EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

Federal Marijuana Policy

Subcommittee on Government Operations
Committee on Oversight and Government Reform
United States House of Representatives

Tuesday, February 4, 2014
1:30 p.m.
2154 Rayburn House Office Building

Written Statement
of
Michael P. Botticelli
Deputy Director
Office of National Drug Control Policy

Chairman Mica, Ranking Member Connolly, and distinguished members of the Subcommittee, thank you for this opportunity to address the public health and safety issues surrounding marijuana in the United States. As you know, the Office of National Drug Control Policy (ONDCP) was established in 1988 by Congress with the principal purpose of reducing illicit drug use, manufacturing, and trafficking; drug-related crime and violence; and drug-related health consequences. As a component of the Executive Office of the President, our office establishes policies, priorities, and objectives for the Nation's drug control programs. We also evaluate, coordinate, and oversee the international and domestic anti-drug efforts of Executive Branch agencies and ensure such efforts sustain and complement state and local drug policy activities.

As Deputy Director of National Drug Control Policy, my position allows me to raise public awareness and take action on drug issues affecting our Nation. Before being appointed to my current position by the President in November 2012, I was Director of the Bureau of Substance Abuse Services in the Massachusetts Department of Health. There, I worked to establish a treatment system for adolescents, early intervention and treatment programs, jail diversion programs, re-entry services for those leaving state and county correctional facilities, and drug overdose prevention programs. In addition, I have served in a variety of leadership roles for the National Association of State Alcohol and Drug Abuse Directors. I have also served as a member of the Advisory Committee for the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Prevention, and the National Action Alliance for Suicide Prevention.

At ONDCP, 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 moves beyond an outdated "war on drugs" approach, while also rejecting drug legalization as a "silver bullet" solution to the drug problem. Neither of these approaches is guided by what experience, compassion, or science demonstrate about the true nature of drug use in America.

I am here today to testify specifically about marijuana, the considerable public health consequences associated with the drug, ONDCP's ongoing efforts to reduce and prevent use, and related consequences throughout the Nation.

The Health Risks of Marijuana

Marijuana is classified as a Schedule I drug, meaning it has a high potential for abuse, no currently accepted medical use in treatment in the United States, and lacks accepted safety for use under medical supervision.[1] The main active chemical in marijuana is delta-9-tetrahydrocannabinol, more commonly called THC. THC acts upon specific sites in the brain,

[1] Drug Enforcement Administration: Office of Diversion Control. *Title 21 United States Code (USC) Controlled Substances Act: Section 812. Schedules of Controlled Substances.* U.S. Department of Justice. [date unknown]. Available: http://www.deadiversion.usdoj.gov/21cfr/21usc/812.htm

called cannabinoid receptors, starting off a series of cellular reactions that ultimately lead to the "high" that users experience when they smoke marijuana. Some brain areas have many cannabinoid receptors; others have few or none.[2]

Research has shown that marijuana use can have implications for learning and memory and effects can last for up to one week after the acute effects of the drug wear off.[3] Heavy (used on average 18,000 times and a minimum of 5,000 times in their lives) marijuana users reported that the drug impaired several important measures of health and quality of life, including physical and mental health, cognitive abilities, social life, and career status.[4]

Marijuana is the most commonly used illicit drug in the United States. In 2012 alone, nearly 32 million people ages 12 and older reported using the drug within the past year. [5] A substantial portion of these Americans were using marijuana nearly every day in the past 12 months. In 2012, 17.0 percent of Americans 12 or older who had used the drug in the past year did so on 300 or more days within the past 12 months.[6] This translates into 5.4 million people using marijuana on a daily or almost daily basis over a 12-month period.[7] In fact, approximately 4.3 million people met the diagnostic criteria for abuse or dependence on this drug, more than any other drug.[8]

While significantly lower than the peak use year in 1979 , overall marijuana use rates in the United States have increased in the last decade.[9,10] Since 2002, prevalence of past month marijuana use among Americans 12 and older has increased more than a full percentage point (from 6.2 percent in 2002 to 7.3 percent in 2012).[11] This is also true among young adults aged 18

