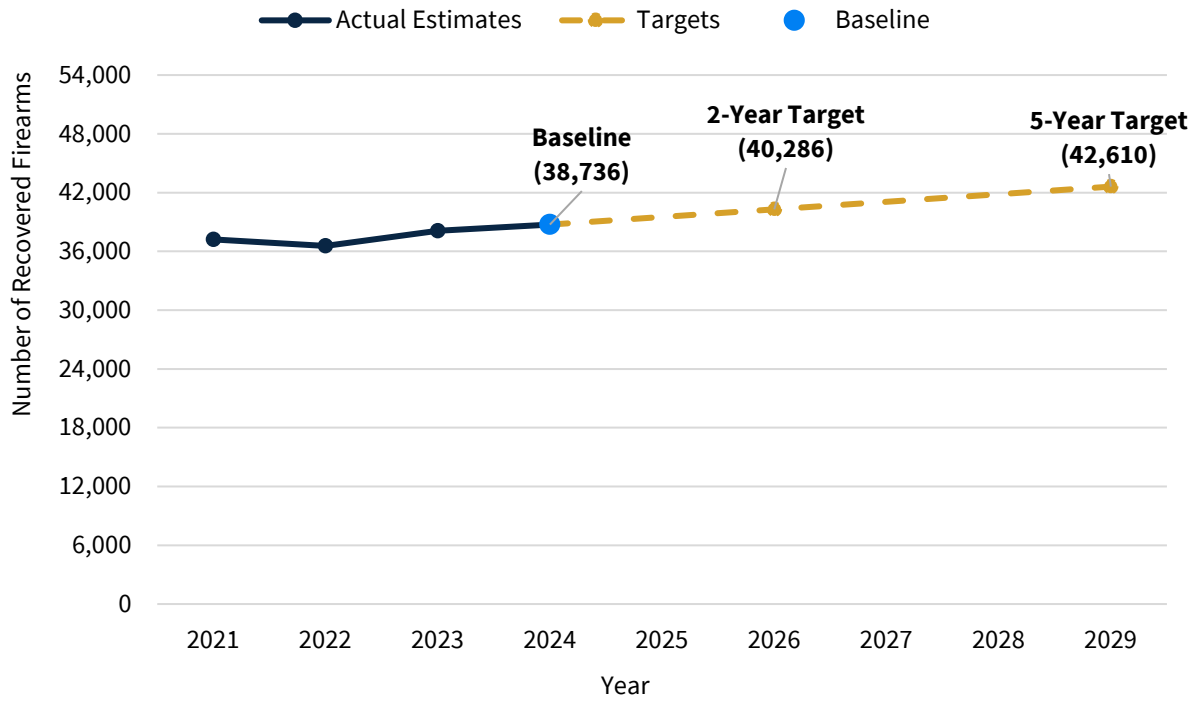
2024 Baseline: 38,736 new firearms recovered

Targets: 40,286 new firearms recovered in 2026; 42,610 new firearms recovered in 2029

Target Setting Approach: Trend Analysis and Percent Improvement

Rationale: The number of firearms recovered and submitted to ATF for tracing has increased slightly since 2021, therefore, we propose a modest 10% in 2029.

Figure 4.3.2: Number of firearms recovered in the Western Hemisphere and submitted to the Bureau of Alcohol, Tobacco, and Explosives for tracing, 2021-2029.



Objective 4.4: Sever Transnational Criminal Organizations from the Global Financial System to Attack Their Core Motivation: Profit

Measure 4.4.1: Increase the impact of new Executive Order 14059 sanctions imposed on foreign persons and entities involved in the Global Illicit Drug Trade.

Data Source: U.S. Department of the Treasury, Office of Foreign Assets Control's Sanctions List Service

Measure Description: Executive Order (EO) 14059 authorizes the Secretary of the Treasury to impose sanctions on foreign persons or entities involved in the global illicit drug trade. These sanctions can restrict the legitimate and illegitimate business streams that support Transnational

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Criminal Organizations (TCOs), some of which are also designated as Foreign Terrorist Organizations (FTOs) and Specially Designated Global Terrorists (SDGTs), resulting in reduced profits and disruption of their overall criminal enterprise. This measure includes the total number of newly sanctioned persons under EO 14059 annually. This measure accounts for the number of new actions taken publicly, but not necessarily the operational impact of sanctions.

Historical Trends: The number of new persons sanctioned under EO 14059 increased from 25 in 2021 to 192 in 2023 before decreasing to 142 in 2024.

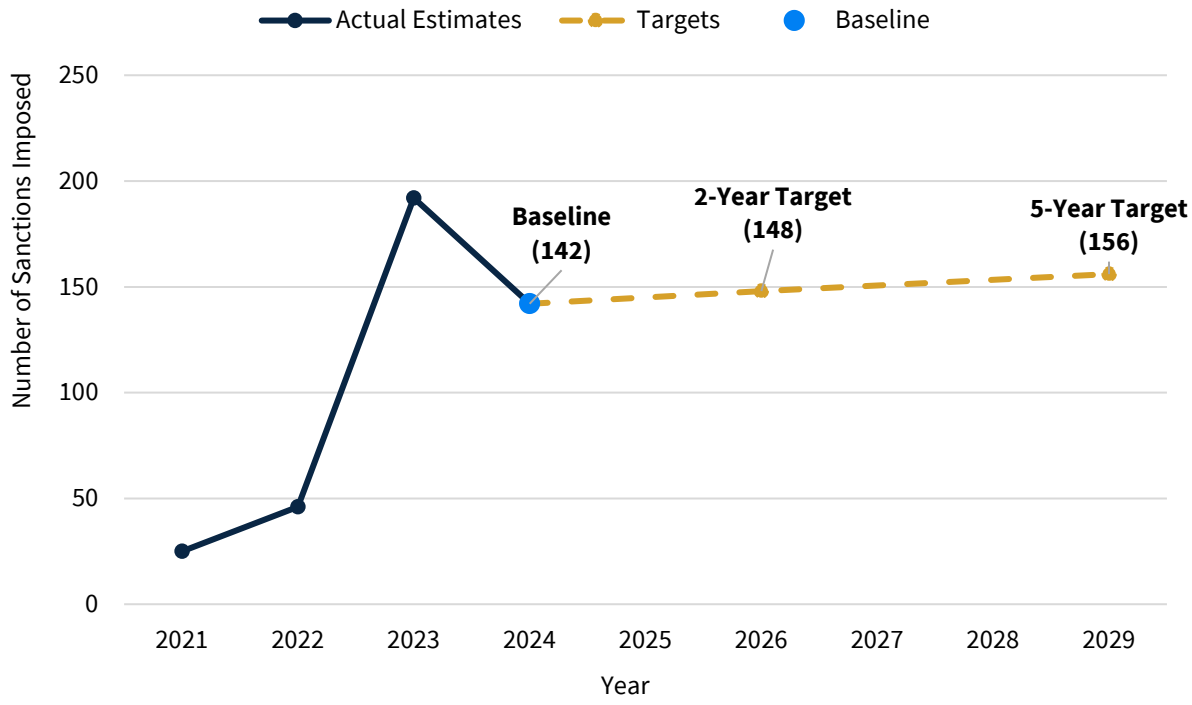
2024 Baseline: 142 newly sanctioned persons

Targets: 148 newly sanctioned persons in 2026; and 156 newly sanctioned persons in 2029

Target Setting Approach: Percent Improvement

Rationale: Given that the number of newly sanctioned persons under EO 14059 decreased from 2023 to 2024, we propose a modest 10% increase in 2029.

Figure 4.4.1: Number of foreign individuals and entities sanctioned under Executive Order 14059 in connection with the Global Illicit Drug Trade, 2021-2029.



Measure 4.4.2: Increase the number of special measures actions, including section 2313a orders against primary money laundering concerns linked to drug trafficking.

Data Source: U.S. Department of the Treasury, Financial Crimes Enforcement Network (FinCEN) Advisories

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Measure Description: *Codified at 21 U.S.C. § 23313a,* the Fentanyl Eradication and Narcotics Deterrence (FEND) Off Fentanyl Act of 2024 authorizes the Secretary of the Treasury to issue orders that, among other measures, prohibit U.S. financial institutions operating outside of the United States, classes of transactions within or involving a jurisdiction outside of the United States, or types of accounts within or involving a jurisdictions outside of the United States found to be of primary money laundering concern in connection with illicit opioid trafficking. These orders will restrict transactions with illegitimate business streams that support FTOs/DTOs, resulting in reduced profits and elimination of their business streams in the global market. This authority added powerful new special measures to the Secretary's existing special measures tools, most notably under section 311 of the USA PATRIOT Act. This measure includes the total number of new special measures actions, including section 2313a orders, issued annually against foreign financial institutions and other targets linked to drug trafficking.

Historical Trends: This is a new initiative; therefore, no historical data are available.

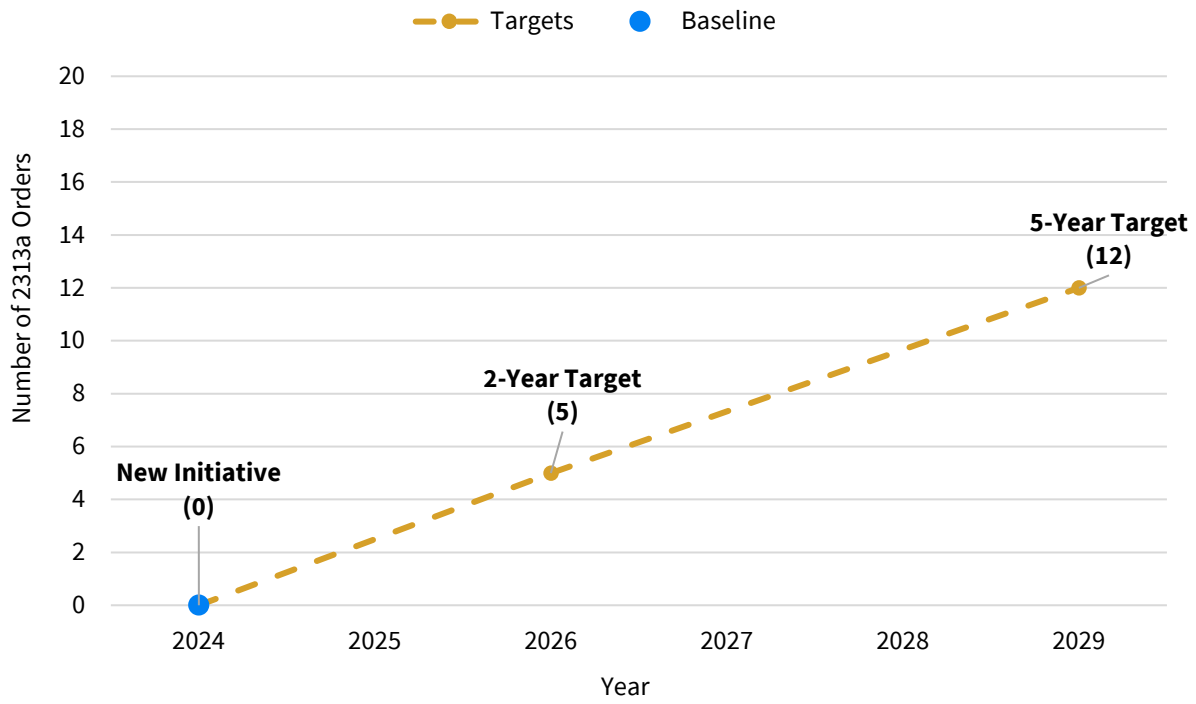
2024 Baseline: 0 special measure actions linked to drug trafficking

Targets: 5 new special measures in 2026; 12 new special measures in 2029

Target Setting Approach: Subject Matter Expertise

Rationale: Section 2313a orders did not exist until 2024, and the first three were issued in June 2025. Given that this is a new mechanism, we are proposing a target of 12 new section 2313a actions or other special measures by 2029.

Figure 4.4.2: Number of special measures actions, including section 2313a orders against primary money laundering concerns linked to drug trafficking, United States, 2024-2029.



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Chapter 5: Creating a Drug Free America as the Social Norm

Objective 5.1: Increase the Percentage of Youth and Young Adults who are Drug-Free

Measure 5.1.1: Increase the percentage of 12- to 17-year-olds who have not used illicit drugs in the past year.

Data Source: Substance Abuse and Mental Health Services Administration (SAMHSA), National Survey on Drug Use and Health (NSDUH)

Measure Description: The percentage of 12- to 17-year-olds who have not used illicit drugs in the past year was derived by subtracting the percentage who reported past year illicit drug use from 100%. Past year illicit drug use includes marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, methamphetamine, or prescription psychotherapeutics that were misused, which include pain relievers, tranquilizers, stimulants, and sedatives.

Historical Trends: Non-use of illicit drugs in the past year among 12- to 17-year-olds has remained stable from 2021 to 2024, ranging from 84.9% to 85.4%.

2024 Baseline: 84.9% of 12- to 17-year-olds

Targets: 85.9% of 12- to 17-year-olds in 2026; 88.3% of 12- to 17-year-olds in 2029

Target Setting Approach: Percentage Point Improvement and Minimal Statistical Significance

Rationale: Given that this measure was derived from a nationally representative sample, a 95% confidence interval was calculated for the baseline estimate, with the upper bound of 85.9% being the threshold for minimal statistical significance. This threshold will serve as the 2-year target for this measure. For the 5-year target, a Cohen's effect size of h = 0.1 was applied to produce a target of 88.3%.

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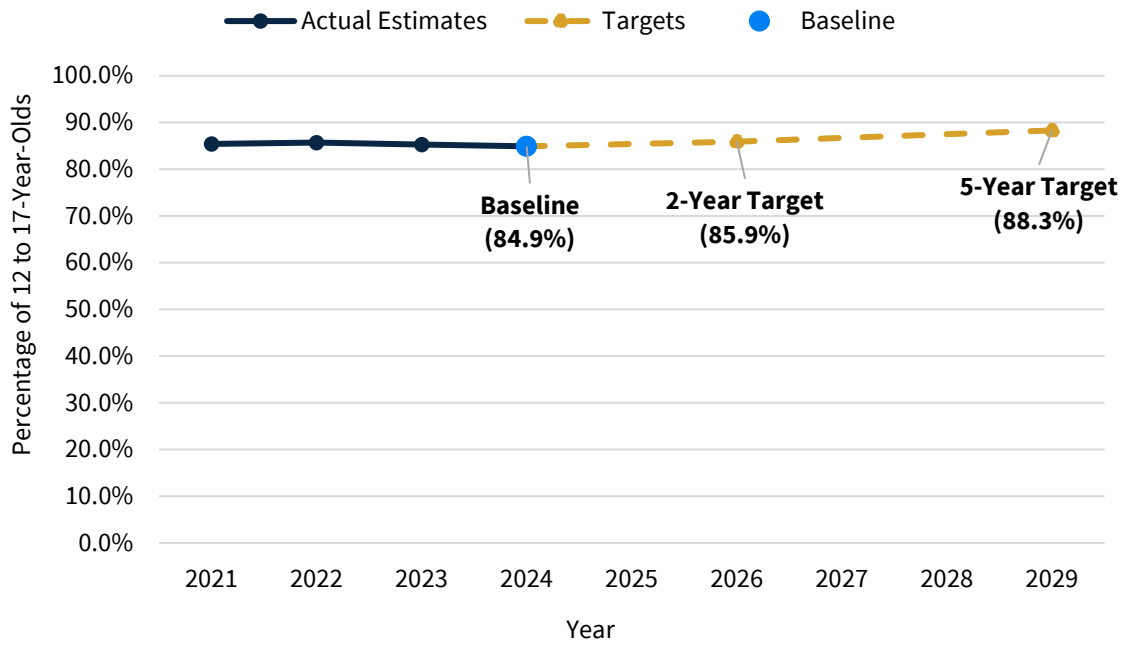
Figure 5.1.1: percentage of 12- to 17-year-olds who have not used illicit drugs in the past year, United States, 2021-2029.



Measure 5.1.2: Increase the percentage of 18- to 25-year-olds who have not used illicit drugs in the past year.

Data Source: Substance Abuse and Mental Health Services Administration (SAMHSA), National Survey on Drug Use and Health (NSDUH)

Measure Description: The percentage of 18- to 25-year-olds who have not used illicit drugs in the past year was derived by subtracting the percentage who reported past year illicit drug use from 100%. Past year illicit drug use includes marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, methamphetamine, or prescription psychotherapeutics that were misused, which include pain relievers, tranquilizers, stimulants, and sedatives.

Historical Trends: Non-use of illicit drugs in the past year among 18- to 25-year-olds has remained stable from 2021 to 2024, ranging from 59.0% to 61.9%.

2024 Baseline: 61.9% of 18 to 25-year-olds

Targets: 63.2% of 18 to 25-year-olds in 2026; 66.7% of 18 to 25-year-olds in 2029

Target Setting Approach: Percentage Point Improvement and Minimal Statistical Significance

Rationale: Given that this estimate was derived from a nationally representative sample, a 95% confidence interval was calculated for the baseline estimate, with the upper bound of 63.2% being the threshold for minimal statistical significance. This threshold will serve as the 2-year target for this measure. For the 5-year target, a Cohen's effect size of h = 0.1 was applied to produce a target of 66.7%.

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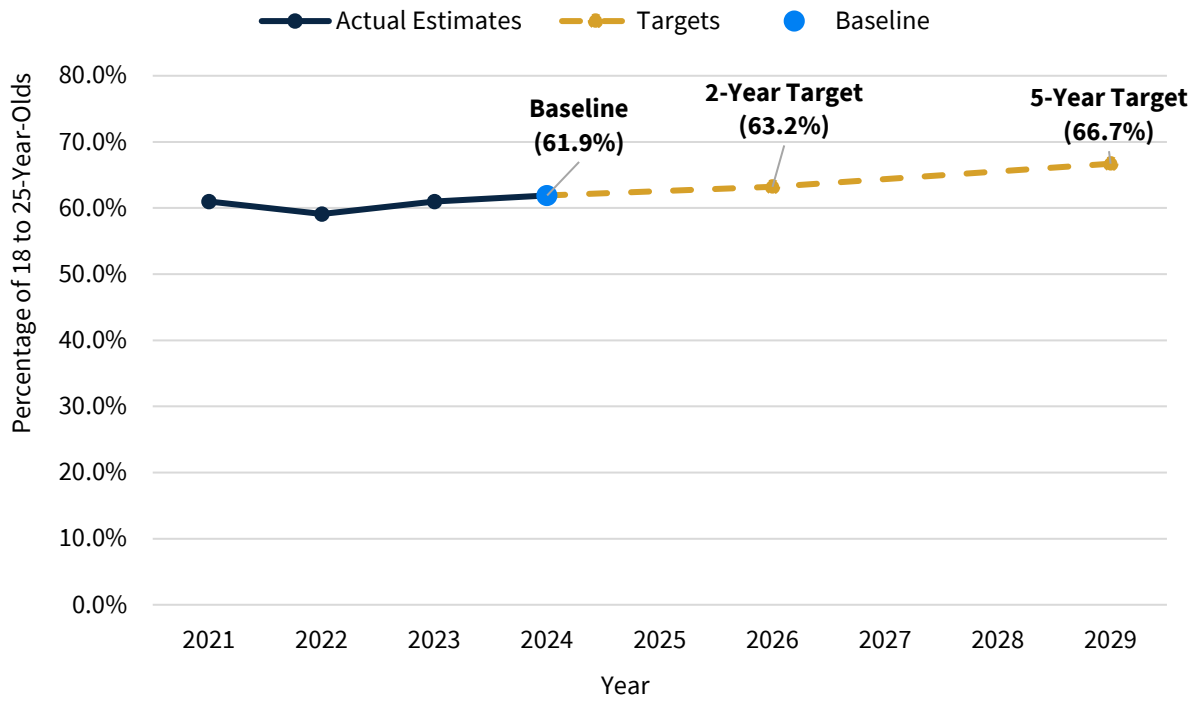
Figure 5.1.2: Percentage of 18 to 25-year-olds who have not used illicit drugs in the past year, United States, 2021-2029.



Objective 5.2: Strengthen Drug-Free Workplace Initiatives

Measure 5.2.1: Decrease the percentage of the general U.S. workforce that tests positive for drug use from a random urine drug test.

Data Source: Quest Diagnostics, Drug Testing Index

Measure Description: Drug testing results provide information on the prevalence of drug use among the American workforce. This measure includes positivity rates for a range of illicit and prescription drugs from random urine drug tests conducted among the general U.S. workforce.

Historical Trends: Positivity rates from random urine drug tests among the general U.S. workforce have increased slightly from 5.8% in 2021 to 6.3% in 2024.

