Reauthorization of the Office of National Drug Control Policy

Subcommittee on Government Operations
Committee on Oversight and Government Reform
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Written Statement
of
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Director
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Chairman Chaffetz, Ranking Member Cummings, Chairman Meadows, Ranking Member Connolly, and Members of the Subcommittee, I am pleased to appear before you today to discuss the Administration's proposed legislation to reauthorize the Office of National Drug Control Policy (ONDCP).

As you know, ONDCP was established by Congress under the Anti-Drug Abuse Act of 1988, with the principal purpose of reducing illicit drug use, manufacturing, and trafficking; drug-related crime and violence; and drug-related health consequences. November 2015 marked the 27th anniversary of ONDCP, and the Office was most recently reauthorized by the Office of National Drug Control Policy Reauthorization Act of 2006. As a component of the Executive Office of the President, ONDCP establishes policies, priorities, and objectives for the Nation's drug control programs and ensures that adequate resources are provided to implement them. We also develop, evaluate, coordinate, and oversee the international and domestic anti-drug efforts of Executive Branch agencies and, to the extent practicable, ensure such efforts complement state and local drug policy activities.

In addition, we are charged with producing the *National Drug Control Strategy* (*Strategy*), the Administration's primary blueprint for drug policy, along with a national drug control budget. The *Strategy* is a 21st century plan that outlines a series of evidence-based reforms that treat our Nation's drug problem as a public health challenge, not just a criminal justice issue. It has moved beyond an outdated "war on drugs" approach and is guided by what science, experience, and compassion demonstrate about the true nature of drug use in America. The *Strategy* is rooted in the science of drug addiction as a brain disease – one that can be prevented and treated, and from which people can recover.

As you may know, I am the first person to serve as Director of National Drug Control Policy who is in recovery. I share this with you and in remarks I give to the public because I believe it is important for those of us in recovery from substance use disorders to speak up, to defy stereotypes and strike down the stigma too often associated with people in recovery. The millions of others who are in recovery and I are living proof that substance use disorders are diseases for which treatment works, and recovery is possible. Substance use disorders are medical conditions, and reducing the stigma surrounding these medical conditions is a particularly important component of drug policy reform – one in which every American can play a part.

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

Our children, and their children, will only be equipped to compete with their peers around the globe if the United States has a sound economy fueled by an educated, prepared, and healthy workforce. By reducing drug use and its consequences, by teaching children the importance of

healthy and responsible life choices, and by promoting education, innovation, and excellence, we can ensure that the future is ours to win.

The Obama Administration is committed to restoring balance to U.S. drug control efforts by coordinating an unprecedented Government-wide public health and public safety approach to drug policy. In 2010, ONDCP released the Obama Administration's inaugural *Strategy*, which promoted emphasizing community-based drug prevention, integrating evidence-based interventions and treatment into the primary health care system, promoting innovations in the criminal justice system to decrease recidivism, and forging and maintaining strong international partnerships to disrupt drug trafficking organizations.

Since the release of the 2010 *Strategy*, we have seen significant progress in addressing the challenges we face along the entire spectrum of drug policy – including prevention, early intervention, treatment, recovery support, criminal justice reform, law enforcement, and international cooperation. We also still face serious drug-related challenges. Illicit drug use is a public health issue that jeopardizes not only our well-being, but also the progress we have made in strengthening our economy. Last month, we released the 2015 *Strategy*, which provides a review of our progress in implementing the goals we established in the inaugural *Strategy*.

In addition to our work with international partners as part of the comprehensive *Strategy*, we have responsibility for working with Federal agency and international partners in the development of the *National Southwest Border Counternarcotics Strategy* and the *National Northern Border Counternarcotics Strategy*, and earlier this year, ONDCP released a *National Caribbean Border Counternarcotics Strategy*. These strategies put the goals, strategies and action items of the *National Drug Control Strategy* into more regionally-based focus to help disrupt the trafficking of illegal drugs into this country while enhancing our efforts to provide border communities with enhanced prevention and drug treatment assistance that will help curb drug use in the long term.