---

[2] Herkenham M, Lynn A, Little MD, et al. Cannabinoid receptor localization in the brain. Proc Natl Acad Sci, USA 87(5):1932–1936, 1990. Available: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC53598/

[3] Pope HG, Gruber AJ, Hudson JI, Huestis MA, Yurgelun-Todd D. Neuropsychological performance in long-term cannabis users. *Arch Gen Psychiatry* 58(10):909–915, 2001. Available: http://www.ncbi.nlm.nih.gov/pubmed/11576028

[4] Gruber AJ, Pope HG, Hudson JI, Yurgelun-Todd D. Attributes of long-term heavy cannabis users: A case control study. Psychological Med 33(8):1415–1422, 2003. Available: http://www.ncbi.nlm.nih.gov/pubmed/14672250

[5] Substance Abuse and Mental Health Services Administration. Results from the 2012 National Survey on Drug Use and Health: Detailed Tables. Department of Health and Human Services. [September 2013]. Available: http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/DetTabs/NSDUH-DetTabsSect6peTabs1to54-2012.htm#Tab6.1A

[6] Substance Abuse and Mental Health Services Administration. Results from the 2012 National Survey on Drug Use and Health: Detailed Tables. Department of Health and Human Services. [September 2013]. Available: http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/DetTabs/NSDUH-DetTabsSect6peTabs1to54-2012.htm#Tab6.1B

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

[8] Substance Abuse and Mental Health Services Administration. Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings. Department of Health and Human Services. [September 2013]. Available: http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/NationalFindings/NSDUHresults2012.htm#fig7.2

[9] Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health, National Household Survey on Drug Abuse.

[10] Institute for Social Research, the University of Michigan. Monitoring the Future Survey.

[11] Substance Abuse and Mental Health Services Administration. Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings. Department of Health and Human Services. [September 2013]. Available:

to 25, with rates of past month use increasing from 17.3 percent in 2002 to 18.7 percent in 2012.[12] There may be some positive news among young people ages 12 to 17. According to national survey data, youth use rates have decreased from 8.2 percent in 2002 to 7.2 percent in 2012; however, this overall trend masks recent year-to-year increases in use among young people, particularly between 2008 and 2011.[13] These variations indicate that use by America's youth should remain a key focus for policymakers, law enforcement, and public health leaders.

Marijuana poses considerable health and safety implications for the users themselves, their families, and our communities. Decades of research into the use and effects of the drug have found an array of negative consequences. Research finds that approximately 9 percent (1 in 11) of marijuana users become dependent,[14] and the younger a person starts using it, the more likely he or she is to become dependent on marijuana or other drugs later in life.[15] These are not the only problems connected to marijuana use. For example, marijuana use can have implications for learning and memory, and its effects can last for days to weeks after the acute effects of the drug wear off, particularly in chronic users.[16] Researchers have also found that adolescents' long-term use of marijuana begun during adolescence is associated with an average eight-point lower IQ later in life.[17]

One study found that people who smoke marijuana frequently but do not smoke tobacco have more health problems, including respiratory illnesses, than nonsmokers.[18] The harms of marijuana use can also manifest in its users' quality of life. In one study, heavy marijuana users reported negative effects of their marijuana use on several important measures of health and

---

http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/NationalFindings/NSDUHresults2012.htm#fig2.2

[12] Substance Abuse and Mental Health Services Administration. Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings. Department of Health and Human Services. [September 2013]. Available: http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/NationalFindings/NSDUHresults2012.htm#fig2.9

[13] Substance Abuse and Mental Health Services Administration. Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings. Department of Health and Human Services. [September 2013]. Available: http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/NationalFindings/NSDUHresults2012.htm#fig2.7

[14] Anthony, JC, Warner, LA, and Kessler, RC (1994) Comparative Epidemiology of Dependence on Tobacco, Alcohol, Controlled Substances, and Inhalants: Basic Findings from the National Comorbidity Survey, *Experimental and Clinical Psychopharmacology* 2(3):244-268. Available: http://psycnet.apa.org/index.cfm?fa=buy.optionToBuy&id=1994-45545-001