2024 Baseline: 6.3% of the general workforce

Targets: 5.4% of the general workforce in 2026; 4.1% of the general workforce in 2029

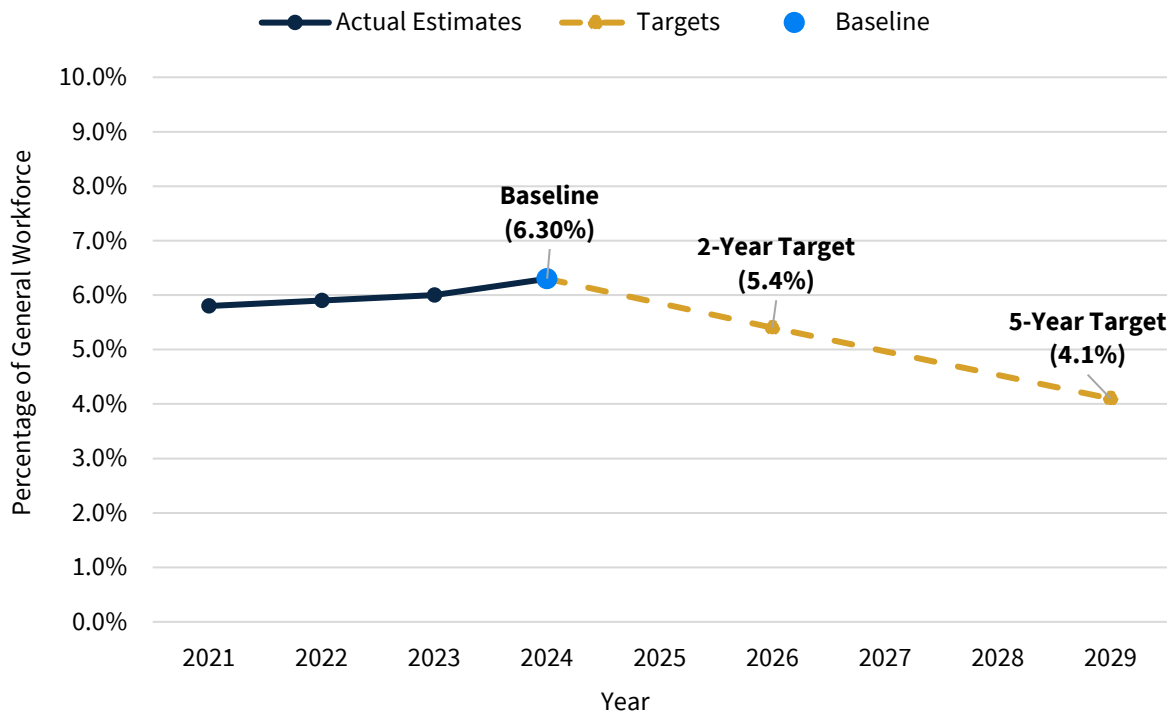
Target Setting Approach: Percentage Point Improvement

Rationale: The positivity rate for random urine drug tests among the federally mandated, safety sensitive workforce[1] is 1.9%. Our long-term goal is to close the gap between this population and

[1] The federally mandated, safety sensitive workforce works at agencies that perform public safety and national security roles. These agencies include: the Federal Aviation Administration, the

the general workforce. A Cohen's effect size of h = 0.1 was applied to produce a modest 5-year target of 4.1%.

Figure 5.2.1: Percentage of the general workforce who test positive for drug use from a random urine drug test, United States, 2021-2029.



Federal Motor Carrier Safety Administration, the Federal Railroad Administration, the Federal Transit Administration, the National Highway Traffic Safety Administration, the Pipeline and Hazardous Materials Safety Administration, and the U.S. Coast Guard. Federal agencies have established specific drug-testing requirements for this workforce.

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Chapter 6: Bringing Help at all Stages of Addiction into the Mainstream

Objective 6.1: Increase the number of screenings for drug use and early interventions

Measure 6.1.1: Increase the number of Original Medicare allowed claims for screening and brief intervention for substance use.

Data Source: Centers for Medicare & Medicaid Services (CMS), Physician & Other Practitioners - by Provider and Service

Measure Description: This measure includes the total annual service counts among Original Medicare beneficiaries for Medicare-covered Part B services for an alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., AUDIT, DAST), and brief intervention (Healthcare Common Procedure Coding System codes (G2011 and G0396)). These estimates exclude services for Medicare Advantage beneficiaries. This measure may underestimate the number of Medicare beneficiaries assessed because beneficiaries may also be assessed during other preventive screening visits such as the Medicare Annual Wellness visit.

Historical Trends: The annual number of allowed claims provided to Original Medicare beneficiaries for screening and brief intervention for substance use decreased from 61,100 in 2021 to 54,577 in 2023.

2023 Baseline: 54,577 allowed claims provided for screening and brief intervention for substance use

Targets: 56,760 allowed claims provided for screening and brief intervention for substance use in 2026; 60,035 allowed claims provided for screening and brief intervention for substance use in 2029

Target Setting Approach: Trend Analysis and Percent Improvement

Rationale: Given that the number of allowed claims provided to Original Medicare beneficiaries for screening and brief intervention for substance use was consistently decreasing from 2021 to 2023, we are looking to correct course. Given the change in direction, we propose a modest 10% increase by 2029.

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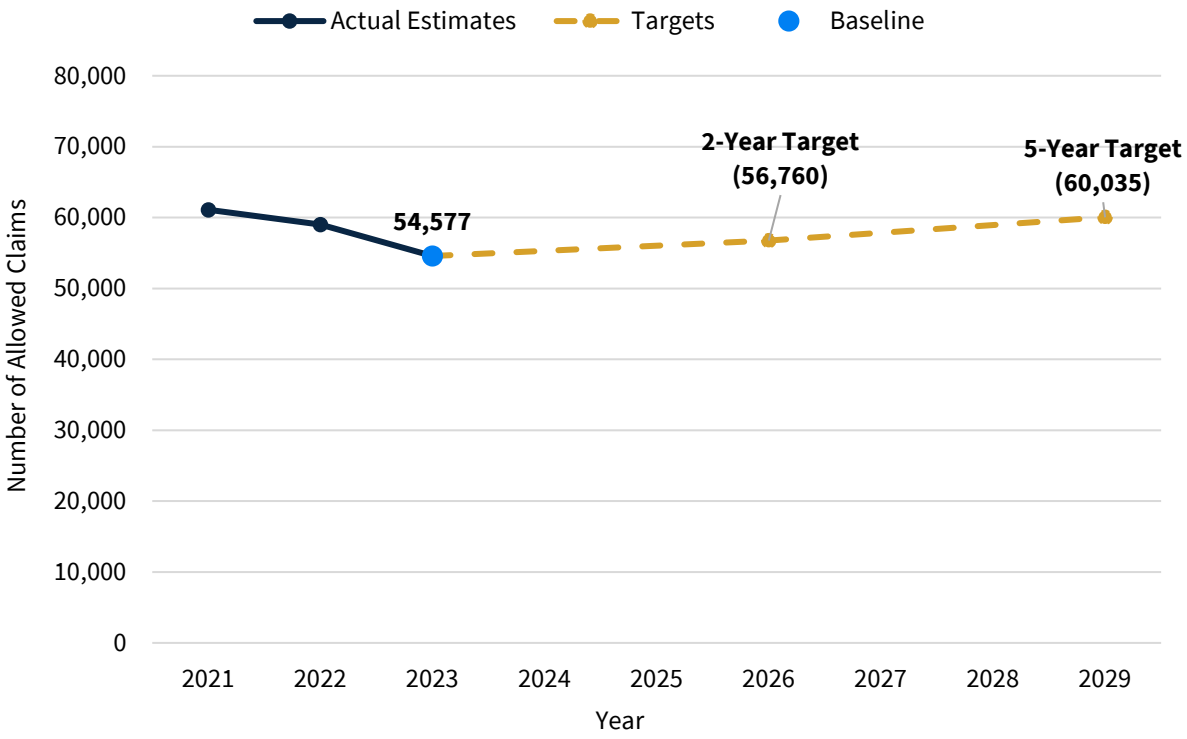
Figure 6.1.1: Number of Original Medicare allowed claims for screening and brief intervention for substance use, United States, 2021-2029.



Objective 6.2: Increase access to treatment for people with a substance use disorder

Measure 6.2.1: Increase the percentage of people with a past-year substance use disorder who received treatment in the past year.

Data Source: Substance Abuse and Mental Health Services Administration (SAMHSA), National Survey on Drug Use and Health (NSDUH)

Measure Description: The percentage of people aged 12 or older with a past-year substance use disorder (SUD) who received treatment was calculated among people classified as needing SUD treatment, which includes people who met the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) criteria for a drug or alcohol use disorder or received treatment for drug or alcohol use in the past year. Substance use treatment includes treatment for drug or alcohol use through inpatient treatment/counseling; outpatient treatment/counseling; medications for alcohol or opioid use disorder; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.

Historical Trends: No historical data were available from the National Survey on Drug Use and Health (NSDUH) due to changes that were made to the inpatient and outpatient substance use treatment questions in 2024.

2024 Baseline: 19.3% of people with SUD

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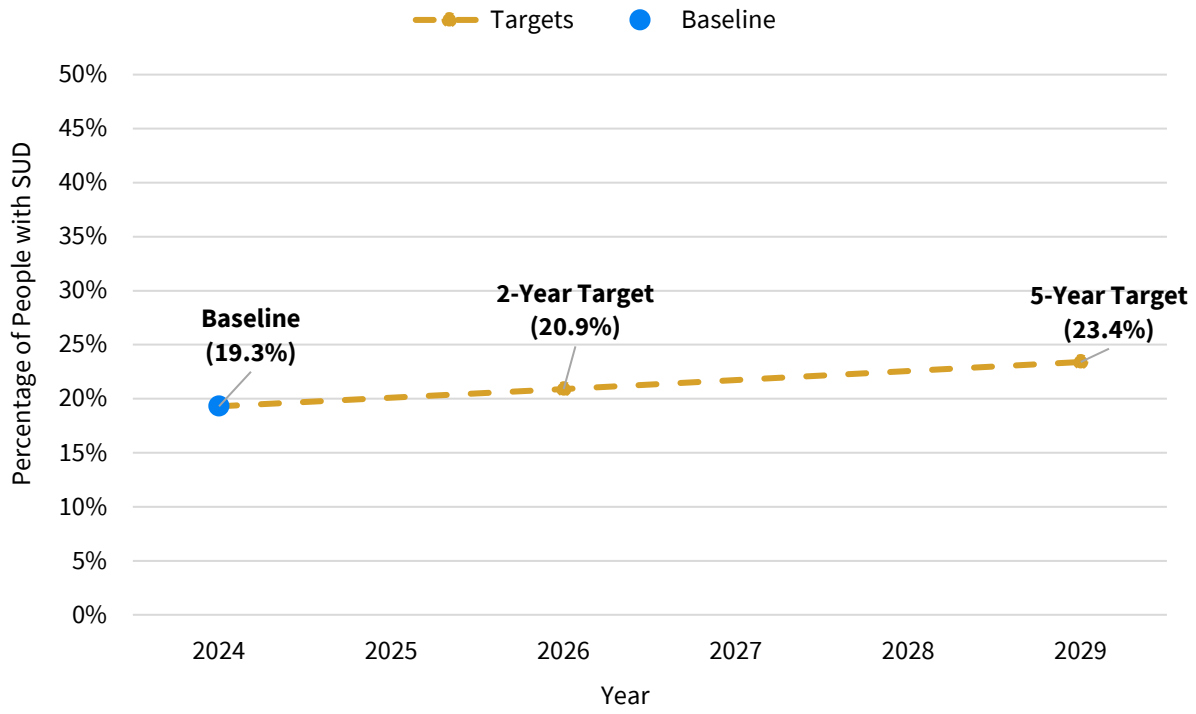
Targets: 20.9% of people with SUD in 2026; 23.4% of people with SUD in 2029

Target Setting Approach: Percentage Point Improvement and Minimal Statistical Significance

Rationale: Given that this estimate was derived from a nationally representative sample, a 95% confidence interval was calculated for the baseline estimate, with the upper bound of 20.9% being the threshold for minimal statistical significance. This threshold will serve as the 2-year target for this measure. For the 5-year target, a Cohen's effect size of h = 0.1 was applied to produce a target of 23.4%.

Figure 6.2.1: Percentage of people with a substance use disorder who received treatment in the past year, United States, 2024-2029.



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Chapter 7: Celebrate and Support Recovery

Objective 7.1: Increase the number of people in recovery

Measure 7.1.1: Increase the number of Americans who consider themselves to have successfully recovered from a substance use problem.

Data Source: Substance Abuse and Mental Health Services Administration (SAMHSA), National Survey on Drug Use and Health (NSDUH)

Measure Description: The number of people who considered themselves to be in recovery or to have recovered from a drug or alcohol use problem is a self-reported measure among people who reported that they ever had a problem with their drug or alcohol use.

Historical Trends: The number of people aged 18 or older who consider themselves to be in recovery has steadily increased from 21.4 million people in 2021 to 23.5 million people in 2024.

2024 Baseline: 23.5 million people

Targets: 24.7 million people by 2026; 25.9 million people by 2029

Target Setting Approach: Percentage Point Improvement and Minimal Statistical Significance

Rationale: Given that this estimate was derived from a nationally representative sample, a 95% confidence interval was calculated for the baseline estimate, with the upper bound of 24.7 million people being the threshold for minimal statistical significance. This threshold will serve as the 2-year target for this measure. For the 5-year target, a 10% improvement was applied to produce a target of 25.9 million people.

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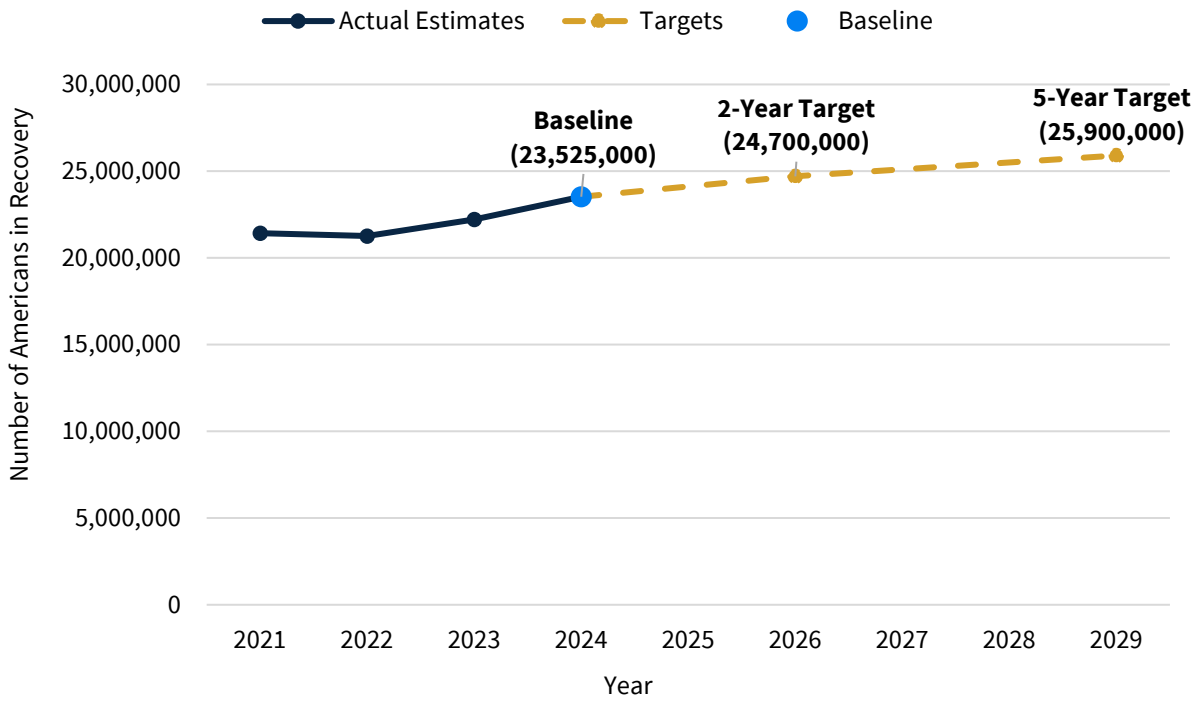
Figure 7.1.1: Number of Americans who consider themselves to have successfully recovered from a substance use problem, United States, 2021-2024.



Objective 7.2: Expand recovery-friendly workplaces

Measure 7.2.1: Increase the number of nationally-certified recovery-ready workplaces.

Data Source: National Recovery Friendly Workplace Institute

Measure Description: National Recovery Friendly Workplace Certification recognizes employers who are committed to supporting employees in recovery from substance use disorders and fostering a healthy workplace culture. This measure includes all nationally-certified recovery-friendly workplaces.

Historical Trends: National Recovery Friendly Workplace Certification did not begin until 2024, therefore there are no historical data.

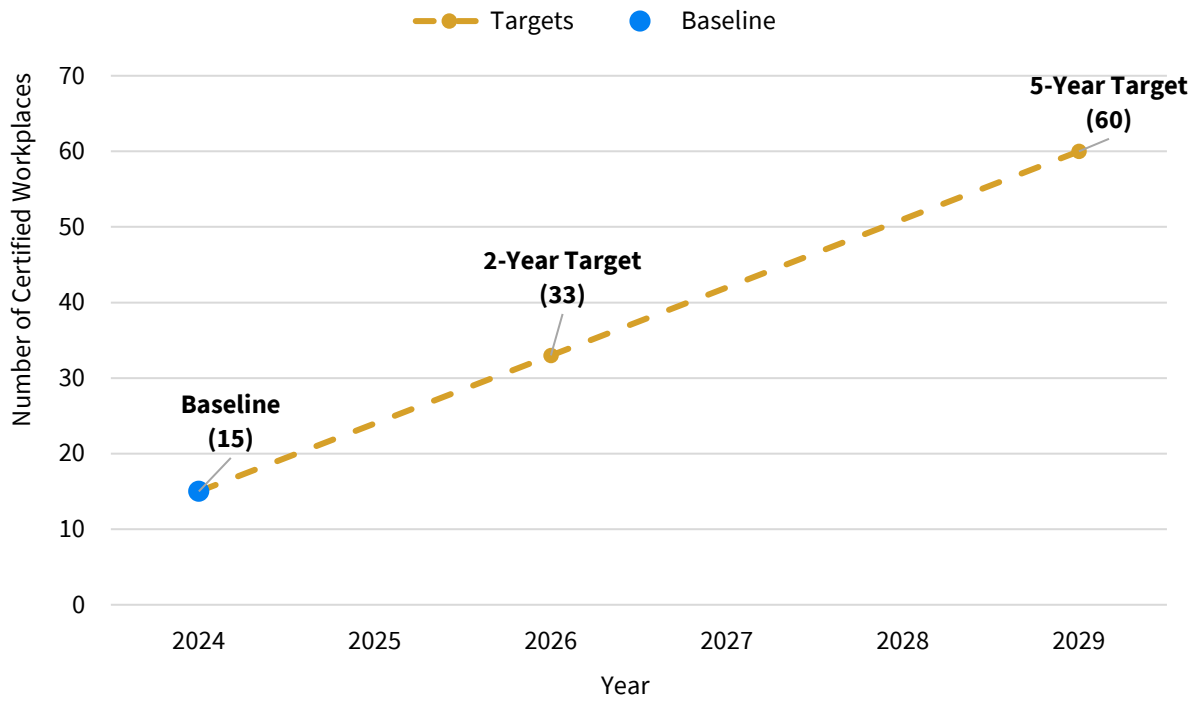
2024 Baseline: 15 new workplaces

Targets: 33 new workplaces in 2026; 60 new workplaces in 2029

Target Setting Approach: Subject Matter Expertise

Rationale: This is a new program that did not exist until 2024. Given that this is a new program, we are proposing a target of 60 new nationally-certified recovery-ready workplaces in 2029 to encourage broad adoption across the private sector.

Figure 7.2.1: Number of new nationally-certified recovery-ready workplaces, United States, 2024-2029.



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Chapter 8: Rescue & Overdose Response

Objective 8.1: Improve distribution of naloxone

Measure 8.1.1: Increase the number of federally-funded opioid overdose reversal kits distributed to states.

Data Source: Substance Abuse and Mental Health Services Administration (SAMHSA), Performance Accountability and Reporting System (SPARS), Web Block Grant Application System (WebBGAS), and Centers for Disease Control and Prevention (CDC), Partner's Portal

Measure Description: This measure includes the total number of opioid overdose reversal kits purchased and distributed by states through federal grants.

Historical Trends: The number of federally-funded opioid overdose reversal kits distributed to states has increased from 1.0 million in 2021 to 5.2 million in 2024.