ONDCP Grant Programs

In addition to our activities across the interagency, ONDCP administers two significant grant programs – the High Intensity Drug Trafficking Areas (HIDTA) Program and the Drug-Free Communities (DFC) Support Program.

High Intensity Drug Trafficking Areas Program

The HIDTA Program was created as part of ONDCP's original authorization to reduce drug trafficking and production in the United States by facilitating cooperation among Federal, state, local, and tribal law enforcement agencies. The HIDTA Program is a locally-based program that responds to the drug trafficking issues facing specific areas of the country. Law enforcement agencies at all levels of government share information and implement coordinated enforcement activities; enhance intelligence sharing among Federal, state, local, and tribal law enforcement agencies; provide reliable intelligence to law enforcement agencies to develop effective enforcement strategies and operations; and support coordinated law enforcement strategies to maximize available resources and reduce the supply of illegal drugs in designated areas. There are currently 28 HIDTAs located in 48 states, as well as in Puerto Rico, the U.S. Virgin Islands, and the District of Columbia.

In addition to the individual initiatives supported by the 28 HIDTAs, there are three national initiatives supported by the HIDTA Program: the Domestic Highway Enforcement Program, the National Marijuana Initiative (NMI), and the National Methamphetamine and Pharmaceuticals Initiative (NMPI). NMI and NMPI are training and best practices initiatives.

The HIDTA program helps improve the effectiveness and efficiency of drug-control efforts by facilitating cooperation between drug-control organizations through resource and information sharing, and co-locating and implementing joint initiatives. HIDTA funds help Federal, state, local, and tribal law enforcement organizations invest in infrastructure and joint initiatives to confront drug-trafficking organizations.

Currently, 27 regional HIDTA programs support prevention initiatives, connecting law enforcement with local prevention efforts to support best-practice activities designed to reduce drug use by replicating the HIDTA multi-agency model. HIDTA members work with community-based coalitions and adhere to evidence-based prevention practices, such as community mobilization and organizational change.

The HIDTA program's primary mission is to dismantle and disrupt drug trafficking organizations. However, expanding prevention efforts offers HIDTAs the ability to address the drug threat in a community in a more comprehensive fashion. As recently as 2010, only four HIDTAs used funding for prevention initiatives. Currently, 27 HIDTAs, including all 5 Southwest Border HIDTA Regions, sponsor prevention activities. Eight HIDTAs (Houston, Michigan, Northwest, Puerto Rico, Southwest Border-Arizona and San Diego/Imperial Valley Regions, Texoma, Washington/Baltimore, and Wisconsin) specifically target marijuana, among other substances, in their prevention efforts.

This past summer, ONDCP committed $2.5 million in HIDTA funds to develop a strategy to respond to the Nation's heroin epidemic. This unprecedented project by ONDCP combines prevention, education, intelligence, and enforcement resources to address the heroin threat across 15 states and the District of Columbia. The effort will be carried out through a unique partnership of five regional HIDTA programs – Appalachia, New England, New York/New Jersey, Philadelphia/Camden, and Washington/Baltimore.

Drug-Free Communities Support Program

The DFC Support Program, created by the Drug Free Communities Act of 1997, serves as the Nation's leading effort to mobilize communities to prevent youth drug use. Directed by ONDCP in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) in the Department of Health and Human Services, the DFC Program provides grants to local drug-free community coalitions, enabling them to increase collaboration among community partners and to prevent and reduce youth substance use. ONDCP provides oversight of the DFC Support Program to include final award determination, program regulation, policy, and its national evaluation.