[15] Grant, B and Dawson, DA. (1998) Age of onset of drug use and its association with DSM-IV drug abuse and dependence: results from the National Longitudinal Alcohol Epidemiologic Survey. J Stust Abuse 10(2):163-73. Available: http://www.ncbi.nlm.nih.gov/pubmed/9854701

[16] Pope HG, Gruber AJ, Hudson JI, Huestis MA, Yurgelun-Todd D. Neuropsychological performance in long-term cannabis users. *Arch Gen Psychiatry* 58(10):909–915, 2001. Available: http://www.ncbi.nlm.nih.gov/pubmed/11576028

[17] Meier et al., "Adolescent-onset cannabis and neuropsychological health." Proceedings of the National Academy of Sciences. [August 27, 2012]. Available: http://www.pnas.org/content/early/2012/08/22/1206820109

[18] Polen MR, Sidney S, Tekawa IS, Sadler M, Friedman GD. Health care use by frequent marijuana smokers who do not smoke tobacco. West J Med 158(6):596–601, 1993. Available: http://www.ncbi.nlm.nih.gov/pubmed/8337854

quality of life, including physical and mental health, cognitive abilities, social life, and career status.[19]

The consequences of marijuana use are particularly acute in our health care and substance abuse treatment system. In 2011, marijuana was involved in nearly 456,000 emergency department (ED) visits nationwide, representing approximately 36 percent of all ED visits involving illicit drugs.[20] And in 2012, approximately 314,000 Americans 12 or older reported receiving treatment for marijuana use in the past year, more than any other illicit drug, and trailing only alcohol and pain relievers.[21] These figures present a sobering picture of this drug's very real and serious consequences.

State Medical Marijuana Laws

Since 1996, 20 states and Washington, D.C., have passed laws allowing smoked marijuana to be used for a variety of medical conditions. Many of these state laws originated in order to create a legal defense to state criminal possession laws or to remove state criminal penalties for purported medical use of marijuana. Since then, many have evolved into state authorization for production and distribution of marijuana for purported medical purposes. These laws vary greatly in their criteria and implementation, and many states are experiencing vigorous internal debates about the safety, efficacy, and legality of their marijuana laws.

State marijuana laws do not change the criteria or process for Food and Drug Administration (FDA) approval of new drugs. The FDA, as the authority charged with approving new drugs based on a finding of safety and efficacy, has noted that smoking marijuana is a potentially harmful method for delivering the constituent elements of marijuana. The FDA has not found smoked marijuana to have an accepted medical use in treatment in the United States and has not approved smoked marijuana for the treatment of any disease. These state laws are not the primary test for declaring a substance a recognized medication. Marijuana should be subjected to the same rigorous clinical trials and scientific scrutiny the FDA applies to all other new medications, a comprehensive process that ensures the highest standards of safety and efficacy.

The FDA has approved drugs containing synthetic compounds similar to naturally occurring delta-9-THC. Dronabinol is one such synthetically produced compound, used in the FDA-approved medicine Marinol, which is already legally available for prescription by

---

[19] Gruber AJ, Pope HG, Hudson JI, Yurgelun-Todd D. Attributes of long-term heavy cannabis users: A case control study. Psychological Med 33(8):1415–1422, 2003. Available: http://www.ncbi.nlm.nih.gov/pubmed/14672250

[20] Substance Abuse and Mental Health Services Administration. *Drug Abuse Warning Network, 2011: National Estimates of Drug-Related Emergency Department Visits.* Department of Health and Human Services. [May 2013]. Available: http://www.samhsa.gov/data/2k13/DAWN2k11ED/DAWN2k11ED.htm#3.1