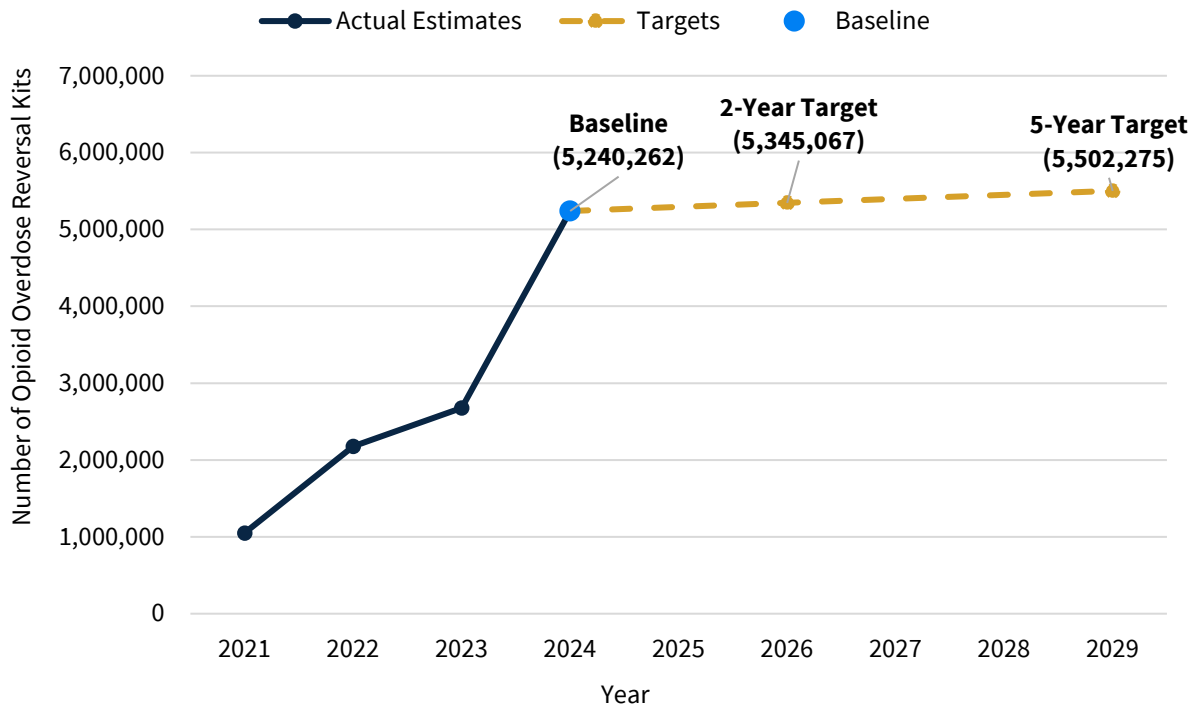
2024 Baseline: 5,240,262 new opioid overdose reversal kits

Targets: 5,345,067 new opioid overdose reversal kits in 2026; 5,502,275 new opioid overdose reversal kits in 2029

Target Setting Approach: Percent Improvement

Rationale: There has been a rapid increase in federally-funded opioid overdose reversal kits distributed to states from 2021 to 2024. Given the decline in opioid overdose deaths observed between 2023 and 2024 and the FDA’s continued work to extend the shelf-life of opioid overdose reversal, we are proposing a modest 5% increase over five years.

Figure 8.1.1: Number of new federally-funded opioid overdose reversal kits distributed to states, United States, 2021-2029.



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Summary Table: PRS Goals, Objectives, Measures, and Targets

Chapter	Objective	Measure	Baseline (2024)	2- Year Target	5-Year Target
Overarching Goal	Single Goal: Save American Lives by Reducing Fatal Overdoses from All Drugs	Overall Measure: Reduce the number of drug overdose deaths.	79,384	71,630	60,000
Chapter 1: Defining Current and Emerging Drug Threats	Objective 1.1: Establish Standardized Processes to Define and Detect Drug Threats	Measure 1.1.1: Increase the number of states meeting all reporting requirements for the CDC's SUDORS Program.	43	47	50
	Objective 1.2: Disseminate Accurate, Timely Data to Public and Private Sector Audiences	Measure 1.2.1: Increase the number of core data sources that have at least 80% of data completed, processed, and available for use within six months of collection.	10	13	17
		Measure 1.2.2: Increase the number of peer-reviewed scientific publications that examine the intersection between the drug supply and drug overdose.	10	13	17

Chapter	Objective	Measure	Baseline (2024)	2- Year Target	5-Year Target
Chapter 2: Securing the Global Supply Chain from Foreign Terrorist and Transnational Criminal Organizations	Objective 2.1: Decrease the Movement of Precursor Chemicals and Finished Drugs through Legitimate Shipping Modalities	Measure: 2.1.1: Increase the number of chemical and pharmaceutical companies participating in the Customs Trade Partnership Against Terrorism program.	428	445	471
		Measure 2.1.2: Increase the number of freight forwarders (i.e., consolidators) participating in Customs Trade Partnership Against Terrorism program.	769	800	846
		Measure 2.1.3: Increase the cumulative number of companies participating in international trusted trader programs that have Mutual Recognition Agreements (MRAs) with Customs and Border Protection.	23,412	24,068	25,465

Chapter	Objective	Measure	Baseline (2024)	2- Year Target	5-Year Target
Chapter 3: Stop the Flow of Illicit Drugs into American Communities	Objective 3.1: Attack Foreign Drug Production at the Source	Measure 3.1.1: Increase the annual combined number of incidents of precursor and related chemicals, along with related equipment seizures reported in the Precursor Incident Communication System by China, Colombia, India, and Mexico.	11	48	208
	Objective 3.2: Secure U.S. Borders and Approaches	Measure 3.2.1: Increase the weight (in metric tons) of cocaine destined for the United States that is removed by the Coast Guard.	106.3	210	210
		Measure 3.2.2: Increase the weight (in pounds) of illicit drug seizures destined for the United States at ports of entry and between ports of entry via land, sea, and air by U.S. Customs and Border Protection.	807,131	887,844	887,844

Chapter	Objective	Measure	Baseline (2024)	2- Year Target	5-Year Target
Chapter 3: Stop the Flow of Illicit Drugs into American Communities	Objective 3.3: Disrupt Domestic Drug Distribution and Degrade Transnational Criminal Organization Logistics Inside the Border	Measure 3.3.1: Increase the number of drug trafficking and money laundering organizations disrupted or dismantled by High Intensity Drug Trafficking Area task forces.	3,209	3,337	3,530
		Measure 3.3.2: Increase the number of Food and Drug Administration Warning Letters sent to companies selling unauthorized products containing Delta-8 THC, Kratom/7-OH, and other opioids.	9	13	18
	Objective 3.4: Enhance Interdiction by Exploiting and Fusing Intelligence from Seizures	Measure 3.4.1: Increase the number of electronic devices seized during drug operations from which data is extracted and uploaded into intelligence platforms and digital forensic tools.	39	47	60

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Chapter	Objective	Measure	Baseline (2024)	2- Year Target	5-Year Target
Chapter 4: Global Campaign Against Transnational Criminal and Foreign Terrorist Threats	Objective 4.1: Unify Law Enforcement and Intelligence Community Efforts Against Designated Transnational Criminal Organizations	Measure 4.1.1: Increase the percentage of requests for information submitted by Homeland Security Task Forces that were responded to by the intelligence community.	New Initiative - No baseline available.	90%	95%
	Objective 4.2: Systematically Dismantle Transnational Criminal Organizations and Foreign Terrorist Organization Command and Control	Measure 4.2.1: Increase the number of individuals arrested on the Consolidated Priority Organization Target List.	7	9	12
		Measure 4.2.2: Increase the number of arrests by law enforcement agencies for the sale or manufacturing of illicit drugs.	78,367	81,502	86,204
	Objective 4.3: Sever Transnational Criminal Organizations and Foreign Terrorist Organizations' Access to Firearms to Degrade Their Capacity for Violence and Control	Measure 4.3.1: Increase the number of firearms seized that were destined Southbound	3,917	4,230	4,700
Chapter 4: Global Campaign Against Transnational Criminal and Foreign Terrorist Threats		Measure 4.3.2: Increase the number of firearms recovered in the Western Hemisphere and submitted to the Bureau of Alcohol, Tobacco, and Explosives for tracing.	38,736	40,286	42,610

Chapter	Objective	Measure	Baseline (2024)	2- Year Target	5-Year Target
	Objective 4.4: Sever Transnational Criminal Organizations from the Global Financial System to Attack Their Core Motivation: Profit	Measure 4.4.1: Increase the impact of new Executive Order 14059 sanctions imposed on foreign persons and entities involved in the Global Illicit Drug Trade.	142	148	156
		Measure 4.4.2: Increase the number of special measures actions, including section 2313a orders against primary money laundering concerns linked to drug trafficking.	New Initiative - No baseline available.	5	12
Chapter 5: Creating a Drug Free America as the Social Norm	Objective 5.1: Increase the Percentage of Youth and Young Adults who are Drug-Free	Measure 5.1.1: Increase the percentage of 12- to 17-year-olds who have not used illicit drugs in the past year.	84.9%	85.9%	88.3%
		Measure 5.1.2: Increase the percentage of 18- to 25-year-olds who have not used illicit drugs in the past year.	61.9%	63.2%	66.7%
	Objective 5.2: Strengthen Drug-Free Workplace Initiatives	Measure 5.2.1: Decrease the percentage of the general U.S. workforce who test positive for drug use from a random urine drug test.	6.3%	5.4%	4.1%

Chapter	Objective	Measure	Baseline (2024)	2- Year Target	5-Year Target
Chapter 6: Bringing Help at all Stages of Addiction into the Mainstream	Objective 6.1: Increase the number of screenings for drug use and early interventions	Measure 6.1.1: Increase the number of Original Medicare allowed claims for screening and brief intervention for substance use.	54,577 (2023)	56,760	60,035
	Objective 6.2: Increase access to treatment for people with a substance use disorder	Measure 6.2.1: Increase the percentage of people with a past-year substance use disorder who received treatment in the past year.	19.3%	20.9%	23.4%
Chapter 7: Celebrate and Support Recovery	Objective 7.1: Increase the number of people in recovery	Measure 7.1.1: Increase the number of Americans who consider themselves to have successfully recovered from a substance use problem.	23,525,000	24,700,000	25,900,000
	Objective 7.2: Expand recovery-friendly workplaces	Measure 7.2.1: Increase the number of nationally-certified recovery-ready workplaces.	15	33	60
Chapter 8: Rescue & Overdose Response	Objective 8.1: Improve distribution of naloxone	Measure 8.1.1: Increase the number of federally-funded opioid overdose reversal kits distributed to states.	5,240,262	5,345,067	5,502,275

Appendix C: Plan for Collecting, Using, and Acquiring Data to Facilitate the Use of Evidence in Drug Control Policymaking (Data Plan)

Introduction

The policies laid forth by the *National Drug Control Strategy*, hereinafter the *Strategy*, are informed by the best available, data-derived evidence. The ongoing systematic collection of accurate, timely, and relevant data is critical to support the Trump Administration's efforts to disrupt the production and trafficking of illicit drugs as well as enable the development of effective drug use prevention, overdose prevention, treatment, and recovery services.[130]

However, merely collecting data is not sufficient to meet the Administration's ambitious goals. The *Strategy* therefore continues the Administration's ongoing efforts to break information silos and integrate all available information at every level of the decision-making process. In terms of addressing the drug crisis, this principle requires integrating data on the drug supply (e.g., trafficking patterns, types of drugs in the supply) with data on drug use and its consequences (e.g., overdoses and types of drugs used) to provide the most insight into the factors driving the drug crisis, enabling the identification of the most efficient solutions. The data sources identified in this annex will permit analysis of current trends against previously compiled data and information to enhance long-term assessment of the *Strategy*.

This data plan is a statutorily mandated requirement for the *Strategy* and presents the following sections as mandated by the SUPPORT Act: Policy-relevant questions for which National Drug Control Program Agencies intend to develop evidence to support the *Strategy*; Data to Collect, Use or Acquire to facilitate the use of evidence in drug control policymaking and monitoring; Methods and analytical approaches that may be used to develop evidence to support the *Strategy* and related policy; Challenges to developing evidence to support policymaking, including any barriers to accessing, collecting, or using relevant data; and a description of the steps needed to implement this plan. Data topics that informed the Data Plan were discussed during the consultation meetings with the Demand and Supply groups. Further, specific agencies were engaged to provide information or clarification for the sections that are pertinent to them.

Policy-Relevant Questions

This section presents a list of policy-relevant questions for which evidence will be developed to support the National Drug Control Program and *Strategy*. These questions are organized by the chapters of the *Strategy*, and are aligned with the principles, objectives, and action items of those chapters.

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Defining Current and Emerging Drug Threats

a) How can data gathered from existing drug surveillance systems, which come from sources such as clinical (e.g., emergency departments), postmortem (e.g., overdose deaths) and law enforcement (e.g., seizures), be improved and integrated with novel surveillance methods (e.g., social media, wastewater, public health testing) to detect emerging and evolving threats and identify geographic and temporal trends in drug supply, drug consumption, substance use disorders, and overdose?

b) How can data analysis tools, including artificial intelligence and machine learning, be applied to anticipate and model emerging drug threats (e.g., geographic and temporal trends)?

c) What are the best approaches to update and standardize toxicology testing across public safety, public health, forensic laboratories, and medical examiners/coroners?

d) What are the most effective methods to communicate, equip, and support State, local, and Tribal communities to spur action and save lives from emerging and evolving threats?

e) How can public safety and public health organizations work together to integrate data and conduct research on the relationships between drug supply, drug consumption, and adverse consequences of drug use to anticipate and address emerging threats?

Securing the Global Supply Chain from Foreign Terrorist and Transnational Organizations

a) How will United States intelligence and analysis on global drug trafficking networks be shared with domestic and international partners?

b) How will international organizations and private sector actors be leveraged to secure the global drug supply chain?

c) How can the regulatory and legislative processes more quickly adapt to changes in unregulated chemicals and equipment as they become exploited by illicit actors?

Stop the Flow of Illicit Drugs into American Communities

a) How can the Northern and Southwest Borders be made more secure against the trafficking of illicit drugs and their chemical precursors?

b) How can law enforcement agencies collaborate across organizational and jurisdictional lines to develop and report comprehensive seizure statistics and share essential information with the public?

c) How can joint operations and intelligence sharing be improved to increase the number and impact of interdictions and organizational disruptions?

d) How will the ports of entry be secured against illicit drugs and their chemical precursors?

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Global Campaign Against on Transnational Criminal and Foreign Terrorist Threats

a) What tools and resources are needed by law enforcement and other federal partners to better detect and interdict illicit drugs and related contraband?

b) How can actionable data collection on the TCOs and FTOs be improved to improve the success of dismantling criminal organizations?

c) What are the current limitations in interdicting and preventing the online sale of illicit drugs and drug trafficking-related financial transactions?

d) How is progress monitored and what data metrics will be used to determine progress or success over time?

e) How will local, state, and federal agency cooperation be improved to more effectively disrupt the full drug supply chain?

Creating a Drug Free America as a Social Norm

a) How can we best implement effective primary prevention strategies to reduce substance use?

b) How will drug-free workplaces be encouraged and supported nation-wide?

Bringing Help at All Stages of Addiction to the Mainstream

a) How will access to evidence-based addiction treatment be expanded to meet the current demand?

b) What are the best practices for treating marijuana withdrawal and cannabis use disorder?

c) How do we best increase implementation of contingency management for stimulant use disorder?

d) What steps are needed to ensure quality and consistency of standards for treatment of substance use disorders?

e) How will access to treatment be expanded for individuals with co-occurring substance use and mental health disorders?

f) What healthcare resources are needed to decrease extended emergency department stays for patients with co-occurring substance use and mental health disorders?

Celebrate and Support Recovery

a) How can faith-based organizations, schools, and employers help more people seek, achieve, and sustain recovery?

b) What policies and strategies are needed to increase the number of Americans who seek, achieve, and sustain recovery?

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Rescue and Overdose Response

a) How do we best identify locations for the strategic placement of opioid overdose reversal medications?

b) How do we identify and implement the most effective standards for responding to mass drug overdose clusters?

c) How can nonfatal overdose data include the intended drug used to inform our strategic response to the drug use environment?

d) How can we improve nonfatal overdose estimates by triangulating data from multiple sources (e.g., emergency department visits, inpatient (hospitalization) data, EMS encounters)?

e) How does current guidance for administration of overdose reversal medications and education match the current drug supply, polydrug use, and threats of potent fentanyl analogs?

Data Needed to Facilitate the Use of Evidence in Drug Control Policymaking and Monitoring

Data are essential to inform the *Strategy* and its implementation, as well as measure the Nation's progress in meeting the *Strategy*'s goal of saving lives. Specifically, National Drug Control Agencies (NDCAs) need to collect and analyze data along the drug availability and use continuum (Figure 1) to better understand the magnitude of the drug crisis in the United States; identify factors contributing to the drug crisis; develop evidence-based programs and policies to address the drug crisis; and continuously monitor and evaluate the effectiveness of drug control policies and programs.

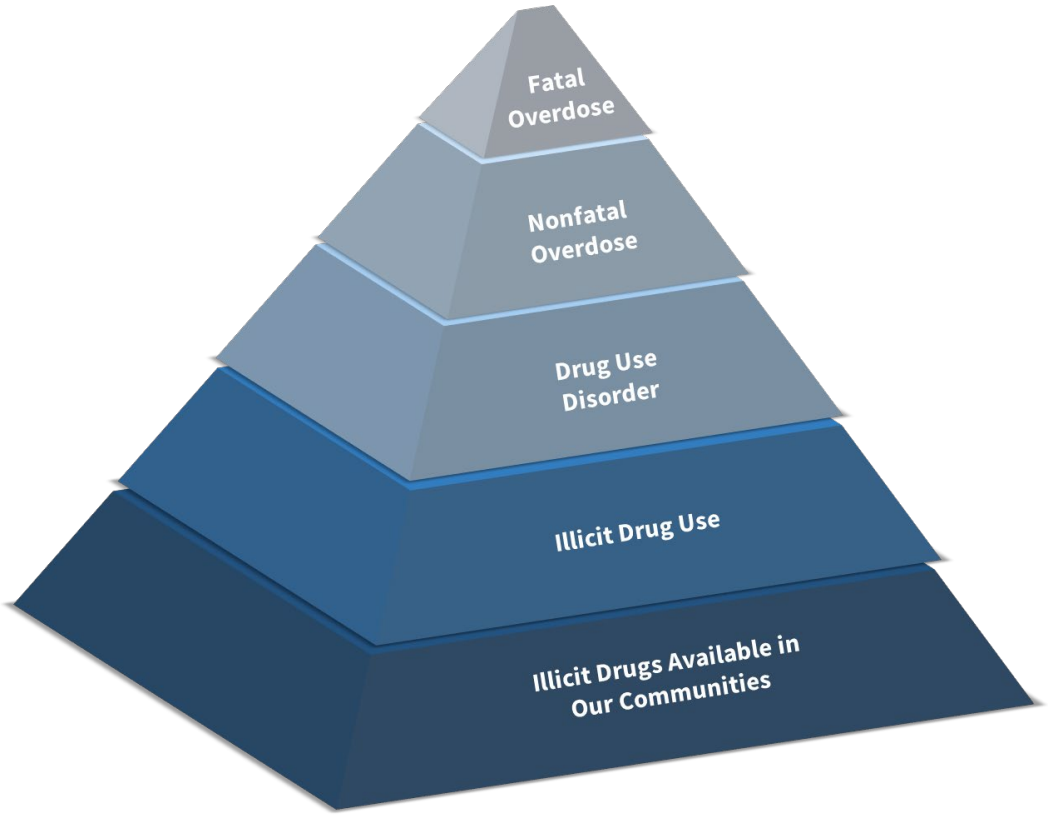

Figure 1: Collecting Data Along the Drug Availability and Use Continuum

One data source does not usually contain all the information necessary to fully understand or efficiently implement effective solutions. Effective drug control policy should therefore rely on a suite of data sources, each being appropriate to the policy questions they are intended to address, including surveys, public health administrative data, public safety administrative data, laboratory data, and novel data sources (Figure 2). In particular, laboratory data with its toxicological testing, should be a critical component of NDCAs' efforts for effective illicit drug control, given the extensive adulteration in the drug supply, the ever-changing supply composition, and the consumers' lack of knowledge of the drugs they are taking. NDCAs should also leverage new data to maximize illicit drug control – including wastewater-based drug epidemiology, social media data, digital forensics and intelligence, open-source intelligence, sensor and satellite data – and strengthen partnerships with private industry and research organizations to expand access to non-federal sources and facilitate the analysis and dissemination of data from non-federal sources.