During Fiscal Year (FY) 2015, following a competitive grant process a total of 697 DFC grants were awarded to 188 new DFC grantees, 486 DFC continuation grantees, and 23 DFC Mentoring

grantees. These awards followed a competitive grant process. The most recent evaluation of the DFC program found that, between DFC coalitions' first report and most recent report, rates of substance abuse are continuing to decline in DFC communities. The DFC 2014 National Evaluation Report showed a significant decrease in past 30 day use of prescription drugs among youth in DFC communities. The report also noted increases in the perception of risk, perception of peer disapproval, and perception of parent disapproval in relation to non-medical prescription drug use. The report also found a significant decrease in past 30 day use between the first and most recent data reports for alcohol, tobacco, and marijuana use among middle school and high school youth in DFC communities.[1]

Overview of Drug Trends

SAMHSA's 2014 National Survey on Drug Use and Health shows signs of progress in reducing some forms of substance use, including lower levels of nonmedical prescription drug use and teen alcohol and tobacco use. The number of past-month cocaine users is significantly lower than it was in the early 2000s.[2] However, challenges remain.

Opioid Drug Use

The nonmedical use of opioids – a category of drugs that includes heroin and prescription pain medicines like oxycodone, oxymorphone, and hydrocodone – is having a considerable impact on public health and safety in communities across the United States. According to the Centers for Disease Control and Prevention, approximately 120 Americans on average died from a drug overdose every day in 2013. Of the nearly 44,000 drug overdose deaths in 2013, opioid pain relievers were involved in over 16,200, while heroin was involved in over 8,200. Overall, drug overdose deaths now outnumber deaths from gunshot wounds (over 33,600) or motor vehicle crashes (over 32,700)[3] in the United States.[4] Heroin use remains relatively low in the United States when compared to other drugs; however, the increase in the number of people using the drug in recent years – from 373,000 past-year users in 2007 to 914,000 in 2014[5] – and the high rate of overdose deaths are troubling.

There has been considerable discussion around potential connections between the non-medical use of prescription opioids and heroin use. There is evidence to suggest that some users eventually begin to substitute heroin for prescription opioids, which are often more expensive than heroin. While research into the potential nexus between these two types of opioids remains sparse, a SAMHSA report found that four out of five (79.5%) recent heroin initiates had previously used prescription pain relievers non-medically. However, only a very small proportion (3.6%) of those who had started using prescription opioids non-medically initiated

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[1] ICF International. Drug Free Communities Support Program 2014 National Evaluation Report. Available at: https://www.whitehouse.gov/sites/default/files/DFC2014Interim%20ReportJuly2015Final.pdf

[2] Substance Abuse and Mental Health Services Administration. *Results from the 2014 National Survey on Drug Use and Health: Detailed Tables. Table 7.3A – Types of Illicit Drug Use in the Past Month among Persons Aged 12 or Older: Numbers in Thousands, 2002-2014.* Department of Health and Human Services. [September 2015] Available at: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.htm#tab7-3a

[3] Fatality Analysis Reporting System (FARS) Encyclopedia Available at: http://www-fars.nhtsa.dot.gov/Main/index.aspx

[4] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death, 1999-2013 on CDC WONDER Online Database, released 2015. Extracted by ONDCP from http://wonder.cdc.gov/mcd-icd10.html on January 30, 2015.

[5] Substance Abuse and Mental Health Services Administration. *Results from the 2014 National Survey on Drug Use and Health: Detailed Tables. Table 7.2A – Types of Illicit Drug Use in the Past Year among Persons Aged 12 or Older: Numbers in Thousands, 2002-2014.* Department of Health and Human Services. [September 2015] Available at: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.htm#tab7-2a

heroin use in the following five-year period.[6] This suggests that while most new heroin users have previously used prescription opioids non-medically, a very small portion of all non-medical prescription opioid users transitions to heroin.