[21] Substance Abuse and Mental Health Services Administration. Results from the 2012 National Survey on Drug Use and Health: Detailed Tables. Department of Health and Human Services. [September 2013]. Available: http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/DetTabs/NSDUH-DetTabsSect5peTabs1to56-2012.htm#Tab5.42A

physicians whose patients suffer from nausea, vomiting, and appetite and weight loss.[22] Another FDA-approved medicine, Cesamet, contains the active ingredient Nabilone, which also has a chemical structure similar to THC.[23] And Sativex, an oromucosal spray approved in Canada, the United Kingdom, and other parts of Europe for the treatment of multiple sclerosis spasticity and cancer pain, is currently in late-stage clinical trials to support FDA approval.[24] In November 2013, the FDA granted orphan drug designation to Epidiolex, an oral liquid formulation of a highly purified extract of plant-derived cannabidiol (CBD), a non-psychoactive molecule from the cannabis plant, for treating Dravet syndrome, a rare and severe form of infantile-onset epilepsy.[25]

Physicians routinely prescribe medications with standardized modes of administration that have been shown to be safe and effective at treating the same conditions that marijuana proponents claim are relieved by smoking marijuana. The biomedical research and medical judgment that guide the FDA approval process should continue to determine what are safe and effective medications.

State Legalization Efforts

The Administration continues to oppose attempts to legalize marijuana and other drugs. This opposition is driven by medical science and research. Above all, though, it bears emphasizing that the Department of Justice's (DOJ) responsibility to enforce the Controlled Substances Act (CSA) remains unchanged. As DOJ has historically noted in its guidance to prosecutors, Federal drug enforcement resources prioritize and target the serious crimes of drug dealing, violent crime, and trafficking. The law enforcement officials who have sworn an oath to uphold Federal law will continue to pursue drug traffickers, drug dealers, and transnational criminal organizations that weaken our communities and pose serious threats to our Nation. The Department of Justice has not historically devoted resources to prosecuting individuals whose conduct is limited to possession of small amounts of marijuana for personal use on private property.

In 2012, voters in the states of Colorado and Washington passed initiatives legalizing marijuana for adults 21 and older under state law. In establishing the CSA, Congress determined that marijuana is a dangerous drug and that the illegal distribution and sale of marijuana is a serious crime. DOJ is committed to enforcing the CSA consistent with these determinations. On August 29, 2013, DOJ issued guidance to Federal prosecutors concerning marijuana enforcement

---

[22] U.S. National Library of Medicine, Medline Plus. Dronabinol. National Institutes of Health. [September 2010]. Available: http://www.nlm.nih.gov/medlineplus/druginfo/meds/a607054.html

[23] U.S. National Library of Medicine, Daily Med. Cesamet. National Institutes of Health. [November 2009]. Available: http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=10553514-8001-4281-85b6-96d99ef6822ahttp://www.nlm.nih.gov/medlineplus/druginfo/meds/a607048.html

[24] eMC. Sativex Oromucosal Spray. Medicines.org.uk. [October 2012]. Available: http://www.medicines.org.uk/emc/medicine/23262

[25] GW Pharmaceuticals Provides Update on Orphan Program for Childhood Epiplepsy for Epidiolex [November 2013] Available at: http://www.gwpharm.com/GW%20Pharmaceuticals%20Provides%20Update%20on%20Orphan%20Program%20in%20Childhood%20Epilepsy%20for%20Epidiolex.aspx

under the CSA. In this guidance, DOJ stated that it expects states and local governments that have enacted laws authorizing marijuana-related conduct to establish and enforce strict regulatory schemes that protect eight public health and safety interests, including preventing the distribution of marijuana to minors, preventing revenue from going to criminal enterprises, and preventing the diversion of marijuana to other states.[26] All of these interests are critical, and we will work closely with DOJ and other Federal and state partners to monitor the implementation of these state laws.

Calls for legalization often paint a misleading picture. Although state legalization efforts include taxes on marijuana, costs associated with legalization may far exceed any additional tax revenue. For example, the tax revenue collected from alcohol pales in comparison to the costs associated with it. Federal excise taxes collected on alcohol in 2009 totaled around $9.4 billion;[27] state and local revenues from alcohol taxes totaled approximately $5.9 billion.[28] Taken together ($15.3 billion), this is just over six percent of the nearly $237.8 billion (adjusted for 2009 inflation) in alcohol-related costs from health care, treatment services, lost productivity, and criminal justice.[29] These figures present a much more complicated picture of the potential revenue streams and costs that marijuana legalization might bring to states and localities.