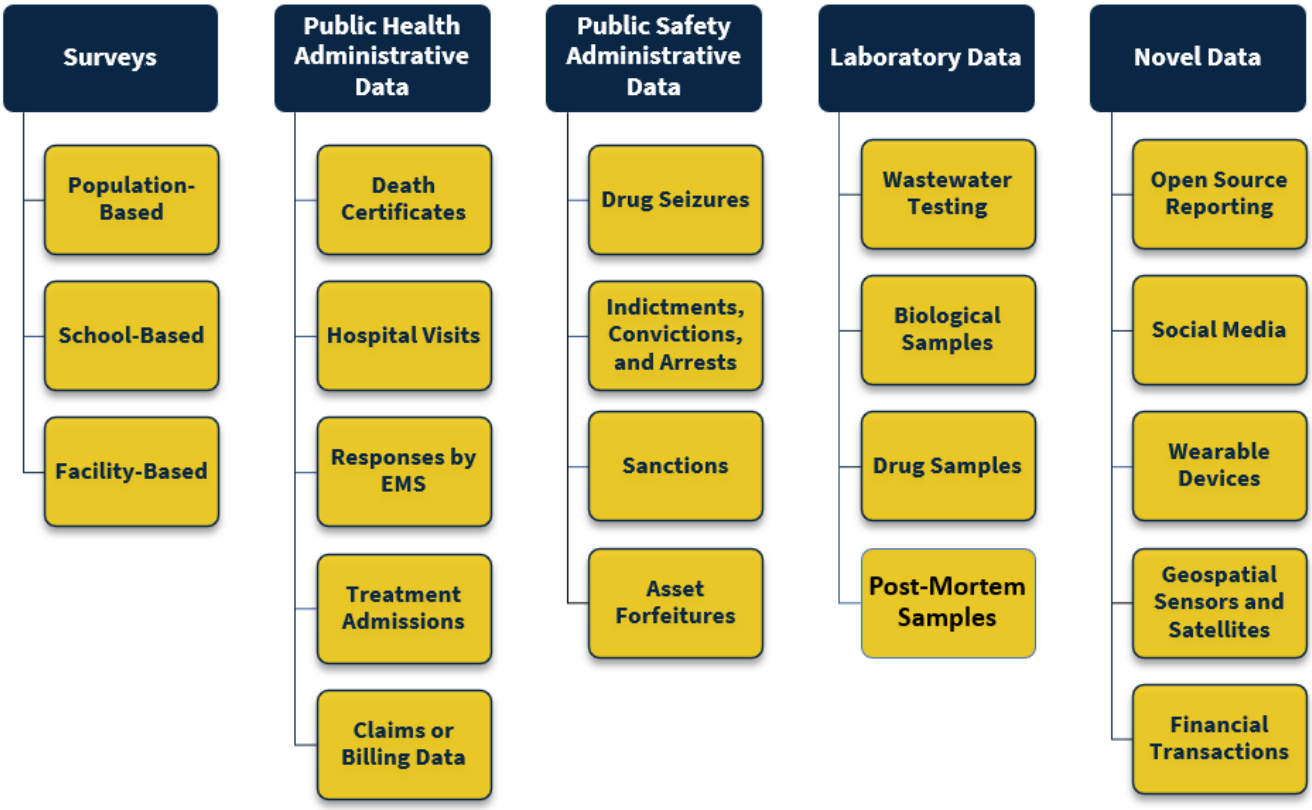

Figure 2: Data Sources to Monitor Drug Demand and Supply

The most effective data to inform policymaking are those verified to possess key characteristics, including accuracy, timeliness, completeness, validity, reliability, relevance, and comprehensiveness:

Accuracy: Data are correct and generally free from errors. Accurate estimates of the types, potency and price of drugs in the drug supply, as well as drug trafficking flow, are critical to determine the most effective approaches for drug supply disruption and interdiction. Similarly, accurate estimates of the number of people with substance use disorder in need of treatment and of nonfatal overdoses are key to inform policies and programs for demand reduction, such as the number and geographic distribution of treatment facilities and emergency medical services.

Timeliness: Data are collected and shared in as close to real-time as possible to inform decision-making. Where practical, the time lag from data collection to reporting should be minimized, and the reporting refresh frequency should be maximized. Effective drug control relies on timely surveillance to enable early detection of drug trafficking hotspots as well as types of drugs consumed and overdose outbreaks, develop rapid responses, inform decision-making for resource allocation and policy actions, and track and evaluate the progress of drug control efforts. Although important data sets may have emerged from the collection of operational data, for it to be as useful as possible to policymakers it should be collected, analyzed, and published on a predictable timetable.

Completeness: Data include all the needed information to inform the questions they are intended to address (i.e., minimal missing information). Policies based on data with significant missing information, especially when the missing information is not at random, could be biased and may not achieve the intended drug control results. For example, underreporting of fatal and nonfatal overdoses, incomplete drug trafficking data, non-systematic coverage of populations and geographic locations most impacted by the drug crisis, missing drug type information, and incomplete data on new psychoactive substances could significantly hamper drug control efforts.

Validity: Data are generated through established rules and standards to ensure they are measuring what they are intended to measure. The use of standard toxicological testing, standardized survey measures, and standardized procedures for drug seizures testing and analysis ensures that the data reflect the reality of the drug problem and can most effectively inform policymaking.

Reliability: Data must retain their characteristics over time (e.g., accuracy, completeness) so they can be consistently trusted and counted on for analyses to inform policy. Both reliability and validity are critical for data reproducibility and are key characteristics to inform trend analysis and time period comparisons.

Comprehensiveness: The *Strategy* needs data that are as comprehensive as possible to reflect the populations and geographic locations they are meant to represent. Comprehensive data can inform the development of effective drug control policies, resource allocation for policy implementation, and drug control policy monitoring and evaluation.

There are core federal data systems, currently in use, that are relevant for drug surveillance, and verify the previously-outlined characteristics. Table 1 includes the Dataset Name, Responsible Agency, Weblink, Short Description, Data Source, Geographical Coverage, and Drug Indicator Classification. Those core federal data systems verify the following criteria:

1. Exhibit the characteristics listed previously[m,] or are the dataset(s) most aligned with these characteristics, for the drug indictors they represent. For example, the National Survey on Drug Use and Health (NSDUH) and the National Forensic Laboratory Information System (NFLIS) share their data within 7 – 10 months of data collection, so timeliness could improve. However, for their respective drug indicators (drug use, substance use disorder, and seizures), they are among the best data sources available.
2. Include indicators for drug surveillance, such as drug use, substance use disorder, overdose, seizures (whether drugs or firearms), arrests, or sanctions. While important, datasets focusing on processes and operations are not considered core data sets.
3. Are not duplicative of other datasets. Some datasets, such as the National Seizure System, may be an overarching data system that includes data that are also available through several different systems. A core data system will be the overarching one.

[m] These are listed in a previous section of the data plan, and include: Accuracy, Timeliness, Completeness, Validity, Reliability, Comprehensiveness.

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Methods and Analytical Approaches to Develop Evidence for Drug Control Policymaking and Monitoring

Artificial intelligence (AI) – including machine learning, deep learning, and natural language processing – will be an increasingly powerful analytical tool to develop evidence for drug control policy. The use of AI will increase effectiveness and efficiency at each stage of the data lifecycle, including data collection, management, and analysis, thereby ushering in more innovations, and at a quicker pace, to maximize drug control strategies. AI will improve data timeliness and accuracy through automated data collection processes, facilitate record linkages and the integration of different data sources, such as structured and unstructured ones, during data management, and allow the processing of vast and complex datasets at high speeds to expand analytical capabilities.[131]

The application of AI will have numerous benefits for drug control, by strengthening efforts to cut off the drug supply and reduce addiction across America. By forecasting where and when illicit drug activities might occur through the analysis of historical data, AI will facilitate forecasting drug threats, allowing law enforcement to deploy resources strategically in high-risk areas. Through combining data from multiple sources, including crime reports, financial transactions, social media, and open-source intelligence, AI can assist with identifying patterns, visualizing networks of organized crime, and solving cases more quickly, thereby improving investigations. Artificial intelligence can inform overdose response and prevention efforts, by integrating data from state and federal-level datasets with geospatial data, allowing for the tailoring of prevention campaigns and the targeted distribution of overdose reversal medications, like naloxone. AI's use in natural language processing may be leveraged to identify new and emerging substances online in social media, which can be geographically confirmed by wastewater-based drug monitoring.

While AI will be a critical analytical tool to usher innovations for addressing the drug crisis, it does need to be complemented by, and can inform, other analytical approaches (Figure 3). Correlations provide insights into patterns and trends and are usually an initial first step in examining the landscape for drug control, but they do not provide strong evidence for policymaking. Longitudinal modeling can inform causality, addressing policy questions such as what is contributing to the decrease in drug overdoses, or why are some people more likely to develop substance use disorder than others. Predictive modeling, forecasting what is likely to happen in the future based on historical data, can be used to predict how new emerging drugs will spread geographically. Finally, prescriptive modeling, recommending optimal courses of action for illicit drug control by forecasting various interventions, can optimize interdiction efforts (e.g., analyzing illicit finance flows providing recommendations for disruptions), law enforcement strategies (e.g., identifying high-level dealers), prevention tactics (e.g., identifying high-risk individuals and geographic locations), and treatment plans (e.g., recommending personalized treatment).

Figure 3: Analytical Approaches to Develop Evidence for Drug Control Policymaking and Monitoring

Challenges to Developing Evidence to Support Policymaking

Key challenges to developing evidence to support policymaking include siloed data and their lack of interoperability, delays in data dissemination, and the disproportionate reliance on self-reports for drug consumption.

First and foremost, siloed data approaches have slowed our fight against illicit drug control by creating gaps and inconsistencies in critical information, which limits our understanding of drug production, trafficking and distribution, as well as of drug use and overdose patterns, and prevention and treatment needs. Importantly, limited data integration within the disciplines of public health and public safety, as well as across these disciplines, reduces the effectiveness of interventions to decrease drug supply and demand. ONDCP, in support of the Director and the National Drug Control Program Agencies, will work to champion the sharing and integration of more datasets for a more comprehensive picture of the drug landscape. The Overdose Response Strategy (ORS), which is an unprecedented and unique public health-public safety partnership between the Office of National Drug Control Policy (ONDCP),the U.S. Centers for Disease Control and Prevention (CDC),the High Intensity Drug Trafficking Areas (HIDTA) program, and the CDC Foundation, is an example of a cross-agency, interdisciplinary collaboration with a single mission of reducing overdose deaths and saving lives across the United States. ORS will continue to support breaking down siloes and support collaboration.

Data timeliness is critical for effective drug control policies, for monitoring emerging drug threats, and for designing effective public health and public safety interventions. Untimely data challenges our knowledge of the drug supply composition and trafficking networks. With significant data delays, federal, state, and tribal and territorial agencies may base their policies on outdated information, potentially reacting to a drug problem that may have already peaked or

shifted. Agencies have taken steps to address these lags, such as with the publication of provisional and predicted provisional overdose mortality; publicly-facing data dashboards like DOSE-SYS, which provides near real-time data on nonfatal overdoses and provides timely insights on trends (Centers for Disease Control and Prevention); and rapid drug testing to provide near real-time insights into the illicit drug landscape (National Institute of Standards and Technology).[132] ONDCP will work closely with the National Drug Control Program Agencies to lead further efforts to provide timely data on the drug landscape in our Nation, notably by prioritizing the establishment of new data systems to monitor drug consumption in real-time, through a national wastewater-based monitoring system and biosurveillance.

Finally, the reliance on self-reported measures for national estimates of drug use gives an incomplete picture of the types of drugs that Americans are consuming. Survey respondents may be reluctant to admit to potentially illegal behavior, or may not know what drugs they are consuming, given the high rates of drug adulteration.[133] This survey data needs to be complemented with more objective measures of drug use, such as wastewater testing and biologic specimen testing.

Steps for Implementation

The implementation of the data plan relies on the joint efforts of the Office of National Drug Control Policy (ONDCP) and the National Drug Control Program Agencies (NDCPAs). ONDCP will establish a Drug Data Interagency Working Group (IWG), which will include representatives from all NDCAs. This IWG will be the nexus for coordinating drug data-related activities and reporting on progress. Multiple sub-IWGs will be formed to address the following priorities that are aligned with the *Strategy*:

1) *Review and Update Compendium of Available Data Resources:* ONDCP has developed a compendium of existing data resources that includes key characteristics of these resources, such as the types of drugs covered, the drug indicator (e.g., seizures, drug use, overdose), the periodicity of data updates, the earliest data available, the data lags between data collection and publication, and the smallest units for temporal and geographic analyses. This document will be shared with NDCAs and updated regularly.

2) *Develop Approaches for Increasing Data Linkages and Interoperability*: Facilitate data sharing within and across NDCAs to provide stronger systems to detect emerging drug threats, identify drug trafficking routes, and inform prevention, treatment, and recovery needs.

3) *Expand Data Sources for Objective Measures of Drug Consumption*: Explore the utility of more objective measures of drug consumption to supplement insights provided by traditional national surveys. This includes wastewater testing, which identifies new and emerging illicit substances and metabolites at the community level. Testing of biological specimens (e.g., urine, blood) from people treated in emergency departments or entering treatment may also provide more accurate and detailed information on the type of substances consumed.

4) *Identify Opportunities for Public-Private and Foreign Partnerships to Address Federal Data Gaps*: Leverage private and foreign partner expertise and resources to complement federal data collection, management, and analysis, with the aim of improving efficiency and performance.

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Table 1 – Core Federal Data Systems to Inform the National Drug Control Strategy

Datas\et Name	Responsible Agency	Weblink	Short Description	Data Source	Geographic Coverage	Drug Indicator Classification
PUBLIC SAFETY						
Drug Seizures						
National Seizure System (NSS)	El Paso Intelligence Center (EPIC)/DEA/DOJ	https://www.dea.gov/what-we-do/law-enforcement/epic	A central repository for cataloguing federal drug seizure information	Laboratory Confirmed Data	National	Drug seizures
National Forensic Laboratory Information System (NFLIS)	Drug Enforcement Administration (DEA)/Department of Justice (DOJ)	https://www.nflis.deadiversion.usdoj.gov/	System collecting confirmed drug identification results and associated information from drug cases submitted to and analyzed by participating federal, state, and local forensic laboratories	Laboratory Confirmed Data	National	Drug seizures
Drug Seizure Statistics	U.S. Customs and Border Protection (CBP)	https://www.cbp.gov/newsroom/stats/drug-seizure-statistics	Includes CBP seizures of all drug types	Public Safety Administrative Data	National	Drug seizures
Consolidated Counterdrug Database (CCDB)	Department of War	Internal to DoW	Records all vetted and recorded drug trafficking events in the transit zone, primarily related to cocaine	Public Safety Administrative Data	Worldwide transit zone	Drug availability Drug seizures
Firearm Seizures and Recovery						
Firearms Trace Data	Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF)	https://www.atf.gov/resource-center/data-statistics	Captures data gathered when a firearm is recovered in connection with a crime	Public Safety Administrative Data	National	Firearms seized or recovered that could be related to illicit drugs

Datas\et Name	Responsible Agency	Weblink	Short Description	Data Source	Geographic Coverage	Drug Indicator Classification
Weapons and Ammunti-on Seizures	U.S. Customs and Border Protection (CBP)	https://www.cbp.gov/newsroom/stats/weapons-and-ammunition-seizures	Includes CBP seizures of all weapons, ammunition, and gun parts	Public Safety Administrative Data	National	Firearm Seizures
Sanctions & Asset Forfeitures						
Sanctions List Service (SLS)	Office of Foreign Assets Control (OFAC), Department of the Treasury	https://ofac.treasury.gov/sanctions-list-service	Depicts a comprehensive list of people and entities sanctioned by the U.S. Government	Provided by the U.S. Government	Global	Sanctions
Indictments, Convictions, Arrests, and Disruptions/ Dismantlement						
Performance Management Process (PMP) system	National HIDTA Program	https://hidtadirectors.org/summaries/	Collects performance data from 33 regional HIDTA programs	Public Safety Administrative Data	National	Disruption/ dismantlement of drug trafficking organizations; Drug seizures
Management Information System	Homeland Security Task Force (HSTF) National Coordination Center (NCC)	Internal to Federal Law Enforcement Agencies and USAOs	Case tracking and reporting system designed to provide a platform for investigative personnel to track and coordinate investigative efforts	Public Safety Administrative Data	National	Disruption/dismantlement of transnational organized crime

Datas\et Name	Responsible Agency	Weblink	Short Description	Data Source	Geographic Coverage	Drug Indicator Classification
PUBLIC HEALTH						
Drug Use						
National Survey on Drug Use and Health (NSDUH)	Substance Abuse and Mental Health Services Administration (SAMHSA)/ Department of Health and Human Services (HHS)	https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health	Nationally representative data on the use of tobacco, alcohol, and drugs; substance use disorders; mental health issues; and receipt of substance use and mental health treatment among the civilian, noninstitutionalized population aged 12 or older in the United States	Survey Findings	National	Drug/ substance use Substance use disorder Substance use disorder treatment
Monitoring the Future (MTF)	National Institute on Drug Abuse (NIDA)/National Institutes of Health (NIH)/HHS	https://nida.nih.gov/research-topics/trends-statistics/monitoring-future	A nationally representative survey measuring drug and alcohol use and related attitudes among adolescent students	Survey Findings	National	Drug/substance use
Drug Use						
Treatment Episode Data Set (TEDS)	SAMHSA/HHS	https://www.samhsa.gov/data/data-we-collect/teds-treatment-episode-data-set	Demographic and drug history data on treatment admissions and discharges	Public Health Administrative Data	National	Drug/ substance use Substance use disorder treatment/recovery

Datas\et Name	Responsible Agency	Weblink	Short Description	Data Source	Geographic Coverage	Drug Indicator Classification
Medicaid claims: Transformed Medicaid Statistical Information System (T-MSIS)	CMS/HHS	https://www.medicaid.gov/medicaid/data-systems/macbis/transformed-medicaid-statistical-information-system-t-msis	Information on enrollment and utilization of healthcare services as well as quality measures and other provider data for individuals in Medicaid	Public Health Administrative Data	National	Drug/ substance use Substance use disorder Substance use disorder treatment/ recovery Prescription drugs
Substance Use Disorder (SUD) Treatment						
Treatment Episode Data Set (TEDS)	SAMHSA/HHS	https://www.samhsa.gov/data/data-we-collect/teds-treatment-episode-data-set	Demographic and drug history data on treatment admissions and discharges	Public Health Administrative Data	National	Drug/ substance use Substance use disorder treatment/recovery
Medicaid claims: Transformed Medicaid Statistical Information System (T-MSIS)	CMS/HHS	https://www.medicaid.gov/medicaid/data-systems/macbis/transformed-medicaid-statistical-information-system-t-msis	Information on enrollment and utilization of healthcare services as well as quality measures and other provider data for individuals in Medicaid	Public Health Administrative Data	National	Drug/ substance use Substance use disorder Substance use disorder treatment/ recovery Prescription drugs

Datas\et Name	Responsible Agency	Weblink	Short Description	Data Source	Geographic Coverage	Drug Indicator Classification
Nonfatal Overdose						
National Emergency Medical Services Information System (NEMSIS) Drug Overdose Surveillance Dashboard	National Highway Traffic Safety Administration (NHTSA)/Department of Transportation	https://nemsis.org/drug-overdose-surveillance-dashboard/	Near real-time fatal and nonfatal overdose data and naloxone administration in the pre-hospital setting for patients treated by Emergency Medical Services	Public Health Administrative Data	National	Fatal overdoes, Nonfatal overdose, Opioid overdose reversal medications (e.g., naloxone)
Nonfatal Drug Overdose Surveillance and Epidemiology (DOSE) System	CDC/HHS	https://www.cdc.gov/overdose-prevention/data-research/facts-stats/about-dose-system.html	Emergency department (ED) and inpatient hospitalization syndromic (DOSE-SYS) discharge (DOSE_DIS) data, collected from forty-nine states and the District of Columbia (DC), about patients who sought care in EDs and were either discharged from the ED or admitted to the hospital	Public Health Administrative Data	Select states/ jurisdictions	Nonfatal overdose
Fatal Overdose						
National Vital Statistics System (NVSS)	National Center for Health Statistics (NCHS)/CDC/HHS	https://www.cdc.gov/nchs/nvss/index.htm	County, state, and national overdose death rates and counts recorded in this intergovernmental system of sharing data on vital events experienced by the population of the United States	Laboratory confirmed data Public Health Administrative Data	National	Fatal Overdose

Datas\et Name	Responsible Agency	Weblink	Short Description	Data Source	Geographic Coverage	Drug Indicator Classification
State Unintentional Drug Overdose Reporting System (SUDORS)	CDC/HHS	https://www.cdc.gov/overdose-prevention/data-research/facts-stats/sudors-dashboard-fatal-overdose-data.html	Data on drug overdose deaths that are unintentional or of undetermined intent, collected from death certificates, medical examiner or coroner reports, and postmortem toxicology results across forty-nine states and Washington, DC	Laboratory confirmed data Public Health Administrative Data	Select states/ jurisdictions	Fatal Overdose

Appendix D: 2026 Counternarcotic Border Strategies

Introduction

This Annex establishes the United States Government's comprehensive, unified whole-of-government approach to securing the Nation's Southwest, Northern, and Caribbean Borders against the trafficking of illicit drugs and the corrosive influence of Transnational Criminal Organizations (TCOs). It directly supports the 2026 *National Drug Control Strategy* ("the *Strategy"*) and the *National Interdiction Command and Control Plan* (NICCP) and is executed in accordance with the authorities vested in the President by the Constitution and the laws of the United States, including Title 21 of the U.S. Code. The overarching intent of these strategies is to dismantle the criminal organizations that threaten our homeland. This is achieved by securing the Nation's borders against their entry and preventing their subsequent distribution within our communities.