In April 2011 the Administration released a comprehensive *Prescription Drug Abuse Prevention Plan (Plan)* entitled, "Epidemic: Responding to America's Prescription Drug Abuse Crisis." This *Plan* builds upon the *Strategy* and brings together Federal, state, local, and tribal leaders to reduce diversion and abuse of prescription drugs. It strikes a balance between our need to prevent the diversion and nonmedical use of pharmaceuticals with the need to ensure legitimate access to them. The *Plan* focuses on improving education for patients and healthcare providers, supporting the expansion of state-based prescription drug monitoring programs, developing more convenient and environmentally responsible disposal methods to remove unused medications from the home, and reducing the prevalence of pill mills and doctor shopping through targeted enforcement efforts. The Administration has made considerable progress in implementing all four areas of the *Plan*.

This progress was highlighted on October 21 during President Obama's trip to West Virginia, where I accompanied the President to hear directly from individuals, families, and law enforcement officials affected by the opioid epidemic. As part of this visit, the President announced additional Federal, state, local and private sector efforts aimed at addressing the consequences of nonmedical prescription opioid and heroin use. In addition, the President issued a memorandum to Federal departments and agencies directing important steps to address this epidemic.

In May, the Administration inaugurated the congressionally-mandated interagency Heroin Task Force, which is co-chaired by ONDCP and DOJ. The Task Force includes Federal agency experts from law enforcement, medicine, public health and education. In a few weeks, the Task Force will produce a report focused on evidence-based public health and public safety recommendations to reduce the health and safety consequences of opioid use and the supply and demand of opioids. With the cooperation of the National Security Council (NSC), ONDCP has recently established the National Heroin Coordination Group (NHCG), a diverse, multi-disciplinary team of subject matter experts that will lead interagency efforts to reduce the availability of heroin in the United States. The NHCG will work with the NSC to guide and synchronize interagency activities against the heroin/fentanyl supply.

Since much of the heroin that is coming into the United States across our Southwest border is produced in Mexico, during recent high-level discussions in Mexico City I discussed in detail the opioid/heroin challenge with Mexican counterparts. We expect expanded efforts to reduce the production and trafficking of heroin by Mexico-based drug cartels to be initiated in the near term.

[6] Substance Abuse and Mental Health Services Administration. *Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States*. Department of Health and Human Services. [August 2013]. Available: http://www.samhsa.gov/data/2k13/DataReview/DR006/nonmedical-pain-reliever-use-2013.pdf

New Psychoactive Substance Use

New Psychoactive Substances (NPS) such as synthetic cannabinoids, sometimes referred to as "K2," and synthetic cathinones, commonly referred to as "bath salts," present an array of health and safety risks. The contents and effects of these substances are unpredictable due to a constantly changing variety of chemical compounds used in manufacturing processes that are devoid of quality controls and regulatory oversight.

The use of NPS is burdening our health care system. According to a 2013 report by SAMHSA's Drug Abuse Warning Network, 28,531 emergency department visits involving a synthetic cannabinoid product occurred in 2011, a figure 2.5 times higher than the 11,406 emergency department visits just a year earlier in 2010.[7] Reporting also found that bath salts were involved in 22,904 emergency department visits in 2011, highlighting the considerable toll these drugs are taking in health care settings nationwide.[8] According to information from the American Association of Poison Control Centers, counts for synthetic cannabinoid cases reported to poison control centers peaked in 2011 with 6,968 but decreased through 2014. However, as of October 31, 2015, poison centers have received 6,949 reported exposures to synthetic cannabinoids, a trajectory which will likely make 2015 the year with the highest number of cases reported.[9]

ONDCP is working with Federal, state, local, and community partners throughout the country, as well as regionally and internationally, to address the dynamic problem of NPS. Through directives in our national strategies and action plans related to reducing drug use and its consequences, we are working closely with the international community and China, where the majority of these chemicals are produced, to address manufacturing; Congress to improve regulatory tools to schedule NPS; law enforcement to support their investigations both domestically and abroad; the research community to better understand the effects of these substances; and prevention stakeholders, parents, and community organizations to inform about the dangers of NPS.