The existing black market for marijuana likely will not disappear if the drug is legalized and taxed. Research by the RAND Corporation noted that "there is a tremendous profit motive for the existing black market providers to stay in the market, as they can still cover their costs of production and make a nice profit."[30]

It is for these reasons and others that the *National Drug Control Strategy* focuses on drug prevention, treatment, support for recovery, and innovative criminal justice strategies to break the cycle of arrest, incarceration, and re-arrest.

Administration Response/Prevention Efforts

Drug-Free Communities Support Program

The Administration has focused efforts on addressing the public health and public safety consequences of illegal drug use. ONDCP is taking a number of steps to prevent marijuana use by working closely with the public, particularly young people and parents. ONDCP funds the

---

[26] Office of the Deputy Attorney General. "Guidance Regarding Marijuana Enforcement." U.S. Department of Justice. [August 29, 2013]. Available: http://www.justice.gov/iso/opa/resources/305201382913275685746 7.pdf

[27] Tax Policy Center. "Annual Federal Excise Tax Revenue by Type of Tax 1996-2009." Urban Institute and Brookings Institution. [March 2011]. Available: http://www.taxpolicycenter.org/taxfacts/displayafact.cfm?Docid=74&Topic2id=80

[28] Tax Policy Center. "Alcohol Tax Revenue." Urban Institute and Brookings Institution. [December 2011]. Available: http://www.taxpolicycenter.org/taxfacts/displayafact.cfm?Docid=399

[29] Ellen E. Bouchery, Henrick J. Harwood, Jeffrey J. Sacks, Carol J. Simon, Robert D. Brewer. *Economic Costs of Excessive Alcohol Consumption in the U.S., 2006.* American Journal of Preventive Medicine - November 2011 (Vol. 41, Issue 5, Pages 516-524, DOI: 10.1016/j.amepre.2011.06.045). Available: http://www.ajpmonline.org/article/S0749-3797(11)00538-1/fulltext

[30] Pacula, Rosalie L. Legalizing Marijuana: Issues to Consider Before Reforming California State Law. RAND Corporation. [October 2009]. Available: http://www.rand.org/pubs/testimonies/2009/RAND_CT334.pdf

Drug-Free Communities (DFC) Support Program, a powerful tool supporting drug prevention efforts in communities nationwide. The rationale behind the DFC program is that local drug problems require local solutions, and since the passage of the DFC Act in 1997, ONDCP has awarded nearly 2,000 DFC grants to community coalitions across the Nation. DFC grantees have included community coalitions in all 50 states, the District of Columbia, the Virgin Islands, American Samoa, Puerto Rico, Guam, Micronesia, and Palau. With a small Federal investment, the DFC program doubles the amount of funding to address youth substance use through the DFC program's match requirement. The program currently provides grants to approximately 650 local drug-free community coalitions, enabling them to increase collaboration among community partners, including local youth, parent, business, religious, civic, law enforcement, and other groups, to prevent and reduce youth substance use, including marijuana use.

DFC coalitions across the country have identified marijuana as a significant problem in their communities. In fact, nearly 90 percent of Fiscal Year (FY) 2012 DFC coalitions list marijuana as one of their top five targeted substances, and are taking action to prevent young people from using the drug.[31] 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.

DFC coalitions are also working to prevent youth marijuana use in states with more permissive laws. For example, a DFC coalition in Mercer Island, Washington, is partnering with the local high school to produce a video to be shown to all students that advises them about Washington state law regarding minors and marijuana, as well as the consequences of breaking the law. In addition, the coalition started an outreach campaign in the community that lasted through spring and summer and included information in the City newsletter, online news outlets in the community, Faith Community outreach, and other media efforts, seeking to better inform citizens about the law and its constraints. This is just one example of the many DFC grantees around the country seeking to prevent marijuana use among young people in their communities.