The three distinct strategies herein – addressing the unique challenges of the Southwest, Northern, and Caribbean Borders – are designed to be mutually reinforcing. The United States recognizes that TCOs are adaptive adversaries; success in hardening one border requires a commensurate strategy to prevent the displacement of threats to another. These strategies therefore represent an integrated, layered defense designed to dismantle the TCOs that threaten the United States' national security and public health, as well as the rule of law.

Central to the implementation of these strategies is the Homeland Security Task Force (HSTF). As mandated in Chapters 3 and 4 of the 2026 *Strategy*, the HSTFs coordinate all counter-TCO investigative and prosecutorial activities. This ensures that border interdictions are systematically linked to broader, intelligence-driven efforts to dismantle the entirety of these criminal enterprises, from their leadership and financial networks to their logistical and distribution cells. By leveraging the HSTFs as a force-multiplying effort, the United States will secure its communities against drug trafficking and its attendant violence, holding these criminal organizations accountable to the fullest extent of the law.

In addition to the HSTFs, our whole-of-government approach to border security requires action by the full range of federal stakeholders. The following tables delineates Departments' and Agencies' responsibilities to effectively execute the Counternarcotics Border Strategies. These National Drug Control Program Departments and Agencies were consulted in the formulation of the border control strategies, along with relevant State, local, and Tribal governments, and the governments of relevant countries.

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Department and Agency Responsibilities

Department/Agency	Southwest Border Counternarcotics Strategy	Northern Border Counternarcotics Strategy	Caribbean Border Counternarcotics Strategy
Deptartment of Homeland Security (DHS)	Overall Lead for Border Security and Interdiction; Co-Lead for Counter-TCO Investigations (via HSTFs).	Overall Lead for Border Security and Interdiction; Co-Lead for Counter-TCO Investigations (via HSTFs).	Lead for Maritime Law Enforcement Interdiction; Co-Lead for Counter-TCO Investigations (via HSTFs).
Customs & Border Protection (CBP)	Lead for Interdiction at and between Ports of Entry (POEs); Counter-tunnel operations. Personnel and equipment will be required to conduct surveillance, screen cargo and passengers, and affect interdictions.	Lead for Interdiction at and between POEs; Air and Marine surveillance. Personnel and equipment will be required to conduct surveillance, screen cargo and passengers, and affect interdictions.	Support for interdiction at POEs in Puerto Rico/USVI; Air and Marine surveillance. Personnel and equipment will be required to conduct surveillance, screen cargo and passengers, and affect interdictions.
U.S. Coast Guard (USCG)	Maritime interdiction lead in coastal approaches, including the Rio Grande River. Personnel and equipment will be required to conduct surveillance, screen vessels arriving at U.S. ports, and affect interdictions.	Maritime interdiction lead in Great Lakes and coastal approaches. Personnel and equipment will be required to conduct surveillance, screen vessels arriving at U.S. ports, and affect interdictions.	Lead for maritime law enforcement interdiction operations; works in concert with DoW. Personnel and equipment will be required to conduct surveillance, screen vessels arriving at U.S. ports, and affect interdictions.
Homeland Security Investigations (HSI)	Co-Lead for Counter-TCO Investigations (via HSTFs). Personnel and equipment will be required to conduct investigations.	Co-Lead for Counter-TCO Investigations (via HSTFs). Personnel and equipment will be required to conduct investigations.	Co-Lead for Counter-TCO Investigations (via HSTFs). Personnel and equipment will be required to conduct investigations.
Department of Justice (DOJ)	Co-Lead for Counter-TCO Investigations (via HSTFs), lead for prosecutions.	Co-Lead for Counter-TCO Investigations (via HSTFs), lead for prosecutions.	Co-Lead for Counter-TCO Investigations (via HSTFs), lead for prosecutions.
Federal Bureau of Investigations (FBI)	Co-lead for Counter-TCO Investigations (via HSTFs). Personnel and equipment will be required to conduct investigations.	Co-lead for Counter-TCO Investigations (via HSTFs). Personnel and equipment will be required to conduct investigations.	Co-lead for Counter-TCO Investigations (via HSTFs). Personnel and equipment will be required to conduct investigations.
Drug Enforcement Admin. (DEA)	Counter-TCO Investigations; Foreign operations coordination. Personnel and equipment will be required to conduct investigations and enforcement operations.	Counter-TCO Investigations; Foreign operations coordination. Personnel and equipment will be required to conduct investigations and enforcement operations.	Regional Counter-TCO investigations; Foreign operations coordination. Personnel and equipment will be required to conduct investigations and enforcement operations.
Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF)	Lead for weapons trafficking intelligence and operations. Personnel and equipment will be required to conduct investigations and enforcement operations.	Lead for weapons trafficking intelligence and operations. Personnel and equipment will be required to conduct investigations and enforcement operations.	Lead for weapons trafficking intelligence and operations. Personnel and equipment will be required to conduct investigations and enforcement operations.

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Department/Agency	Southwest Border Counternarcotics Strategy	Northern Border Counternarcotics Strategy	Caribbean Border Counternarcotics Strategy
U.S. Attorneys' Offices (USAO) and Criminal Division	Lead for prosecution of all federal counter-TOC cases originating from the border. Personnel will be required to effectuate prosecutions.	Lead for prosecution of all federal counter-TOC cases originating from the border. Personnel will be required to effectuate prosecutions.	Lead for prosecution of all federal counter-TOC cases in U.S. Territories. Personnel will be required to effectuate prosecutions.
Department of War (DoW)	Single lead agency of the Federal Government for the detection and monitoring (D&M) of aerial and maritime transit of illegal drugs into the United States. Under different authorities, DoW supports other USG partners on the southwest border to disrupt, deter, and degrade DTOs, TCOs, and FTOs. Dow supports DHS in securing the SWB. DoW is the lead for securing the National Defense Areas.	Lead for detection and monitoring of air/maritime transit of illegal drugs into the United States in support of law enforcement agencies. Provides defense support to civil authorities to secure the border against asymmetric threats and trafficking vectors. Personnel and equipment will be needed to conduct detection and monitoring operations.	Single lead agency of the Federal Government for the detection and monitoring (D&M) of aerial and maritime transit of illegal drugs into the United States. DoW supports other USG partners in the Caribbean to disrupt, deter, and degrade DTOs, TCOs, and FTOs.
Department of State	Lead for Foreign Policy and Diplomatic Engagement.	Lead for Foreign Policy and Diplomatic Engagement.	Lead for Foreign Policy and Diplomatic Engagement.
Bureau of Intl. Narcotics & Law Enforcement Affairs (INL)	Lead for diplomatic engagement and capacity building with Mexico in coordination with the Department of Justice. Personnel will be needed to conduct diplomatic operations.	Lead for diplomatic engagement and binational policy coordination with Canada. Personnel will be needed to conduct diplomatic operations.	Lead for regional capacity building through the Caribbean Basin Security Initiative (CBSI) in coordination with the Department of Justice. Personnel will be needed to conduct diplomatic operations.
Department of the Treasury	Lead for Countering Illicit Finance	Lead for Countering Illicit Finance	Lead for Countering Illicit Finance
Office of Terrorist Financing and Financial Crimes (TFFC)	Lead for foreign partner engagement on illicit finance issues. Personnel and equipment will be required to conduct investigations and enforcement operations.	Lead for foreign partner engagement on illicit finance issues. Personnel and equipment will be required to conduct investigations and enforcement operations.	Lead for foreign partner engagement on illicit finance issues. Personnel and equipment will be required to conduct investigations and enforcement operations.
Office of Foreign Assets Control (OFAC)	Lead for sanctions against TCOs/FTOs, leadership, and financial networks. Personnel and equipment will be required to conduct investigations and enforcement operations.	Lead for sanctions against TCOs/FTOs, leadership, and financial networks. Personnel and equipment will be required to conduct investigations and enforcement operations.	Lead for sanctions against TCOs/FTOs, leadership, and regional facilitators. Personnel and equipment will be required to conduct investigations and enforcement operations.

Department/Agency	Southwest Border Counternarcotics Strategy	Northern Border Counternarcotics Strategy	Caribbean Border Counternarcotics Strategy
Financial Crimes Enforcement Network (FinCEN)	Lead for analysis of financial intelligence; coordination with Mexico's FIU, "Special Measures," and information collection authorities under the BSA. Personnel and equipment will be required to conduct investigations and enforcement operations.	Lead for analysis of financial intelligence; coordination with Mexico's FIU, "Special Measures," and information collection authorities under the BSA. Personnel and equipment will be required to conduct investigations and enforcement operations.	Lead for analysis of financial intelligence; coordination with Mexico's FIU, "Special Measures," and information collection authorities under the BSA. Personnel and equipment will be required to conduct investigations and enforcement operations.
Intelligence Community (IC)	Lead for Intelligence Collection, Analysis, and Support.	Lead for Intelligence Collection, Analysis, and Support.	Lead for Intelligence Collection, Analysis, and Support.

The National Southwest Border Counternarcotics Strategy

1.0 Operating Environment and Threat Assessment

1.1 The Southwest Border as the Epicenter of the Synthetic Drug Threat

The nearly 2,000-mile land border with Mexico remains the principal corridor for the illicit drugs posing the gravest threat to American lives.[134] The 2025 National Drug Threat Assessment (NDTA) definitively identifies the mass production and trafficking of synthetic drugs, primarily fentanyl and methamphetamine, by Mexican cartels as the most significant drug-related threat to the United States. Plant-based drugs, primarily cocaine from South America, are at record-high levels and are now compounded with mass production and trafficking of synthetic drugs from Mexico, fundamentally altering the threat landscape and resulting in the most dangerous and deadly drug crisis the Nation has ever faced. The cartels capitalize on the relative ease of synthetic drug production, which is unconstrained by the geographic and environmental limitations of plant-based drugs, to generate immense revenues and flood American communities with these poisons. While overdose deaths have shown a hopeful decline of 25 percent in the 12-month period ending in October 2024, the total of 84,076 deaths underscores the gravity of the threat that persists.[135]

1.2 Primary Threat Actors: Designated FTOs

TCOs operating in Mexico that have been designated as FTOs are the dominant actors in this deadly trade.[136] They control vast, sophisticated global networks that manage every facet of the synthetic drug supply chain, from the procurement of precursor chemicals primarily from China and to a lesser extent India to clandestine production in Mexico and the subsequent smuggling and distribution within the United States. These organizations operate with a level of impunity in parts of Mexico that directly challenges the sovereignty of the state, employing extreme violence to control lucrative smuggling corridors into the United States.

In recognition of the terrorism and terrorist activity of these organizations, the Secretary of State has designated these and certain other TCOs as FTOs.[137,n] This designation is not merely symbolic; it is a strategic trigger that reframes the U.S. Government's approach from a traditional law enforcement problem to a national security threat. Where law enforcement operates under Title 18 and Title 21 of the U.S. Code, focused on investigation and prosecution, counter-terrorism operations can involve authorities under Title 10 (Armed Forces) and Title 50 (War and National Defense). This shift provides new and expanded authorities to attack the entirety of these networks, including their financial and logistical support systems, using all U.S. Government capabilities—including diplomatic, informational, military, and economic tools.

[n] A list of designated foreign terrorist organizations is available here: https://www.state.gov/foreign-terrorist-organizations.

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1.3 Key Trafficking Modalities

TCOs employ a diverse and adaptive range of smuggling methods to breach the Southwest Border. Intelligence and seizure data consistently show that the majority of illicit opioids, methamphetamine, and cocaine, particularly fentanyl, are smuggled through official Ports of Entry (POEs).[138] Traffickers conceal these drugs in hidden compartments within passenger vehicles or co-mingle them with legitimate goods in commercial cargo trucks.[139] This methodology is a direct consequence of fentanyl's extreme potency. A lethal dose is measured in micrograms, meaning a relatively small, well-concealed package can contain millions of lethal doses.[140] For a mercenary criminal enterprise focused on maximizing profit and minimizing risk, smuggling a high-value, low-volume product through a high-traffic POE presents a more efficient risk-reward calculation than attempting to move it across miles of monitored, open desert. This reality creates a formidable "needle in a haystack" challenge for U.S. Customs and Border Protection (CBP), where a single missed vehicle can have catastrophic consequences for American communities.

Between the POEs, TCOs continue to exploit remote and rugged terrain to smuggle both drugs and people. A persistent and highly sophisticated threat is the use of subterranean tunnels. Since 1990, law enforcement has discovered over 230 such tunnels, which allow for the clandestine movement of large quantities of high-value contraband, completely bypassing surface-level security infrastructure and personnel.[141] The continued discovery of these tunnels demonstrates the long-term, strategic investment TCOs are willing to make to guarantee their access to U.S. markets. Additionally, traffickers are increasingly using unmanned aerial vehicles, or drones, to smuggle drugs across the border and into the United States.[142]

2.0 Strategic Objectives and Integrated Lines of Effort

2.1 Objective 1: Dismantle TCO Command and Control and Logistical Networks

To defeat the TCO threat, the United States will move beyond a strategy of simple interdiction at the border and will systematically target and dismantle the criminal organizations themselves through a coordinated, whole-of-government campaign.

Line of Effort 1.1: Intelligence-Driven Law Enforcement Operations. Through Homeland Security Task Forces (HSTFs), the Department of Homeland Security (DHS), through Homeland Security Investigations (HSI), and the Department of Justice (DOJ), through the Federal Bureau of Investigations, will co-lead intelligence-driven investigations to identify, target, and dismantle the command-and-control structures, transportation cells, and distribution networks of designated FTOs. This requires deep and continuous integration with the Intelligence Community to fuse national-level intelligence with tactical law enforcement operations, enabling a predictive and proactive posture. The HSTF National Coordination Center will serve as a key all-threats operational support center, leveraging the expertise of its partner agencies to deliver actionable intelligence with a particular emphasis on the Southwest border. For TCOs designated as FTOs, the HSTF NCC will ensure this information is passed to the National Counterterrorism Center (NCTC) to be integrated with terrorism intelligence, supporting the full spectrum of the U.S. counterterrorism mission.

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Line of Effort 1.2: Coordinated Investigations and Prosecutions through HSTFs. All counter-TCO investigations originating from border interdictions will be coordinated through the relevant regional HSTF. This framework ensures that a drug seizure by CBP at a POE is not an operational endpoint, but the starting point for a comprehensive, multi-agency investigation led by HSI and DEA to target the entire criminal conspiracy. By mandating this coordination, the United States will connect interdictions to criminal enterprise investigations, targeting TCOs through prosecutions, financial targeting, and seizures. The HSTFs will leverage the proven High Intensity Drug Trafficking Area (HIDTA) model, combining the resources and expertise of federal, state, local, territorial, and tribal partners to conduct coordinated prosecutions.

Line of Effort 1.3: Targeting Drug Warehousing and Staging Operations. The HSTFs will prioritize the detection and dismantlement of drug warehousing and consolidation operations in U.S. border communities that facilitate cross-border smuggling. These staging points are critical logistical nodes for TCOs. Leveraging intelligence gained from border interdictions, human sources, and financial investigations, the HSTFs will coordinate multi-agency law enforcement operations to identify and neutralize these facilities, seize contraband, and arrest the TCO associates who manage them, thereby disrupting the supply chain before drugs can be distributed deeper into the United States.

Line of Effort 1.4: Disrupting Southbound Firearms Trafficking. In alignment with Chapter 4, this *Strategy* explicitly recognizes that disrupting the flow of U.S.-sourced firearms to TCOs in Mexico is a critical border control element. The HSTFs, with robust participation from DOJ's Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF), will lead investigations to dismantle illegal firearms smuggling networks. This effort is a core component of the whole-of-government approach to weakening TCOs.

2.2 Objective 2: Harden the Border Through an Integrated System of Technology, Infrastructure, and Personnel

The United States will deploy a layered security system that leverages advanced technology and physical infrastructure to deny TCOs the ability to operate freely at or between our ports of entry.

Line of Effort 2.1: Deploying Advanced Technology and Physical Barriers. The United States will employ a layered security approach. Between the Ports of Entry, this includes the strategic construction and maintenance of physical barriers, such as walls and fencing, in high-traffic illicit corridors. These barriers are designed to impede and channel cross-border flows, slowing down TCO smuggling operations and directing them into areas where they can be more readily detected and interdicted. This physical infrastructure will be fully integrated with an expanded network of surveillance towers, ground sensors, and Unmanned Aerial Systems (UAS) to achieve persistent domain awareness and cue a rapid law enforcement response. At the Ports of Entry, DHS, led by CBP, will accelerate the deployment of Non-Intrusive Inspection (NII) technology.

Line of Effort 2.2: Enhancing data fusion and intelligence driven targeting. To sharpen the focus of interdiction efforts, the United States will establish a robust data sharing and analysis framework among federal, state, local, territorial, and tribal partners, coordinated through the HSTF. This initiative will fuse traditional law enforcement intelligence on TCOs and drug movements with advanced analysis of commercial trade and shipping data. By leveraging

artificial intelligence and machine learning to analyze vast datasets, including commercial manifests and supply chain information, this effort will identify anomalies and patterns indicative of drug trafficking. The resulting high-fidelity intelligence will enable CBP to better target high-risk commercial shipments for inspection, significantly increasing the probability of interdiction at ports of entry.

Line of Effort 2.3: Department of War Detection and Monitoring Support. The Department of War (DoW) serves as the single lead agency of the federal government for the detection and monitoring of aerial and maritime transit of illegal drugs into the United States, which is carried out in support of the counter-drug activities of federal, state, local, and foreign law enforcement agencies. DoW detection and monitoring support to DHS is a critical component of the whole-of-government effort.

Line of Effort 2.4: Counter-Tunnel Operations. DHS will lead a multi-agency effort to execute a comprehensive counter-tunnel strategy. CBP Border Patrol, as the lead law enforcement agency for subterranean missions, will mature its National Subterranean Operations (NSO) and Tunnel Reachback Center (TRC) to provide expert analysis and on-demand support for counter-tunnel operations. DoW will share the results of its research, development, and testing of innovative detection technologies. All counter-tunnel operations will be coordinated via the HSTF to ensure any resulting investigations target the full scope of the TCO's operational and financial infrastructure. Criminals who use tunnels to smuggle illicit narcotics into the United States will be prosecuted to the fullest extent under the law–no additional sentencing measures are recommended at this time. All discovered tunnels will be rapidly and fully remediated to render them permanently unusable.

2.3 Objective 3: Employ All U.S. Government Capabilities

The TCO threat originates beyond our borders and requires the application of all U.S. Government capabilities – diplomatic, financial, and military – to defeat it, coordinated to support the central counter-TOC mission.

Line of Effort 3.1: Diplomatic Engagement and Capacity Building with Mexico. The Department of State, through the Bureau of International Narcotics and Law Enforcement Affairs (INL), in coordination with the Department of Justice and with support from DoW, will lead diplomatic and justice sector efforts to secure robust, sustained, and measurable cooperation from the Government of Mexico to target and dismantle TCOs and FTOs operating within its territory. This includes enhancing U.S.-Mexican coordination against transnational threats through capacity-building programs for Mexican law enforcement and justice sector officials, intelligence sharing, border security, and support for joint operations. This assistance will be conditioned on tangible results, including taking appropriate measures to arrest, prosecute, and extradite FTO leaders and to dismantle synthetic drug labs.[o]

Line of Effort 3.2: Attacking TCO Financial Infrastructure. The Department of the Treasury, through the Office of Foreign Assets Control (OFAC) and the Financial Crimes Enforcement

[o] The North American Drug Dialogue (NADD) is the primary mechanism for trilateral cooperation between the United States, Mexico, and Canada on counterdrug policies and laws. Through the NADD, Canada and Mexico can demonstrate their commitment to disrupting precursor chemical flows to North America, and reducing fentanyl flows to the United States.

Network (FinCEN), will aggressively leverage authorities under Executive Order 14059 and the terrorism designations by the State Department to sanction terrorist leaders, their financial facilitators, and their global procurement networks. This includes a specific focus on targeting the precursor chemical suppliers in the People's Republic of China and elsewhere that enable the production of fentanyl. Additionally, the Department of the Treasury, through the Financial Crimes Enforcement Network (FinCEN), will leverage its unique authorities to identify primary money laundering concerns and take one or more "special measures" to protect the U.S. financial system. Treasury will lead a whole-of-government effort to deprive these organizations of access to the U.S. financial system and to seize their illicit assets worldwide, breaking the financial backbone of these criminal enterprises. Concurrently, federal law enforcement will prioritize interagency investigations into Chinese Money Laundering Networks (CMLNs) to disrupt the informal value transfer systems that facilitate the bulk of cartel revenue repatriation.