DFC coalitions across the country have identified NPS as a growing problem in their communities and have taken action. For example, the Franklin Mayor's Drug and Alcohol Abuse Task Force in New Hampshire worked to adopt the first synthetic cannabinoid ordinance in that state. The ordinance brought the issue of NPS to the forefront in the community, as many residents had never heard of "K2" or "Spice," and many did not know that they were being sold in Franklin convenience stores. Other cities in New Hampshire have since reached out to Franklin as they consider adopting similar laws. Another DFC grantee, the Clinton Substance Abuse Council in Iowa, worked with the Clinton Police Department to facilitate an NPS drop off day for retailers. And in California, the Santee Solutions Coalition in Santee helped local law enforcement identify businesses selling NPS. These are just a few examples of the many DFC grantees around the country seeking to educate their communities about these dangerous substances.

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[7] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, *Drug Abuse Warning Network, 2011: National Estimates of Drug-Related Emergency Department Visits*. May 2013. Available: http://www.samhsa.gov/data/2k13/DAWN2k11ED/DAWN2k11ED.htm

[8] Substance Abuse and Mental Health Services Administration, *The DAWN Report Data Spotlight: "Bath Salts" Were Involved in Over 20,000 Drug-Related Emergency Department Visits in 2011*. September 2013. Available at: http://www.samhsa.gov/data/sites/default/files/spot117-bath-salts-2013/spot117-bath-salts-2013.pdf.

[9] American Association of Poison Control Centers. Synthetic Cannabinoid Data. https://aapcc.s3.amazonaws.com/files/library/Syn_Marijuana_Web_Data_through_10.31.15.pdf

U.S. drug control agencies are also working to address the supply of NPS. Many of the chemical compounds that are used to manufacture NPS originate in Asia. Dialogue with China, in particular, appears to have resulted in greater control efforts in that country. In addition, interdiction agencies are working to track and disrupt the flow of NPS from Asia and continue to work towards tightening monitoring of these chemical shipments.

Methamphetamine

Southwest border seizure data,[10] law enforcement reporting,[11] localized drug consequence information such as treatment admissions,[12] and overdose data[13] all indicate that methamphetamine trafficking and use continue to pose an increasing threat to the United States. Mexican transnational criminal organizations (TCOs) have adapted to legal restrictions placed on precursor chemicals, in the United States and Mexico, and are able to continue producing large amounts of high-purity, high-potency methamphetamine. The majority of methamphetamine available in the United States is Mexican cartel-produced.[14] This methamphetamine relies on precursor chemicals from China and India. To address this issue, ONDCP and our interagency partners at the U.S. Department of State, the Drug Enforcement Administration, and the U.S. Pacific Command are engaging with international partners in Asia, as well as multilateral organizations and key bilateral partners, to improve international controls of precursor chemicals. We are also working to improve the capacity of Mexico and Central American nations to detect, seize and safely dispose of diverted precursors. In addition, SAMHSA and NIDA, for example, are helping to educate and inform the public about the risks associated with methamphetamine, as well as supporting basic molecular and neuroscience research, prevention strategies, medications development, and clinical research testing new treatment strategies for this drug.

Cocaine

While cocaine smuggling, availability, and consumption in the United States are all down when compared to historically high levels in the mid-2000s, we need to be attentive to the potential resurgence of cocaine, as indicated by recent potential production estimates[15] and transit zone seizures.[16] Cocaine production estimates have been increasing, and the Consolidated Counterdrug Data Base shows a commensurate increase in the flow of cocaine through the Western Hemisphere Transit Zone. Mexican TCOs obtain multi-ton shipments of cocaine from source countries in South America, primarily from Colombia. In 2014, an estimated 86 percent of this cocaine was smuggled through the Mexico/Central America corridor.[17] Mexican TCOs smuggle the majority of U.S.-bound cocaine across the Southwest border. After large loads reach shipment points in Mexico or Central America, they are broken down into small, more difficult-to-detect loads that are smuggled across the Southwest border into the United States. The U.S.