Recent evaluation data indicate that where DFC dollars are invested and coalitions operate, youth substance use is lower. Between 2002 and 2012, youth living in DFC communities have experienced reductions in use of alcohol, tobacco, and marijuana among both middle school and high school students. In fact, across all DFC grantees, long-term prevalence of past 30-day marijuana use by middle school youth declined 23 percent. Marijuana use among high school youth also declined over this time period, though only by four percent.[32] Among current DFC grantees, evaluations found similar promising results among middle school youth, with the long-term prevalence rate of past 30-day marijuana use declining by 21 percent from the first to the most recent evaluation report.[33] And when compared to national trends in high school students' use of marijuana, DFC communities demonstrated consistently lower rates of use in

[31] Unpublished Drug Free Communities Support Program Evaluation Tracking.
[32] ICF International. *Drug Free Communities Support Program: 2012 National Evaluation Report.* Report Prepared for the Office of National Drug Control Policy, page 16. [June 2013]. Available: http://www.whitehouse.gov/sites/default/files/dfc_2012_interim_report_annual_report_-_final.pdf#page=18
[33] Ibid.

2003, 2005, 2007, and 2009.[34] In DFC communities, both middle and high school students' perception of parental disapproval of marijuana also increased significantly among all grantee cohorts.[35]

All of these results suggest that DFC community coalitions play a significant role in decreasing marijuana use and changing attitudes for the better among young people across the country. For these reasons, ONDCP continues to support the DFC program through training, technical assistance, and evaluation to ensure that community prevention efforts are based in evidence, and can address the challenges presented to young people by marijuana and other substances. ONDCP recently announced the FY 2013 DFC grants, including $19.8 million in new grants to 147 communities and 19 new DFC Mentoring grants across the country. These awards join the $59.4 million in DFC continuation grants released to 473 currently funded DFC coalitions and 4 DFC Mentoring continuation coalitions. Colorado currently has 5 community coalitions funded through the DFC program, and Washington state has 34 coalitions, all focused on preventing youth drug use in communities throughout their states.

National Youth Anti-Drug Media Campaign/Above the Influence

In addition, the National Youth Anti-Drug Media Campaign provides teens exposure to anti-drug messages, using targeted outreach through outlets such as online social media, radio, and television. The Media Campaign's youth-targeted "Above the Influence" (ATI) campaign balances broad prevention messaging at the national level with targeted efforts at the local community level. This approach allows the campaign to reach teens across the country with a highly visible and effective national messaging presence while encouraging youth participation with ATI at the community level. Youth-serving organizations, such as DFC grantees, Boys and Girls Clubs of America, SADD Chapters, Girls Inc., Girl Scouts, Community Anti-Drug Coalitions of America (CADCA), the National Organization for Youth Safety (NOYS), ASPIRA, and Y's (formerly YMCAs), worked directly with the Media Campaign to implement on-the-ground ATI activities with teens.

The "Above the Influence" campaign, which is being transitioned to the Partnership at Drugfree.org, is an important national tool for informing and inspiring young people to lead healthy lives that include rejecting illicit drugs, including marijuana. The new home of the ATI, the Partnership at DrugFree.org, has a long-standing commitment to educating parents and young people about the dangers of marijuana use, as well as connecting people to intervention and treatment information they may need.

Drugged Driving

Driving under the influence of drugs or alcohol continues to pose a significant threat to public safety. A systematic review of the literature indicates that acute marijuana consumption is associated with an increased risk of motor vehicle collisions resulting in serious injury or death,

[34] Ibid, pg. 17
[35] Ibid, pg. 19

compared with drivers not consuming marijuana.[36] Sadly, this is too frequently being demonstrated on America's roads. In 2009, marijuana accounted for 25 percent of all positive drug tests for fatally injured drivers for whom drug-test results were known and for 43 percent among fatalities involving drivers 24 years of age and younger with known drug-test results.[37] Moreover, approximately one in eight high school seniors responding to the 2013 Monitoring the Future survey reported driving after smoking marijuana within two weeks prior to the survey interview, more than the number who reported driving after consuming alcohol.[38]