The National Northern Border Counternarcotics Strategy

1.0 Operating Environment and Threat Assessment

1.1 The Unique Vulnerabilities of a Vast and Porous Border

The 5,525-mile border with Canada is the world's longest international land border. Its vast, often remote and heavily forested terrain, dotted with unique small communities, numerous shared waterways including the Great Lakes, and a high volume of legitimate trade and travel present immense and distinct challenges for law enforcement. The relative scarcity of law enforcement personnel and surveillance infrastructure compared to the Southwest Border creates significant vulnerabilities that TCOs and other criminal networks actively exploit.[143] Even the drastic changes in climate between summer and winter impact the volume of vehicle and pedestrian crossings through ports of entry. Smugglers may take advantage of narrow rivers to escape apprehension and use snowmobiles to transport contraband through remote areas and over frozen lakes and rivers in winter.

1.2 Primary Threat Actors

The threat along the Northern Border is multifaceted, involving a complex web of criminal organizations. This includes not only Mexican TCOs establishing an operational foothold in Canada, but also sophisticated Canada-based TCOs, Outlaw Motorcycle Gangs (OMGs), and other criminal syndicates.[144] A profoundly concerning development, noted in a recent Presidential Proclamation, is the growing presence of Mexican cartels operating fentanyl and nitazene synthesis labs within Canada.[145] This development represents a strategic shift by TCOs to shorten their supply chains, circumvent interdiction efforts along the Southwest Border, and establish a new production hub for synthetic drugs on our northern flank. This elevates the Northern Border from a secondary transit route to a primary source vector for the deadliest drugs threatening our Nation.

1.3 The Bi-Directional Threat

Unlike the primarily inbound flow of drugs on the Southwest Border, the Northern Border is characterized by significant bi-directional smuggling. Cocaine and firearms often flow north into Canada.[146] In the reverse direction, MDMA (ecstasy), and, increasingly, fentanyl and methamphetamine produced in Canadian labs flow south into the United States.[147] This two-way trade in contraband fuels the profitability and resilience of these criminal networks. A critical vulnerability in this environment is the exploitation of Tribal jurisdictions that straddle the international boundary.[148] TCOs deliberately leverage the complex jurisdictional seams between federal, state, local, territorial, and tribal law enforcement to facilitate their smuggling operations.

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2.0 Strategic Objectives and Integrated Lines of Effort

2.1 Objective 1: Enhance Binational Cooperation to Deny Sanctuary and Transit

The shared nature of the threat requires a seamless, binational security posture where there is no daylight between U.S. and Canadian law enforcement efforts.

Line of Effort 1.1: Deepening U.S.-Canada Law Enforcement and Intelligence Integration. The Departments of Justice and Homeland Security will deepen operational integration with Canadian counterparts, including the Royal Canadian Mounted Police (RCMP) and Canada Border Services Agency (CBSA), through frameworks such as the North American Drug Dialogue (NADD)[p] and the Canada-U.S. Joint Action Plan on Opioids. The priority focus will be on real-time, actionable intelligence sharing to jointly target TCOs operating on both sides of the border, with an emphasis on dismantling synthetic drug laboratories in Canada.

Line of Effort 1.2: Joint Operations Coordinated through HSTFs and Canadian Counterparts. Homeland Security Task Forces (HSTFs) in northern border states will establish formal protocols for collaboration and joint operations with Canadian-led law enforcement task forces. The HSTFs and their Canadian counterparts will deconflict and coordinate all significant cross-border investigations using these binational structures to ensure a unified effort to map and dismantle the full extent of TCO networks.

Line of Effort 1.3: Disrupting Northbound Firearms Trafficking. Acknowledging the border control principles outlined in Chapter 4, this S*trategy* will prioritize efforts to disrupt the northbound flow of illegal firearms from the United States into Canada, which arms the TCOs and OMGs operating there. The HSTFs, working with the ATF and Canadian partners, will lead coordinated investigations to dismantle the networks responsible for this trafficking, thereby reducing the violent capacity of criminal organizations that threaten both nations.

2.2 Objective 2: Improve Domain Awareness in Remote and Maritime Environments

The vast and remote nature of the Northern Border necessitates a technology-forward, multi-agency approach to achieve situational awareness and enable targeted interdiction.

Line of Effort 2.1: Bolstering Air and Marine Surveillance Capabilities. DHS, through and the U.S. Coast Guard (USCG) and Air and Marine Operations (AMO), will increase surveillance and interdiction patrols along the extensive maritime border, particularly in the Great Lakes, the St. Lawrence Seaway, and the coastal approaches of the Pacific Northwest and New England.

Line of Effort 2.2: Department of War Defense of Territorial Integrity. The Department of War (DoW) will execute its assigned mission to seal the borders of the United States and repel drug

[p] The North American Drug Dialogue (NADD) is the primary mechanism for trilateral cooperation between the United States, Mexico, and Canada on counterdrug policies and laws. Through the NADD, Canada and Mexico can demonstrate their commitment to disrupting precursor chemical flows to North America, and reducing fentanyl flows to the United States.

trafficking as a threat to national sovereignty integrating with HSTF partners to ensure comprehensive security across all land borders.

2.3 Objective 3: Secure Vulnerable Jurisdictions and Attack Financial Networks

A successful strategy must close vulnerabilities exploited by TCOs and attack the financial incentives that drive their operations through coordinated, interagency action.

Line of Effort 3.1: Strengthening Partnerships with Tribal Nations. The Departments of Justice, Homeland Security, and the Interior will lead a dedicated initiative to enhance the capacity of tribal law enforcement to prevent and investigate drug trafficking on their sovereign lands. This *Strategy* recognizes Tribal governments as essential partners and will include support for equipment and training and streamlining cross-deputization agreements to eliminate jurisdictional seams exploited by TCOs.

Line of Effort 3.2: Countering Cross-Border Illicit Finance. The Department of the Treasury will enhance its collaboration with the Financial Transactions and Reports Analysis Centre of Canada (FINTRAC) to identify and disrupt the bi-directional flow of illicit proceeds. All actionable financial intelligence will be provided to the HSTFs to ensure financial investigations are fully integrated with ongoing counternarcotics operations.

The National Caribbean Border Counternarcotics Strategy

1.0 Operating Environment and Threat Assessment

1.1 The Caribbean Corridor: A Strategic Maritime and Air Transshipment Zone

The Caribbean remains a critical transshipment zone for illicit drugs, primarily multi-ton loads of cocaine, originating in South America and destined for the United States and Europe.[149] The region's complex geography, comprising thousands of islands and vast maritime expanses, provides ample cover for TCOs to conceal their operations. U.S. territories, particularly Puerto Rico and the U.S. Virgin Islands (USVI), are prime targets for traffickers, serving as a staging point from which drugs can be more easily moved to the continental United States.[150]

1.2 Primary Threat Actors: South American TCOs and Designated Narco-Terrorist Networks

The primary threat emanates from powerful South American-based drug production and transportation networks. The recent designation of Venezuelan TCOs, such as Tren de Aragua, as FTOs reflects the dangerous convergence of transnational organized crime and terrorism. These groups leverage endemic corruption and lawlessness to facilitate their operations, posing a direct threat to U.S. national security and regional stability.[151]

1.3 The Maritime Threat

The operational environment in the Caribbean is overwhelmingly maritime. TCOs use high-speed “go-fast” boats, low-profile vessels, submersibles, and semi-submersibles to move multi-ton quantities of cocaine.[152] This threat has led to a fundamental shift in the U.S. Government's posture from a law enforcement-led mission to a security-focused campaign. When directed by the President, the Department of War actively contributes to denying narco-terrorist networks freedom of movement.

2.0 Strategic Objectives and Integrated Lines of Effort

2.1 Objective 1: Achieve Maritime and Air Dominance to Interdict Illicit Flows

The United States will deny TCOs the use of the Caribbean as a permissive transit zone by establishing and maintaining maritime and air domain dominance.

Line of Effort 1.1: Persistent, Layered Interdiction Operations. The Department of War (DoW) and DHS will conduct enhanced, persistent, and layered counterdrug operations throughout the Caribbean basin.

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Line of Effort 1.2: Applying Full Authorities Against Terrorist Organizations. When directed by the President, U.S. forces take decisive action, including the use of force, against vessels and certain organizations with which the President has determined the United States is in an ongoing non-international armed conflict. The objective of these operations is the physical destruction of the contraband and the conveyance, imposing direct and immediate costs on these organizations.

2.2 Objective 2: Strengthen Regional Partnerships and Partner Nation Capacity

Long-term security in the Caribbean depends on the capacity and willingness of our regional partners to combat TCOs within their own territories and maritime zones.

Line of Effort 2.1: Expanding the Caribbean Basin Security Initiative (CBSI). The Department of State, through INL, in coordination with the Department of Justice, will lead a revitalized CBSI to build the law enforcement and judicial capacity of Caribbean partner nations. By providing specialized training, equipment, and technical assistance, the United States will enhance the ability of partner nations to patrol their own maritime zones, target and dismantle TCOs and FTOs operating within their territories, disrupt U.S.-bound illicit drug flows, and combat the public corruption that enables these criminal and terrorist organizations, and for partner nations to cooperate with the United States on mutual legal assistance and extraditions.

Line of Effort 2.2: Enhancing Regional Intelligence Fusion. DoW will expand intelligence sharing and operational fusion with vetted partner nation security forces to improve regional maritime domain awareness and enable more effective, partner-led interdiction operations.

2.3 Objective 3: Secure U.S. Territories and Disrupt Regional Financial and Logistical Networks

The United States will defend its Caribbean border by hardening U.S. territories against TCO infiltration and attacking the financial and logistical infrastructure that sustains these criminal enterprises.

Line of Effort 3.1: Hardening Ports and Borders in Puerto Rico and the U.S. Virgin Islands. The Caribbean HSTF, which integrates federal and territorial law enforcement, will lead a surge effort to secure the borders of Puerto Rico and the USVI. This includes enhancing cargo and passenger screening at all air and sea ports of entry and conducting intelligence-led investigations targeting local distribution cells and their links to offshore TCOs.

Line of effort 3.2: Disrupting Outbound Firearms Trafficking. In accordance with the border control principles of Chapter 4, a key objective is to stop the illegal trafficking of firearms from the continental United States and its territories into the Caribbean. These weapons fuel instability and empower the same TCOs trafficking drugs toward the United States. The Caribbean HSTF, in partnership with the ATF, will coordinate operations to dismantle these firearms smuggling rings, thereby enhancing regional stability and degrading TCO capabilities.

Line of Effort 3.3: Targeting Regional Money Laundering and Illicit Finance. The Department of the Treasury will lead a dedicated effort to map and dismantle the financial networks that support TCO operations in the Caribbean. This includes working closely with Caribbean FIUs, using FinCEN "special measure" authorities, when appropriate, and OFAC sanctions authorities to isolate and block the assets subject to U.S. jurisdiction of TCOs, their leadership, and their

financial facilitators operating in the region, and protect the U.S. financial system from illicit finance threats in the region.

Appendix E: Classified Annex Summary

The 2026 *National Drug Control Strategy (*"the *Strategy"*) is a comprehensive, whole-of-government plan to save American lives and secure our Nation from the threat of illicit drugs. To support this public strategy, a detailed Classified *Strategy* Annex has been produced for Congress, the interagency, and U.S. national security enterprise. This annex lays out the government's strategic posture and describes the objectives and action items required from the national security community to ensure *the Strategy* is as effective as possible.

As detailed in Chapter 3, our *Strategy* is built upon a cycle where intelligence drives interdiction, and interdiction generates new intelligence and investigations. The Classified Annex outlines the strategic-level principles that guide this cycle, establishing the framework for how tactical information from interdictions and investigations is integrated within a national-level intelligence framework.

Building on this, the Classified Annex provides the strategic blueprint for applying all levers of national power to support the enterprise investigations described in Chapter 4. It outlines the strategic approach for mapping designated Foreign Terrorist Organizations and other Transnational Criminal Organizations (TCOs) to identify their critical vulnerabilities and describes the strategic outline for dismantling TCO networks threatening our homeland.

Further, the annex lays out the strategic requirements for the intelligence collection and analysis needed to support the Emerging Threats chapter. It describes the strategic approach to leveraging the entire national security enterprise to identify and analyze shifting global drug trends, monitor the evolving footprint of TCOs, and develop coordinated countermeasures to stay ahead of future threats before they can harm Americans.

This *Strategy* is a fully integrated component of our national security posture. The unclassified *Strategy* provides the direction and public commitment, while the Classified Annex provides the classified strategic roadmap for the intelligence, law enforcement communities, and other interagency partners charged with its execution. Access to the Classified *Strategy* Annex is limited to U.S. government personnel with the appropriate security clearances and a need-to-know, ensuring the protection of the methods and operations vital to our success.

Appendix F: National Treatment Plan

Introduction

The purpose of the National Treatment Plan is to provide comprehensive guidance for addressing the treatment gap for addiction care. However, it is important to understand the data, which itself has some gaps.

Mortality rates are commonly used to gauge the drug and addiction crisis, and our progress combatting it. The majority of overdose deaths occur among adults. However, a significant number of people who died from drugs did not have an addiction, they were poisoned. This includes 342 babies and toddlers aged four and under who died of fentanyl poisoning between 1999 and 2021, who obviously did not have an addiction.[153] Poisonings also include the many teenagers who thought they were taking a standard medication, such as Oxycontin or Xanax, and ended up consuming a lethal amount of fentanyl or nitazene from a counterfeit pharmaceutical.[154] Recently, kratom products with high 7-OH content have resulted in opioid deaths.[155] The percentage of people who died due to intentional versus accidental fentanyl use is not known, and should be a subject of ongoing research.[156]

According to the most recent National Survey on Drug Use and Health (NSDUH), in 2024, 48.4 million, or 16.8% of Americans age 12 and older had a past-year substance use disorder. This includes approximately 27.9 million who had an alcohol use disorder, and another 28.2 million who had a drug use disorder. The NSDUH classifies those who need substance use disorder treatment as those who had a substance use disorder in the past year, or if in the past year they had received treatment for it.[157]

The NSDUH's data for addiction differs from its data for those who need substance use treatment. People who are prescribed MOUD or may need substance use treatment is estimated to be 52.6 million people, or 18.2 percent of people aged 12 or older. The higher number reflects the addition of people who take medications for opioid use disorder.[158] Of those, the NSDUH reports that only 10.2 million, or 19.4 percent received treatment for an alcohol or drug use disorder.[q] NSDUH definition of treatment is limited to specialty care received in specific clinical settings: an inpatient or outpatient facility; via telehealth; in a prison, jail, or juvenile detention center; or through medications for alcohol or opioid use disorder received in any setting, including general medical settings such as primary care or hospitals. The NSDUH estimates that 80.6% of those with an addiction did not receive treatment in these specified settings, creating a significant gap.

This is truly concerning. However, such healthcare specialty treatment is not the only pathway from addiction to recovery. Many find recovery through participation in mutual support groups, such as Alcoholics Anonymous, Narcotics Anonymous, Marijuana Anonymous, or SMART Recovery. Others find recovery through peer support services or faith-based programs. The NSDUH found that during the same period, 6.1 million people participated in support groups, while 2.2 million received services from a peer specialist or recovery coach.[159] It is quite

[q] While the terms "substance use disorder" and addiction differ in some ways, we will use them as synonyms in this document.

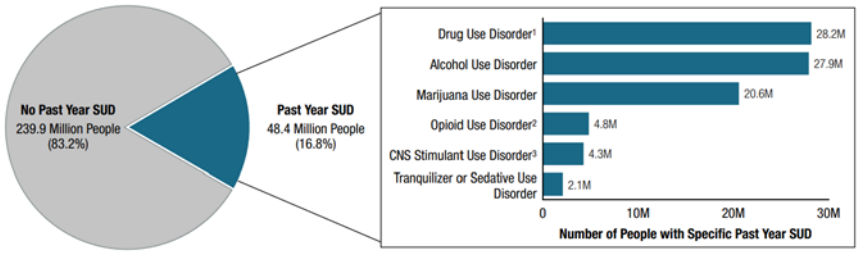
common for individuals to access a combination of mutual support and peer support with or without clinical services, and some are successful in stopping the use of drugs without external services and support, referred to as natural recovery. The various pathways to recovery help explain that a portion of the people represented by the 80.6 percent treatment gap may have received alternate interventions. The 23.5 million people living in recovery today are a testament to the fact that there are many pathways to recovery and many forms of addiction care and support.[160]

Addiction and mental health are closely linked, and nearly 50 percent of those with a substance use disorder have some form of mental illness.[161] Because of this, addiction treatment providers need to be equipped to effectively treat individuals with co-occurring substance use and mental health disorders. Furthermore, there should be focus on intervention of first episode of psychosis associated with drug use to prevent conversion from a single incident to a permanent mental illness. The combination of homelessness, mental health, and addiction represents a downstream and severe manifestation of addiction, and treatment must include a holistic approach to physical and mental health.

Efforts to close the treatment gap rest upon a few foundational principles. First, drug misuse is a dangerous and unhealthy behavior that can lead to addiction and, far too often, death. Beyond seeking to prevent drug use before it starts, we need to focus on intervening early, before a mild or moderate substance use disorder progresses to more severe addiction. Early intervention increases the odds of a positive outcome and can help avoid the more costly consequences of severe addiction in the long-term. Second, addiction is a chronic disease, and those who have the disorder deserve compassion and hope throughout their treatment journey, regardless of how long and difficult that process may be. And third, our goal must be that treatment for addiction to drugs should be easier to obtain than the drugs themselves.

Understanding the variety of reasons for unmet treatment needs is fundamental to addressing the problem and finding tangible solutions. The Trump Administration is committed to making quality, evidence-based treatment available to everyone who needs it. Central to that effort is identifying the reasons why those with a substance use disorder are not receiving treatment and addressing each of those barriers.

Figure 35. Past Year Substance Use Disorder (SUD): Among People Aged 12 or Older; 2024



CNS = central nervous system.

Note: The estimated numbers of people with SUDs are not mutually exclusive because people could have use disorders for more than one substance.

[1] Includes data from all past year users of marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, or prescription psychotherapeutic drugs (i.e., pain relievers, tranquilizers, stimulants, or sedatives). See footnote 2 for more information about opioid use disorder.

[2] Includes data from all past year users of heroin or prescription opioids. Respondents were not included if they used only nonopioid pain relievers and did not use heroin in the past year.

[3] Includes data from all past year users of cocaine, methamphetamine, or prescription stimulants.

Graphic Source: SAMHSA, (2025). 2024 National Survey on Drug Use and Health

There are effective medications to treat addiction to opioids, also known as opioid use disorder. Withdrawal from opioids carries significant negative symptoms that are usually avoidable with

prescribed medication. Every provider with a DEA license can prescribe buprenorphine that can stabilize the patient, address withdrawal, and ensure the patient is receiving evidence-based, life-saving treatment for opioid use disorder. While there is an educational gap in training providers how to effectively treat opioid use disorder, it can be addressed with nationally available provider consultation lines (see resources below).

Effective, evidence-based treatment for stimulant use disorder, particularly methamphetamine use disorder, remains a critical shortfall. In some states, overdose deaths involving methamphetamine have surpassed those associated with fentanyl.[162] While there are no FDA-approved medications for the treatment of methamphetamine use disorder, contingency management (CM) is a highly studied and proven psychosocial approach but remains greatly underutilized.[163]

In 2024, for the first time, the number of Americans with a drug use disorder surpassed the number with an alcohol use disorder.[164] This shift has been driven primarily by increased rates of addiction to marijuana.[165] In addition, the rate of marijuana smoking in the United States has surpassed tobacco use. Marijuana addiction, or cannabis use disorder, affected 20.6 million, or 7.1 percent, of Americans over the age of 12 in 2024,[a] and is the number one stated reason for addiction treatment for those under the age of 20.[a]

The varying legal status of marijuana across the United States notwithstanding, it remains a fact that there are Americans who are suffering from addiction and side effects of marijuana and its associated products such as psychoactive derivatives of hemp or other high-THC products, and they deserve help. People with marijuana addiction may not recognize that withdrawal may cause insomnia and anxiety[166], rather than the drug being an effective means to treat such symptoms. Cannabis-induced psychosis, if diagnosed and addressed early, may mitigate the potential impact on progression towards schizophrenia or other severe mental illness. Cannabis hyperemesis syndrome, also known as scromiting, due to the associated screaming and vomiting, is a common condition association with long-term marijuana use and addiction and warrants an evidence-based approach.[167] Much like stimulants and other drugs, there are currently no FDA-approved medications for marijuana addiction or withdrawal.[168] However, help is available for those who want it, and treatment and cessation tools for marijuana addiction must be made more widely available.

The Treatment Gap

Efforts to address the treatment gap can be approached in terms of the "5 A's": Awareness, Availability, Access, Affordability, and Attendance, as discussed below.