[10] National Seizure System (NSS), El Paso Intelligence Center
[11] Drug Enforcement Administration, 2015. National Drug Threat Assessment Summary, August 2015, p. 49.
[12] Preliminary 2013-14 Treatment Episode Data Set (TEDS), SAMHSA, http://www.samhsa.gov/data/sites/default/files/2014_TEDS_Substance_Abuse_Treatment_Admissions_Tables_as_of_2015_Q2/2014_TEDS_Substance_Abuse_Treatment_Admissions_Tables_as_of_2015_Q2.html
[13] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death, 1999-2013 on CDC WONDER Online Database, released 2015. Extracted by ONDCP from http://wonder.cdc.gov/mcd-icd10.html on October 30, 2015.
[14] Drug Enforcement Administration, 2015. National Drug Threat Assessment Summary, August 2015, p. 53.
[15] U.S. Government Colombia illicit crop estimates, April 2015.
[16] Consolidated Counterdrug Data Base (CCDB), October, 2015.
[17] Interagency Assessment of Cocaine Movement, DIA, 2014

Government is strongly supportive of the Colombian peace process, but we also want to make sure that as Colombia moves forward on what would be an historic accomplishment, that efforts to constrain any increases in cocaine production are maintained.

Marijuana Use

Marijuana is the most commonly used illicit drug in the United States. In 2014 alone, nearly 35 million people ages 12 and older reported using the drug within the past year.[18] A substantial portion of these Americans were using marijuana nearly every day in the past 12 months. In 2014, 18.5 percent of Americans 12 or older who had used marijuana in the past year did so on 300 or more days within the past 12 months,[19] or over 6.5 million people using marijuana on a daily or almost daily basis during that period.[20] Moreover, approximately 4.2 million people met the diagnostic criteria for abuse or dependence on this drug, more than for any other drug.[21] When we look at our progress in meeting the *Strategy*'s 5-year goals related to reducing the 30-day prevalence of use of illicit drugs by youth and young adults, we find that marijuana use overwhelms the data to such an extent that the progress achieved toward reducing use of other illicit drugs is no longer apparent when marijuana use is included.

ONDCP is taking a number of steps to prevent marijuana use, particularly with young people and parents. DFC coalitions across the country have identified marijuana as a significant problem in their communities. In fact, nearly 90 percent of FY 2012 DFC coalitions list marijuana as one of their top 5 targeted substances and are taking action to prevent young people from using the drug.[22] These coalitions employ a host of prevention strategies, including disseminating multi-lingual educational materials, hosting drug-free social events for youth, working with schools and educators to promote drug free campuses, and working with local media to highlight prevention activities.

ONDCP also works closely with other drug control agencies to advance our understanding of the health implications of marijuana; enhance surveillance about the extent and health impacts of marijuana use; provide information and technical assistance to state and Federal officials, and the broader public, based on scientific understandings, with a focus on preventing youth use; ensure required health insurance coverage for screening and medical treatment services include substance use; and provide substance use prevention, treatment and recovery support services through publicly-supported programs.

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[18] Substance Abuse and Mental Health Services Administration. Results from the *2014 National Survey on Drug Use and Health: Detailed Tables. Table 6.1A – Number of Days Used Marijuana in the Past Year among Past Year Users and the Number of Days Used Marijuana in the Past Month among Past Month Users, by Age Group: Numbers in Thousands, 2013 and 2014.* Department of Health and Human Services. [September 2015] Available at: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.htm#tab6-1a

[19] Substance Abuse and Mental Health Services Administration. Results from the *2014 National Survey on Drug Use and Health: Detailed Tables. Table 6.1B – Number of Days Used Marijuana in the Past Year among Past Year Users and the Number of Days Used Marijuana in the Past Month among Past Month Users, by Age Group: Percentages, 2013 and 2014.* Department of Health and Human Services. [September 2015] Available at: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.htm#tab6-1b

[20] Op Cit., SAMHSA Table 6.1A.