Awareness

Many individuals who need treatment simply do not fully understand the nature of their addiction or the importance of seeking treatment for it. Anosognosia, meaning the individual lacks awareness of their impairment, is a hallmark of addiction. Thus, an individual's family and friends often know the individual has an alcohol or other drug problem, but the individual may seem unaware of the issue. According to the latest NSDUH, 75 percent of adults aged 18 and older with past-year substance use disorder thought they could handle their drug or alcohol use on their own.[169]

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The other aspect of addiction that results in lack of awareness is the complex interplay between substance use, physical and psychological symptoms, making it difficult for the individual to differentiate between withdrawal symptoms and the reason given for drug use. A person may find that drugs help their anxiety, but do not realize that withdrawal from the drug is itself causing anxiety. Moreover, the physical symptoms of withdrawal can be severe and be a powerful deterrent to seeking treatment.

Early diagnosis of addiction is often not determined or screened for in healthcare, leading to lack of awareness among individuals or caregivers. Too often, substance use disorder is diagnosed in only severe cases and not detected in mild or moderate forms of the disease. Drug use screening, beginning in middle school and across the healthcare system, is a vital element to early identification and intervention.

A little more than a quarter of those needing treatment did not seek it because they believed that treatment would not help them.[170] Therefore it is important to raise greater awareness of the various pathways of care for addiction, the effectiveness of treatment, and advocate for their wider availability and use.

Additionally, many report not knowing how to begin the process of accessing treatment or are unaware of treatment services funded with a combination of state and federal resources for those without insurance.[171] The gap in awareness of accessing treatment should be the simplest to close.

The Administration will work across the federal government, and specifically with the Department of Health and Human Services (HHS), the Centers for Medicare & Medicaid Services (CMS), and with states, to ensure the expansion of education and screening services and will work across the federal government and with non-governmental partners to improve awareness and intervention for addiction. Screening, early detection, and intervention of addiction will be incentivized and promoted.

Availability

Issues of availability include ready access from crisis to care, the addiction workforce shortage, facility shortages, availability of quality care, and the length of treatment.

In many cases, those who acknowledge their need for treatment believe it is simply not available to them or don't know how to find it. Almost 30 percent of those who believe they need treatment, but are not receiving it, could not find a treatment program they wanted to attend, and more than 14 percent reported there were no openings with their preferred program or healthcare professional.[172]

The United States is facing a shortage of physicians and advanced practitioners specializing in addiction, licensed addiction counselors, and certified peer specialists. According to the Health Resources and Services Administration (HRSA), between 2025 and 2037, the number of addiction counselors is projected to shrink by 22 percent, from 118,700 to 92,160, while the demand for their services will increase 44 percent, from 143,540 to 206,090, an adequacy rate of 45 percent.[173]

In large hospital settings, addiction services must be as accessible as infectious disease and palliative care services. Chronic drug use often creates additional health problems for those who use drugs, some of which require lengthy hospitalizations involving multiple medical specialists.

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Unfortunately, the opportunity to treat the underlying illness of addiction that caused the health crisis is often missed in an effort to focus treatment on the physical consequences.

Detoxification and sobering or stabilization center beds are often not available to people in crisis, leaving them with no connection to services at their most vulnerable state. Services that provide a ready and consistent transition from stabilization to quality treatment should be available for all forms of addiction, regardless of primary drug use.

There are many modalities of treatment and many paths to recovery. Peer support services, faith-based programs, and participation in mutual support groups such as Narcotics Anonymous and Marijuana Anonymous have shown to be effective means of treatment for many individuals. The Trump Administration will work with federal partners to prioritize building the addiction medicine workforce, facilities for care, treatment and resources for addiction, and peer support. States will be encouraged to increase their treatment capacity.

Access

Access is a double-edged sword. On one side, access to drugs is unfortunately easy due to a movement to commercialize and normalize drug use. Children are exposed at a young age to marketing tactics for various drugs that are illegal at their age, including in the movies they watch, the games they play, and extensive advertisements on billboards and social media. There should be deterrence to accessing drugs, and incentives to accessing treatment. The law enforcement, criminal justice, juvenile justice, and child welfare sectors all play a central role in expanding access to treatment for those who need it.

On the other side is the lack of readily available treatment. Ideally treatment would be readily available across all stages of substance use: from intoxication to withdrawal, from crisis to improving health, and from mild disease to severe.

One reason cited for not seeking treatment is that the individual did not believe they had the time for it, a reason provided in more than 40 percent of people surveyed.[174] This is a concern, especially for those trying to maintain employment or living in rural or underserved areas.

As we learned during the COVID-19 pandemic, telehealth is an important tool to increase access to addiction treatment. Additionally, intensive outpatient programs provide access for those who do not require inpatient medical detoxification or 24-hour supervision. These programs are viable alternatives to inpatient and residential treatment, and have shown to be as effective as inpatient treatment for most individuals seeking care.[175] The Trump Administration will work to continue telemedicine flexibilities for addiction care, and treatment at all stages of addiction.

Affordability

Of all the reasons people with addiction are not receiving treatment, cost is the most prevalent.[176] Many who could afford to do so have spent thousands of dollars out of pocket for addiction treatment. But because addiction is a relapsing disease, it can take several sessions and attempts at treatment before arriving at long-term recovery.

Lack of insurance coverage and large out of pocket expenses are significant barriers to treatment. Bringing addiction care to the mainstream, and integrating addiction care with other types of medical care, is an essential element of making treatment affordable. The Mental Health Parity and Addiction Equity Act of 2008 generally requires that group health plans and health insurance

issuers offering group or individual health insurance coverage ensure that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements and limitations applicable to substantially all medical/surgical benefits. Unfortunately, parity laws are not uniformly applied across the country[177], and some insurance providers view substance use disorder treatment separate from other medical treatment.

Medicaid and Medicare are the largest source of funding for addiction services in the United States.[178] For those who are eligible, these programs cover screenings, services, and programs that aid in treatment and recovery for substance use disorders. Of the almost 73 million Medicaid and CHIP beneficiaries ages 12 and older with full or comprehensive benefits, approximately 6.5 million, or 8.9%, were treated for an SUD in 2022, the last year for which data is available.[179] For Original Medicare, for the 28.5 million beneficiaries in 2022, 12.1% were treated for tracked SUDs (2.0% were treated for alcohol use disorder, another 2.0% for opioid use disorder, and 8.1% were treated for tobacco use).[180] The Trump Administration will work to ensure these services remain available.

Attendance

Addiction is a chronic condition where relapse is common. Therefore, it is critically important that those who have entered treatment remain engaged in care and receive ongoing services and support.

Addiction is a disease of despair and solitude, and almost one in five people who need treatment are not getting it because they think no one would care if they got better.[181] Many of the reasons why individuals discontinue their treatment are the same as the ones that prevented them from seeking it in the first place. This includes fear of damage to their reputation, employment consequences, and child custody impacts.[182] By better integrating treatment and peer support, we can better support people on their journey to recovery. The Trump Administration will work to improve treatment retention.

Implementing the National Treatment Plan

The implementation of the National Treatment Plan is outlined in Chapter 6, *Bringing Help at All Stages of Addiction to the Mainstream*. The foundation of treatment efforts under this *Strategy* rest upon accurate and timely detection and early intervention; expanding treatment capacity, availability, and access; and protecting patients, to ensure they receive the quality treatment they need to address their substance use disorder. The Administration will do this by increasing screening for drug use and intervening early, before the development of chronic substance use disorder, and increasing access to quality treatment for those who need it. This will require sustained effort across the federal government, as well as working in partnership with state, local, tribal, and territorial partners. ONDCP will lead the effort among federal government departments and agencies in enhancing support for early intervention, education, and awareness, and prioritizing the availability of quality, evidence-based treatment across the country for those with substance use disorder.

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Conclusion

Addiction is a national health crisis, and increasing access to addiction treatment is a key priority for the Trump Administration. While the treatment gap has traditionally been identified as the percentage of Americans with a substance use disorder not receiving specialty treatment at a medical facility, the issue is more complex.

Sadly, drugs are a public health and public safety crisis, and mortality from fentanyl has been severe. However, not all those who died from fentanyl had an opioid use disorder. Some needed addiction treatment for different drugs, others were poisoned due to the ingestion of what they thought was a different drug, and babies and toddlers were killed due to exposure from products belonging to adults.

Treating addiction at the earliest stages will decrease the human and economic toll of addiction in America. Addressing the treatment gap requires understanding that there is no one-size-fits-all approach to addiction treatment, and a comprehensive approach requires the use of all available tools and the highest quality research.

Resources

For Medical Providers

- **America's Poison Centers** are a valuable resource for the public and medical providers. They often can offer consultation on addiction withdrawal, poisoning, and medication treatment. They can assist with opioid use disorder, benzodiazepine addiction, and other conditions.

- **The National Clinical Consultation Center (NCCC)** has a National Substance Use Warm Line available to providers for assistance in managing withdrawal and addiction in individual patients. The NCCC is well known for assisting providers in prescribing HIV exposure medications and has expanded their consultation to assist with addiction.

- **Providers Clinical Support System-Medications for Opioid Use Disorders (PCSS-MOUD)** provides multidisciplinary training, guidance, mentorship, and implementation support to healthcare and behavioral health professionals to identify and treat their patients using FDA-approved medications for opioid use disorder (MOUD). PCSS also offers training to meet the Drug Enforcement Administration's (DEA) one-time, eight-hour substance use disorder or opioid use disorder training requirement that applies to all DEA-registered practitioners.

- **Drug Enforcement Administration Toxicology Testing Program (DEA TOX)** is a program from the DEA, contracted with the University of California at San Francisco (UCSF) whereby biological samples generated from drug overdose victims can be further analyzed for identification of these synthetic drugs. Medical and law enforcement facilities are encouraged to contact the program for overdose or poisonings caused by unknown drugs if they have leftover biological samples (blood preferred). In many drug overdose cases, it can be difficult to identify novel synthetic drugs because routine forensic drug screens do not

typically target such substances. DEA TOX invites medical and law enforcement facilities to contact their program for cases of unidentified suspected synthetic drugs.

- **Pharmacy Bridge to provide Medications for Opioid Use Disorder** provides resources for States and regulatory agencies on methods for pharmacists to provide Medications for Opioid Use Disorder.

- **CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022** includes 12 recommendations for clinicians providing pain care for outpatients aged 18 years or older with acute pain, subacute pain, or chronic pain. Five guiding principles should broadly inform implementation across guideline recommendations to improve patient care and safety. Includes resources and trainings for clinicians.

- **Addiction Medicine Toolkit** provides an introductory overview of addiction medicine for clinicians and provide strategies that can be implemented in clinical practice.

- **Naloxone Toolkit** offers Naloxone training as a full module or as separate mini-modules and patient cases.

- **CDC Stimulant Guide** answers common questions about stimulants, stimulant use, stimulant overdose, and stimulant overdose prevention strategies.

- **Linking People with Opioid Use Disorder to Medication Treatment** assists healthcare professionals and community leaders in public health, education, criminal justice, social services, business, and government in the role they play in increasing access and linkage to Medications for Opioid Use Disorder (MOUD).

- **CDC Epi-Aid** assists public health authorities with understanding how emerging substances may impact public health and clinical response. These are rapid responses that are epidemiologic in nature used to investigate urgent public health problems and recommend rapid, practical decisions for actions to control and prevent public health problems.

For Individuals

- **SAMHSA's FindTreatment.gov** is a searchable directory of treatment resources by location, type, and specialty.

- **SAMHSA's Find Support** is a site that provides a wide range of resources and information regarding addiction or substance use disorder, mental health treatment, helping others, and paying for treatment.

- **The SAMHSA National Helpline** (1-800-662-4357) provides treatment referrals and information about mental health and drug or alcohol use disorders, prevention, and recovery.

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- **The 988 Suicide and Crisis Lifeline** (call or text 988 or access chat at 988lifeline.org) can help you or someone you know who is struggling or in crisis.

- **Mutual Support Programs** and support groups: for those with addiction include:
  - Alcoholics Anonymous
  - Narcotics Anonymous
  - Marijuana Anonymous
  - SMART Recovery
  - LifeRing Recovery
  - Women for Sobriety

- **Where To Find Naloxone**
  - Naloxone can be purchased in a pharmacy without a prescription in most areas.
  - Naloxone can be purchased online.
  - Free naloxone may be available at local distribution areas.
  - VA provides naloxone at no cost for certain high-risk Veterans.

For Families

- **SAMHSA's Helping Someone** includes information on how to talk to someone about getting help and how to take care of yourself.

- **CDC STOP Overdose Now: 5 Things to Know About Naloxone** provides information on revering opioid overdose to prevent death.

- **Mutual Support Programs for Families:**
  - Ala-Anon offers support and hope for families and friends of those with alcoholism. A lateen offers support for teens who have parents or family with addiction.

  - Nar-Anon is a 12-step program for family and friends of someone with addiction

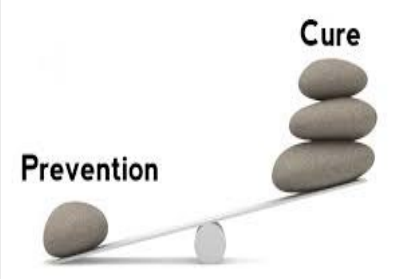
  - Mar-Anon offers support and hope for those affect by another's marijuana use

Appendix G: The National Prevention Framework

Overview

Preventing substance use is the foundation for achieving long-term national health and well-being. Effective prevention safeguards brain development, strengthens communities, and reduces the social and economic burdens associated with addiction. This framework offers a conceptual direction for a prevention effort that is science-driven, community-led, and rooted in public health principles. It highlights what should be done collectively to make prevention a visible, integrated, and sustained national priority.

"An ounce of prevention is worth a pound of cure"
Benjamin Franklin, 1735



The Story of the River - *A well-known public health parable illustrates the National Drug Control Strategy's approach to the drug crisis.*

A well-known public health parable illustrates our approach to the drug crisis. Villagers living by a river were alarmed when children began floating downstream, struggling. They organized rescue teams, pulling victims from the water, but soon became overwhelmed as more people were swept away. Finally, one villager declared, "Instead of only pulling people out, I'm going upstream to see why they are falling in!" This simple story holds a profound truth: while rescue is vital, prevention is paramount.

The *National Drug Control Strategy's* public health approach follows this very continuum and embraces the wisdom of the river story, balancing robust prevention with compassionate care and celebrating the promise of recovery. Upstream efforts described in this Prevention Framework are aimed to prevent drug use before it starts, employing evidence-based strategies to encourage the norm of living drug-free. For those who fall into the river and need treatment, early Intervention midstream should be made before addiction sets in. Under this metaphor, recovery support services will help people avoid falling back in the river.

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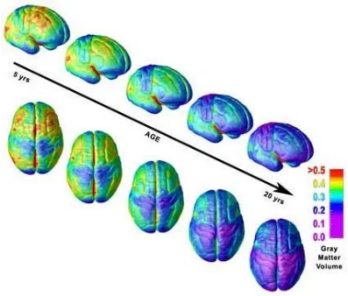
Key Points

A) Brain Health and Development

Although adulthood is legally defined as beginning at 18 or 21, brain maturation continues well into the mid-twenties.[183] Therefore, prevention efforts should focus on protecting individuals from prenatal stages through age 25. This approach aligns with existing guidance, for example encouraging pregnant women to avoid alcohol and drug use to protect their growing fetus.[184] Just as prevention begins before birth, it should continue throughout childhood, adolescence, and young adulthood, using developmentally appropriate strategies to support healthy brain growth.



The frontal lobe of the brain to the last to obtain myelin or white matter coating, displayed as purple in the diagram. (Neuroanthropology, n.d.) Source: Telegram & Gazette

During the mid-twenties, the brain completes critical developmental processes such as myelination, the formation of a protective coating around brain cells that supports executive decisions, and synaptic pruning, through which the brain strengthens essential neuronal pathways and eliminates others.[185] Exposure to addictive substances like alcohol, nicotine, or marijuana during this formative period can interfere with these processes.[186] When drugs are introduced, the brain may reinforce neural pathways associated with substance use at the expense of those supporting healthy behaviors, significantly increasing the risk of addiction.[187] Research shows that addiction is up to seven times more likely when substance use begins while the brain is developing.[188]

Drugs also disrupt the brain's regulation of dopamine[189], a neurotransmitter essential for motivation, pleasure, and survival. Large surges of dopamine caused by drug use train the brain to seek drugs at the expense of other, healthier goals and activities. Over time, as drugs stimulate dopamine production, the brain reduces its natural dopamine output, leading to dependence. Over time, individuals need increasing amount of the substance just to feel normal, creating a destructive cycle that fuels addiction.

Although substance use disorder is often viewed as an adult problem, it is fundamentally a pediatric-onset disorder. Data show that nine out of ten adults with a substance use disorder began using alcohol, nicotine, marijuana, or other drugs before the age of 18.[190] While genetic and environmental factors can increase the susceptibility to addiction, there is no innate biological necessity to use drugs, unlike basic needs such as hunger or thirst. The belief that experimentation with drugs is inevitable is a misconception. In addition, when "hijacked" by drugs, the brain can begin to act as though drug use is as or more important than eating, drinking, sleeping or avoiding danger and the risk of harm to oneself. Preventing early exposure to addictive substances is one of the most effective and cost-efficient strategies to safeguard the Nation's health. Preventing initial exposure during adolescence significantly reduces addiction rates and associated social costs.[191,192]

B) Promoting the Social Norm of Health

Most Americans do not use drugs. In 2024, 214.6 million people (74.5%) aged 12 or older did not use any illicit drug in the past year.[193] The majority of youth also do not use drugs, a reality that underscores that non-use is the norm. Strengthening the message that being drug-free is the norm and is healthy, reinforces positive social standards and helps reshape public perceptions

around substance use. Like seatbelt use or helmet safety, this standard reflects a health norm that protects general well-being, even when not everyone complies. Social norm campaigns can help shift public expectations toward substance-free living, using data that demonstrate how most young people already choose not to use.

There is a bidirectional relationship between substance use and mental health problems where one often makes the other worse. This is one of the reasons why non-use can be framed as part of self-care for young people.[194] According to Monitoring the Future (MTF) Survey, abstention[r] levels in 2024 were the highest recorded by the survey since it first started tracking this outcome in 2017. The percentage of students who abstained from drug use in 2024 was 67% in 12th grade, 80% in 10th grade, and 90% in 8th grade.[195] Highlighting these trends using local data can make non-use contagious, a positive behavior reinforced by peers and culture.

C) Education and Parent Engagement

Prevention starts at home. Parents and caregivers remain the single strongest influence on a young person's decision to use drugs or alcohol or not. More than 80% of youth ages 10–18 cite their parents as the leading factor in their decision-making.[196] Empowering parents with accurate information and effective tools is central to this plan. The gold standard is for parents and caregivers to advise their children against trying drugs. No one wants their loved one to endanger their health or risk addiction, and the very best defense is for parents to educate themselves on the current drug environment and talk to their children about the dangers of drug use.

National initiatives such as the Substance Abuse and Mental Health Services Administration (SAMHSA) *Talk. They Hear You.*[197] campaign and The National Institute on Alcohol Abuse and Alcoholism (NIAAA) *Parenting to Prevent Childhood Alcohol Use*[198] provide effective frameworks for family-based prevention. Encouraging parents to start conversations early, set clear expectations, and model healthy coping skills strengthens resilience in children.

CDC developed the *Free Mind* campaign to help prevent and reduce drug use and overdose among youth. The campaign was created through research and real conversations with youth, parents, and caregivers. Through these conversations, CDC identified a need to address the connection between substance use and mental health among youth ages 12-17.

D) Recognizing the Risks

Commercialization

The commercial marketing of addictive substances poses a major threat to youth health. Legal does not mean safe, and industries selling nicotine, alcohol, marijuana, and psychedelics have adopted strategies similar to Big Tobacco's historical targeting

[r] Abstention is defined as no-past 30 day use of alcohol, marijuana, or nicotine by vaping or by cigarettes.

of young audiences. Helping young people think critically about who benefits from the sales and use of substances is a powerful tool in prevention, and in implementing effective policies to reduce the adverse effects of these substances.

The commercialization of marijuana plays a role in the normalization of use, increases access to it, and decreases perception of risk of harm among youth.[199] Marijuana products are today of unprecedented high potency, are often highly processed, aggressively advertised, and often packaged to appeal to minors.

Educating youth, parents, and communities to recognize these commercial and digital marketing tactics, and their potential health consequences, is critical to building resilience and promoting informed decision-making. By fostering media literacy and awareness, prevention efforts can help inoculate youth and adults against manipulative marketing and reduce the likelihood of substance use and addiction.

Informed Decision-Making – the FDA-Approved Labeling

Informed decision-making among youth and adults is essential for preventing harm from drug use. Prescribing information and associated patient labeling for Food and Drug Administration (FDA)-approved drug products provide a summary of the essential scientific information needed for the safe and effective use of a given product, including its indications, dosage and administration, contraindications, warnings and precautions, adverse reactions, drug interactions, information about use in specific populations, and other important information.[200] For example, the FDA-approved labeling of Marinol (dronabinol), in which the active ingredient is synthetic delta-9 tetrahydrocannabinol (delta-9 THC), the main psychoactive component in marijuana, may help to illustrate some of the medical risks associated with cannabinoids. The label warns of neuropsychiatric adverse reactions, cardiovascular instability, seizures, substance use disorder, and paradoxical symptoms such as nausea and vomiting.[201] Reviewing these official warnings may help individuals better understand the potential dangers of medical or non-medical marijuana use. The prescribing information and patient labeling for Epidiolex (cannabidiol or CBD) may similarly help to inform users of non-prescription CBD products.

Drug-Drug Interactions

People who take prescription medications should consider checking to ensure that any dietary supplement or cannabis-related product does not interact with their medications, making them more potent or ineffective. There are hundreds of medications that interact with marijuana and CBD, including medications used to treat psychiatric or cardiac conditions.[202] Pharmacists serve as a primary and most reliable point of contact for identifying and explaining drug interactions, with additional support from trusted online resources. Tools such as the Drugs.com, Drug Interaction Checker can help users identify potential interactions between cannabis-related products and prescription drugs, reinforcing the importance of using medical guidance and making informed choices.

Mental Health

Youth marijuana use, particularly of high-potency products, has been linked to increased risks of psychosis and serious mental illness such as schizophrenia.[203] In a study of 11,363 records, marijuana use was associated with an 11-fold risk of psychosis for individuals aged 12 to 19.[204] Psychosis is a symptom of disturbances of thinking, perception and emotions. With continued drug use after a first episode of psychosis, the temporary symptom can result in long-term mental

health challenges such as schizophrenia. While all drugs carry some level of risk, marijuana has the highest conversion rate from psychosis to schizophrenia and bipolar disorder.[205] Drug use is also associated with suicide, and the number one drug found in toxicology reports of people who died from suicide under the age of 25 in Colorado and San Diego was marijuana, more than alcohol or any other drug.[206,207]

Physical Health

It is important to make consumers aware of the health risks associated with marijuana use, which include harms to heart health, cognition, and cancer. In one California study, from 2005 to 2019, cannabis-associated diagnosis in emergency department visits went up 1,800% for seniors over age 65.[208] Marijuana use can be associated with exposure to heavy metals and pesticides that can accumulate in the plant through a process known as bioaccumulation.[209] Further, research indicates that marijuana can contain fungal pathogens that cause serious and often fatal infections in persons with immunocompromising conditions, such as cancer, transplant, or infection with HIV.[210]

Psychoactive Derivatives of Hemp Products

Psychoactive derivatives of hemp are a growing concern. Although the hemp plant naturally contains small amounts of cannabinoids such as delta-8 THC, delta-10 THC, THC-O-acetate, THCP, and other THC analogues, they are often produced in laboratories; and since the passage of the 2018 Farm Bill, products containing them have proliferated.[211] Any final hemp-derived cannabinoid product containing these chemicals will be considered a Schedule I controlled substance under the Hemp Restriction regulations that are scheduled to take effect in November 2026.[212] These products are often sold in smoke shops and gas stations, are not regulated, and can contain dangerous chemicals or psychoactive substances. When found in marketed products, these compounds are synthetic, not naturally occurring, have not been evaluated for safety in animals or humans[213], and have been linked to cases of psychosis and suicide attempts.[214,215,216] In many cases, cannabinoids are considered to be Schedule I drugs under the international conventions, and some states have already banned these potentially dangerous products.

Vape Products

E-cigarettes or vape products often deliver high doses of nicotine that strengthen addiction pathways in the developing brain.[217] No tobacco products, including e-cigarettes, are safe, especially for children, teens, and young adults.[218] Vapes can be adulterated and contain products besides nicotine such as highly potent THC oils and other unhealthy chemicals. There have recently been large seizures of vapes manufactured in the People's Republic of China containing dangerous and unregulated products. Products bought in smoke shops and gas stations are often unregulated, and it is often not clear to consumers what is contained in the products they purchase.

Kratom and Mushrooms

The same smoke shops that sell vapes and THC oils can also sell products derived from kratom, which may contain 7-OH. While kratom is a plant, the products sold can be supplemented with synthetic 7-OH, a potent opioid naturally found in kratom, but in a small percentage. In July 2025, HHS recommended classifying 7-OH as a Schedule I substance, indicating it has no legitimate medical usage.[219]

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Available online and in shops, "magic mushrooms" may contain psychoactive chemicals from *Amanita muscaria* or other unregulated products of unknown origin. These psychedelic "shroom" products are increasingly being sold in colorful, professional packaging with misleading labels suggesting high quality testing and consumer safety. In 2024, the San Diego Sheriff's Department purchased and analyzed 113 such products and found that many contained substances not listed on the label, including delta-8 THC, THC-P, psilocybin, and synthetic cathinones sometimes referred to as "bath salts."[220]

Online Pharmacies

The online sale of unregulated drugs further compounds the problem. Of the approximately 35,000 active online pharmacies, only about 5 percent comply with U.S. pharmacy laws and standards.[221] A federal grand jury investigation in the Southern District of New York uncovered a network of illicit pharmacies shipping to all 50 states and internationally, and linked to at least nine deaths.[222] The FDA's BeSafeRx initiative provides consumers with tools and information to safely purchase prescription medicines online.

Dietary Supplements, Vitamins and Health Products

FDA regulations for dietary supplements are not the same as the regulations for drugs, as dietary supplements do not require preapproval before going to market. Quality of marketed supplements may vary considerably and the ingredients on the product label do not always correspond to what is found when the product is tested. In addition, some products marketed as dietary supplements have been shown to contain unsafe ingredients and unsafe levels of contaminants, including heavy metals such as lead.

The United States Pharmacopeia[s] (USP) Dietary Supplement Verification Program[t] is universally recognized as the trusted standard for dietary supplement quality. The program is voluntary and is available to lawfully marketed dietary supplements. Only dietary supplements that meet USP's rigorous testing, review, and auditing criteria are permitted use of the USP Verified Mark. This Mark signals to consumers that USP, an independent, scientific nonprofit organization, has verified the dietary supplement's quality and consistency, thus enhancing trust and protecting public health.[223]

E) Mental Health and Resilience

Substance use and mental health are deeply interconnected. Stress, anxiety, and depression can increase vulnerability to substance use, while substance use exacerbates a range of mental health challenges. Promoting healthy coping skills such as adequate sleep, nutrition, problem-solving skills, movement, and mindfulness provides young people with alternatives to substance use.

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[s] United States Pharmacopeia (USP) is an independent scientific nonprofit organization that publishes standards, including standards for dietary supplements in the United States Pharmacopeia – National Formulary (*USP–NF*). *USP–NF* is an official compendium in the United States (see 21 U.S.C 321).

[t] USP's Dietary Supplement Verification Program is an independent, rigorous, and comprehensive testing and evaluation program that helps ensure dietary supplement quality. https://www.quality-supplements.org/

It is normal to feel stress, be anxious or nervous, or sad on occasion. These are normal emotions. It is not normal or healthy to reach to drugs as an answer to these emotions. Learning healthy coping skills for natural emotions are important for promoting health and drug prevention.

F) Exit Plan, Early Intervention, and Peer Leadership

Every youth and young adult should have a clear established 'exit plan' with a trusted parent, guardian or friend to leave any risky situation or environment. The plan can be a coded text or communication that, when received, offers a quick ride home or exit with no questions asked. While it is best to avoid risky situations, recognizing a problem early and knowing how to leave is an important life skill.

Intervening early, before a substance use disorder develops, yields the very best outcomes in the long-term. Parents and caregivers should be made aware of youth alcohol, vaping, nicotine, or marijuana use at first use, and expressing concern and education can prevent further problematic use. Quick, compassionate intervention can prevent experimentation from turning into addiction.

Early identification and intervention are among the most effective strategies for preventing youth substance use from progressing to more serious problems.[224] Evidence-based approaches such as Screening, Brief Intervention, and Referral to Treatment (SBIRT) have been successfully implemented in school and community settings and have been shown to reduce adolescent substance use.[225] Research demonstrates that students who received SBIRT reported significant reductions in drug use and fewer episodes of heavy drinking over a six-month period. Universal school-wide implementation is also feasible: studies of ninth- and tenth-grade students show that SBIRT can increase youth intentions to delay or reduce substance use, even among those who have not yet begun using.[226] Together, these findings underscore the importance of training educators, counselors, and other youth-serving adults to recognize early signs of substance use and respond appropriately.

Peers also play a meaningful role in prevention. Young people are often most influenced by messages delivered through trusted relationships.[227,228] Youth also report positive experiences with brief interventions delivered by trained adults in schools, including an increased sense of connection to supportive adults, which is a known protective factor.[229] This evidence shows that peer-inclusive, relationship-centered approaches are effective in reinforcing healthy norms and empowering youth to support one another in avoiding substance use.

G) Protecting Children from Accidental Exposure

A growing public health concern is the rise in pediatric marijuana poisonings from edibles, many of which resemble candy.[230] The National Poison Data System reported a 1,375% increase exposure in children under 6-years old from 2017 to 2021. Of those, 22.7% were admitted to the hospital, some requiring intensive care treatment.[231] Toddlers naturally explore by putting objects in their mouths, making colorful or sweet-flavored products particularly dangerous. These incidents can result in severe respiratory, cardiac, and neurological effects, sometimes requiring intensive care.[232]

Regardless of a state's laws regarding marijuana and cannabis derivatives, including psychoactive hemp products, children and toddlers must be protected. Solutions include locking up all such products like locking up other poisons or weapons. In addition, when around children, it is recommended to use child-resistant packaging and avoid products that look like

food or candy. Additional protections can include restricting marketing and packaging that is attractive to children, as well as further regulating high-potency products. Federal and state governments can replicate tobacco-control policies that successfully reduced youth exposure in addressing this problem as well.

H) Drugged Driving

Drunk and drugged driving remains a national safety concern, including the additive effects of alcohol combined with marijuana or other drugs. Simulation studies of people smoking marijuana have shown that drivers are impaired up to 3.5 hours after smoking marijuana, even when the drivers do not have the perception that they are impaired.[233] Edible marijuana products have a longer impairment period of 8 hours or more.[234] Similar to alcohol, people who are impaired should not be driving, and passengers should not get into a car of an impaired driver. Prevention efforts should focus on shaping attitudes before driving begins, emphasizing that impairment, regardless of the substance, has serious and potentially deadly consequences. Collaboration among prevention, transportation, and law enforcement sectors should ensure that safe driving remains a core national prevention message.

Resources:

ADAPT | High Intensity Drug Trafficking Areas (HIDTA) Program	**ADAPT operationalizes the *HIDTA Prevention Strategy*, uniting HIDTA prevention programming across the nation. ADAPT assists HIDTAs with translating, implementing, and evaluating substance use prevention strategies within their unique communities.**	• **https://www.hidta.org/adapt/about/** • **https://www.hidta.org/wp-content/uploads/2023/11/V2-FINAL-Prevention-Communications-Toolkit_r.pdf**
Blueprints for Health and Youth Development	**The Blueprints for Healthy Youth Development mission is to provide a comprehensive registry of scientifically proven and scalable interventions that prevent or reduce the likelihood of antisocial behavior and promote a healthy course of youth development.**	• **https://www.blueprintsprograms.org/**
Center for Substance Abuse Prevention (CSAP)	**SAMHSA's Center for Substance Abuse Prevention (CSAP) aims to develop comprehensive systems through providing national leadership in the development of policies, programs, and services to prevent the onset of substance misuse.**	• **https://www.samhsa.gov/substance-use/prevention/substance-use-disorders** • **https://www.samhsa.gov/about/offices-centers/csap**

Drug-Free Communities (DFC) Support Program | ONDCP	**The Drug-Free Communities (DFC) Support Program is the nation's leading effort to mobilize communities to prevent youth substance use. A federal grant program for community-based coalitions.**	• **https://www.whitehouse.gov/ondcp/information-resources/** • **https://www.cdc.gov/overdose-prevention/php/drug-free-communities/coalitions.html**
DOSE-DIS Dashboard	**Captures both emergency department (ED) and inpatient hospitalization discharge data.**	• **https://www.cdc.gov/overdose-prevention/data-research/facts-stats/dose-dashboard-nonfatal-discharge-data.html**
DOSE-SYS Dashboard	**Emergency Department (ED) visits for suspected nonfatal drug overdose are reported to DOSE-SYS using electronic health record text queries from syndromic surveillance systems.**	• **https://www.cdc.gov/overdose-prevention/data-research/facts-stats/dose-dashboard-nonfatal-surveillance-data.html**
ENGAGE: Evidence-Based Strategies to Prevent Youth Substance Use	**ENGAGE contains effective strategies and approaches to help local, community, state, and other organizations plan for and implement a wide range of prevention activities.**	• **https://www.cdc.gov/overdose-prevention/php/interventions/youth-substance-use-prevention.html**
Free Mind Campaign	**This campaign targets youth aged 12-17 and their parents or caregivers. It aims to raise awareness about the critical link between mental health and substance use, particularly in the context of overdose.**	• **https://www.cdc.gov/free-mind/index.html**
Growing Up Drug Free: A Parent's Guide to Substance Use Prevention	**A Parent's Guide to Substance Use Prevention**	• **https://www.getsmartaboutdrugs.gov/publication/growing-drug-free-parents-guide-substance-use-prevention**
NIDA Prevention Information and Resources	**NIDA information and resources to help prevent substance use and misuse.**	• **https://nida.nih.gov/research-topics/prevention#evidence-based-prevention-strategies**
Overdose Response Strategy (ORS)	**A public health-public safety partnership between ONDCP, HIDTA, and the CDC Foundation. ORS is a cross-agency, interdisciplinary collaboration with a single mission of reducing overdose deaths and saving lives across the United States.**	• **https://orsprogram.org/**

Preventing and Reducing Youth and Young Adult Substance Misuse: Schools, Students, Families	**Resources for how schools can help prevent substance use and create supportive learning environments**	• **https://www.ed.gov/teaching-and-administration/safe-learning-environments/school-safety-and-security/preventing-and-reducing-youth-and-young-adult-substance-misuse-schools-students-families**
Strategic Prevention Framework (SPF)	**The five steps and two guiding principles of the SPF offer prevention practitioners a comprehensive approach to understanding and addressing the substance misuse and related behavioral health problems facing their communities**	• **https://www.samhsa.gov/technical-assistance/sptac/framework**
SUDORS Dashboard	**SUDORS collects data on unintentional and undetermined intent drug overdose deaths from death certificates, medical examiner or coroner reports, and postmortem toxicology results.**	• **https://www.cdc.gov/overdose-prevention/data-research/facts-stats/sudors-dashboard-fatal-overdose-data.html**
Talk. They Hear You.	**This campaign aims to reduce underage drinking and substance use among youths under the age of 21 by providing parents and caregivers with resources to discuss substance use with their children.**	• **https://www.samhsa.gov/substance-use/prevention/talk-they-hear-you**

List of Acronyms

7-OH: 7-hydroxymitragynine

AI: Artificial Intelligence

CBP: U.S. Customs and Border Protection

CBSA: Canada Border Services Agency

CDC: Centers for Disease Control and Prevention[u]

CGI: Crime Gun Intelligence

CJNG: Jalisco New Generation Cartel

CMS: Centers for Medicare & Medicaid Services

CPOT: Consolidated Priority Organization Target

DEA: Drug Enforcement Administration

DFW: Drug-Free Workplace

DHS: Department of Homeland Security

DOJ: Department of Justice

DoW: Department of War

DTO: Drug Trafficking Organization

FDA: Food and Drug Administration

FTO: Foreign Terrorist Organization

HIDTA: High Intensity Drug Trafficking Areas

HSC: Homeland Security Council

HSI: Homeland Security Investigations

HSTFs: Homeland Security Task Forces

IC: Intelligence Community

INCB: International Narcotics Control Board

INL: Bureau of International Narcotics and Law Enforcement Affairs

MOUD: Medications for Opioid Use Disorder

NCC: National Coordination Center for the HSTFs

[u] The FY 2026 Budget requested the reorganization of certain programs in CDC into the Administration for a Healthy America to improve coordination across health programs.

NCTC: National Counterterrorism Center

NIAAA: National Institute on Alcohol Abuse and Alcoholism

NIBIN: National Integrated Ballistic Information Network

NIDA: National Institute on Drug Abuse

NII: Non-Intrusive Inspection

NSC: National Security Council

NSDUH: National Survey on Drug Use and Health

OFAC: Office of Foreign Assets Control

ONDCP: Office of National Drug Control Policy

PRS: Performance Reporting System

SAMHSA: Substance Abuse and Mental Health Services Administration[v]

SBIRT: Screening, Brief Intervention, and Referral to Treatment

SLTAC: State, Local, and Tribal Affairs Coordinator

SOR: State Opioid Response

TCO: Transnational Criminal Organization

TOR: Tribal Opioid Response

USIC: United States Interdiction Coordinator

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Michigan Department of Health and Human Services
Health Services

ATTACHMENT 13

MEMORANDUM

To: Prepaid Inpatient Health Plans and Opioid Treatment Programs

From: Lisa Miller, State Opioid Treatment Authority

Date: 6/01/2026

RE: Change in the Availability of Buprenorphine Provider Lists

On May 11, 2026, correspondence was sent by the Substance Abuse and Mental Health Services Administration (SAMHSA) regarding the discontinuation of previously maintained lists of buprenorphine providers.

Further details about specific lists to be discontinued or changes to other lists regarding practitioners providing buprenorphine can be found in content from the SAMHSA May 11, 2026, correspondence provided below.

> *As of June 1, 2026, the Substance Abuse and Mental Health Services Administration (SAMHSA) will remove listings of practitioners providing buprenorphine services for the treatment of opioid use disorder (OUD) from its website and related treatment locators.*
>
> *The **Mainstreaming Addiction Treatment (MAT) Act**, part of the Consolidated Appropriations Act of 2023, removed the requirement for practitioners to have a special approval (X-waiver) to prescribe buprenorphine for OUD. To enable more practitioners to treat OUD in their practices, the Act allowed all practitioners who have schedules II – V on their Drug Enforcement Administration (DEA) registration to prescribe buprenorphine.*
>
> *The SAMHSA continued to maintain the database of previously waivered practitioners, which populates several locators on SAMHSA.gov, but it was not possible to add new practitioners to this database. To increase access to buprenorphine services, SAMHSA plans to work with other federal agencies and partners to develop a new locator to assist individuals in need of services to find practitioners in their community. Inclusion in the new locator will be voluntary for practitioners to join.*
>
> *In the meantime, as of June 1, 2026, the publicly accessible locators, **Buprenorphine Practitioner Locator** and the **Pharmacist Verification of Buprenorphine Providers**, will be removed from SAMHSA.gov.*
>
> *The **988 Suicide & Crisis Lifeline**, **FindTreatment**, and **SAMHSA's National Helpline** – 1-800-662-HELP (4357) will continue to operate, but will not provide information on buprenorphine practitioners.*

If you have any questions not previously answered in the SAMHSA correspondence, please contact Lisa Miller at millerl12@michigan.gov.

ATTACHMENT 14

AG Nessel Releases Opioid Settlement Spending Guidance and Report

LANSING – Today, Michigan Attorney General Dana Nessel announced the addition of an opioid settlement report and spending guidance to the Department of Attorney General's website to strengthen transparency in how opioid settlement funds are used across the state. In July 2025, the Department of Attorney General and the 86 Michigan Litigating Local Governments negotiated a revised State-Subdivision Agreement for Opioid Settlements. The revised agreement requires an annual report, enables the Department of Attorney General to issue general guidance about opioid settlements, and clarifies the Department of Attorney General's ability to request information about opioid settlements from participating local governments. The two resources released today follow that revised agreement and are designed to support the effective use of settlement funds.

"The opioid epidemic has caused immense damage to Michigan families and communities," said Attorney General Nessel. "By providing spending guidance and accessible data, we are helping ensure that settlement funds remain focused on supporting recovery, prevention, and healing across our state."

The Settlement Spending Guidance and Non-Remediation List provides a framework for local governments to follow when allocating opioid settlement funds. Utilizing existing guidance and evidence, the webpage outlines recommended uses and includes a list of expenditures that likely do not qualify as opioid remediation, which will continue to be updated.

The Opioid Received/Expended Report, located on the opioid settlements webpage, compiles data submitted by local governments detailing how much opioid settlement funding a local government has received and how those funds have been spent. The preliminary report covers data compiled from January 1, 2023, to December 10, 2025, and will continue to be updated as additional local governments submit reports to the Department of Attorney General.

Since taking office in 2019, Attorney General Nessel has prioritized combating the opioid epidemic and holding accountable those responsible for creating and fueling the crisis. Her efforts have resulted in more than $1.8 billion in settlements for Michigan governments. For more information, visit the Opioids Settlement webpage.

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