[21] Substance Abuse and Mental Health Services Administration. Results from the *2014 National Survey on Drug Use and Health: Detailed Tables. Table 5.2A – Substance Dependence or Abuse for Specific Substances in the Past Year, by Age Group: Numbers in Thousands, 2013 and 2014.* Department of Health and Human Services. [September 2015] Available at: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.htm#tab5-2a

[22] Unpublished Drug Free Communities Support Program Evaluation Tracking.

ONDCP Reauthorization Bill

The reauthorization legislation that the Administration has provided to the Chairman and Ranking Member would reauthorize ONDCP through FY 2020. The proposed statutory changes would strengthen ONDCP's ability to effectively respond to the range of complex drug problems confronting our Nation today.

The legislation contains new language reflecting the expanded public health approach to drug policy that ONDCP is undertaking in accordance with the *National Drug Control Strategy.* It explains that the term "demand reduction" encompasses, "prevention, treatment and recovery efforts," and expands the list of authorized demand reduction activities to include: 1) screening and brief interventions for substance use disorders; 2) promoting availability of and access to health care services for the treatment of substance use disorders; and 3) supporting long-term recovery from substance use disorders. These activities all come within ONDCP's existing authorities, and the Office has significantly increased its focus on the availability of medical treatment and recovery support for individuals with substance use disorders. Currently, less than one fifth of those who need specialty treatment for their illicit drug use problem receive it. Including these specific elements of care in the statute on the list of enumerated demand reduction activities will further highlight their importance.

Language has also been added expressly making the reduction of underage use of alcohol part of ONDCP's demand reduction responsibilities. The percentage of adolescents aged 12 to 17 who were current alcohol users was 11.5 percent in 2014. This percentage corresponds to 2.9 million adolescents in 2014, about 1 in 9 adolescents, who drank alcohol in the past month.[23] There is a strong body of evidence linking underage alcohol use and unlawful drug use among teenagers and young adults, and an effective effort to reduce substance use within this population must address both of these related concerns. This has been part of ONDCP's prevention work in the past, and given the important role of youth prevention in averting substance use disorders, it warrants increased attention and a more focused response.

The proposed legislation would also extend authorization for the HIDTA Program through FY 2020 to allow the HIDTA Program to continue providing vital support for joint initiatives by Federal, state, local, and tribal law enforcement targeting illegal drug operations. In addition, the bill would allow local HIDTA boards, with the approval of the Director of ONDCP, to provide support for programs in the criminal justice system that offer treatment for substance use disorders to drug offenders, and to provide support for community prevention efforts.

The pertinent language in the proposed reauthorization states that upon the request of an Executive Board of a High Intensity Drug Trafficking Area, the Director may authorize the expenditure of HIDTA Program funds to support initiatives that provide access to treatment for substance use disorders as part of a diversion or alternative sentencing or community reentry program for drug offenders. Such programs have proven successful in a number of jurisdictions across the country in breaking the cycle of drug dependence and crime by assisting offenders to overcome their substance use disorders. ONDCP's previous authorization prohibited the use of

[23] Substance Abuse and Mental Health Services Administration. *Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health* Results from the *2014.* Department of Health and Human Services. [September 2015] Available at: http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.htm#fig25

funds for "the establishment or expansion of drug treatment programs." The Washington-Baltimore HIDTA has traditionally provided ongoing funding to the District of Columbia drug court, an initiative started before the prohibition was placed in the previous reauthorization. This initiative is an example of the type of program that the proposed reauthorization language would allow to be further supported by the HIDTAs. New language is also added stating that upon the request of a HIDTA Executive Board, the Director of ONDCP may authorize the expenditure of an amount greater than five percent of HIDTA Program funds for drug prevention efforts. Current law authorizes the Director to expend up to five percent of HIDTA program funds for drug prevention. With this modification, HIDTAs could increase the level of support for prevention efforts in their communities, should they see a need and at their discretion.

HIDTA board members come primarily from the law enforcement community and from the geographic areas they serve. They best know the needs of their communities. In some instances, the use of a limited amount of funds to support a treatment program for drug offenders or to support a community prevention initiative may, in the eyes of a local HIDTA board, assist in fulfilling the primary duties of the HIDTA. That is a decision each HIDTA board should have the authority to make. The proposed amendment would grant HIDTA boards that authority.

As we have discussed with the Committee, ONDCP intends to rearrange its organizational structure to facilitate greater collaboration among ONDCP's public health, public safety, and international policy staff across the spectrum of drug policy. Most of the major drug control issues our country is facing today do not fall neatly into the traditional "demand" or "supply" categories. A comprehensive response requires that we address the treatment, prevention, law enforcement, and source country aspects of each drug threat holistically. Our proposed new structure will facilitate the formation of broad-based, issue-focused working groups bringing together staff with expertise in each of these policy areas.

This internal reorganization plan is separate and independent from the reauthorization bill that the Committee is considering. Most of the reorganization can be implemented under ONDCP's existing statutory authority and does not require any statutory change. However, current law provides for the appointment of the Deputy Directors for Demand Reduction, Supply Reduction, and State, Local, and Tribal Affairs. As most of the major drug control issues facing our country do not fall neatly into these traditional categories, we are proposing to eliminate the deputy director positions effective January 20, 2017. The leadership responsibilities of the deputy directors will be overseen by the Director, to be coordinated by him through supervisory staff members.

These are the most significant changes contained in the proposed ONDCP reauthorization bill. We have provided the Committee with a document describing all of the proposed changes in detail.

Conclusion

As the above discussion indicates, the Office of National Drug Control Policy is involved in a large variety of activities to coordinate Federal, state, local, tribal, and international partners to address substance use disorders in this Nation. ONDCP supports a comprehensive public health and safety approach in an effort to reduce drug use and its consequences, as well as the

availability of illicit drugs. The Administration's proposed legislation to reauthorize ONDCP reflects this 21st century approach to drug policy that is set out in the Administration's *National Drug Control Strategy*. We appreciate the Committee's ongoing interest in working with ONDCP on drug policy matters.

Michael Botticelli

Director of National Drug Control Policy

Michael Botticelli was sworn in as Director of National Drug Control Policy on February 11, 2015. Previously, he served both as Acting Director and Deputy Director of National Drug Control Policy. He joined the Office of National Drug Control Policy (ONDCP) as Deputy Director in November 2012.

Mr. Botticelli has more than two decades of experience supporting Americans who have been affected by substance use disorders. Prior to joining ONDCP, Mr. Botticelli served as Director of the Bureau of Substance Abuse Services at the Massachusetts Department of Public Health, where he successfully expanded innovative and nationally recognized prevention, intervention, treatment, and recovery services for the Commonwealth of Massachusetts. He also forged strong partnerships with local, state, and Federal law enforcement agencies; state and local health and human service agencies; and stakeholder groups to guide and implement evidence-based programs. These programs include the establishment of a treatment system for adolescents, early intervention and treatment programs in primary healthcare settings, jail diversion programs, re-entry services for those leaving state and county correctional facilities, and overdose prevention programs.

Mr. Botticelli has served in a variety of leadership roles for the National Association of State Alcohol and Drug Abuse Directors. He was also a member of the Advisory Committee for the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention and the National Action Alliance for Suicide Prevention. He has also co-authored many peer-reviewed articles that have significantly contributed to the substance abuse field .

In 2008, Mr. Botticelli was the first recipient of the annual Ramstad/Kennedy National Award for Outstanding Leadership in Promoting Addiction Recovery. In 2012, he was awarded the Service Award from the National Association of State Alcohol and Drug Abuse Directors.

Born in Upstate New York, Mr. Botticelli holds a Bachelor of Arts degree from Siena College and a Master of Education degree from St. Lawrence University. He is also in long-term recovery from a substance use disorder, celebrating more than 25 years of sobriety.