In response to this problem, four years ago, ONDCP identified drugged driving as a national priority in the 2010 *National Drug Control Strategy* and set an ambitious goal of reducing drugged driving in America by 10 percent by the year 2015. In the four years since we started, we have made progress in addressing this issue. President Obama declared December *National Impaired Driving Prevention Month* in 2010, 2011, 2012, and 2013 and called on all Americans to commit to driving sober, drug free, and without distractions. And in October 2011, leaders in youth prevention, highway safety, law enforcement, government, and research gathered at ONDCP's Drugged Driving Summit to identify priorities to reduce this problem. At this event, ONDCP and Mothers Against Drunk Driving (MADD) agreed to raise public awareness regarding the consequences of drugged driving. The "Above the Influence" campaign also released a Drugged Driving Toolkit to assist parents and community leaders with drugged driving prevention. In 2013 and 2014, the National Transportation Safety Board has included eliminating substance-impaired driving on its Most Wanted List, the top 10 advocacy and awareness priorities for the agency.

The Administration is also making training more available to law enforcement and prosecutors, creating an online version of the Advanced Roadside Impaired Driving Enforcement program (ARIDE), a training course that gives officers additional skills to recognize signs and symptoms of drugs other than alcohol. ONDCP is also supporting driving-simulator research to examine driving impairment as a result of marijuana and combined marijuana and alcohol use and to correlate the findings with the results of oral fluid testing.

As these initiatives move forward, ONDCP continues to support enhanced laws against drugged driving. Through the dissemination of best practices guidance documents, educational packets, and webinars, ONDCP provided states with information and technical assistance needed to enact drugged driving legislation. Both Colorado and Washington have recognized that drugged driving is a significant concern, and have passed laws against driving under the influence of marijuana. Colorado passed its law setting a threshold of 5 nanograms per milliliter of delta 9-tetrahydrocannabinol in the blood as an indication of driving under the influence in

---

[36] Asbridge, M; Hayden, J.; Cartwright, J. (2012). Acute cannabis consumption and motor vehicle collision risk: systematic review of observational studies and meta-analysis, *BMJ* 201;344:e536. Available at http://www.bmj.com/content/344/bmj.e536

[37] Office of National Drug Control Policy. (October 2011). Drug Testing and Drug-Involved Driving of Fatally Injured Drivers in the United States: 2005-2009. Available at http://www.whitehouse.gov/sites/default/files/ondcp/issues-content/fars_report_october_2011.pdf

[38] Institute for Social Research, the University of Michigan. 2011 Monitoring the Future survey.

May 2013,[39] and Washington passed a similar standard as part of its marijuana legalization effort in 2012.[40]

High Intensity Drug Trafficking Areas (HIDTA) Program

ONDCP's High Intensity Drug Trafficking Areas (HIDTA) program provides assistance to Federal, state, local, and tribal law enforcement agencies operating in areas determined to be critical drug trafficking regions of the United States. The HIDTA program facilitates cooperation among an array of law enforcement agencies to share information and implement coordinated enforcement activities to improve law enforcement capabilities to reduce the supply of illegal drugs in designated areas of the United States and in the Nation as a whole. ONDCP currently funds 28 HIDTAs, which cover approximately 16 percent of all counties in the United States and 60 percent of the U.S. population. HIDTA-designated counties are located in 46 states, as well as in Puerto Rico, the U.S. Virgin Islands, and the District of Columbia.

While the HIDTA program's primary mission is to dismantle and disrupt drug trafficking organizations, expanding prevention efforts offers HIDTAs the ability to address the drug threat in a community in a more balanced fashion. As recently as 2010, only four HIDTAs used base funding for prevention initiatives. Currently, 22 HIDTAs, including all 5 Southwest Border HIDTA Regions, sponsor prevention activities. Nine HIDTAs (Houston, Michigan, Milwaukee, North Texas, Northwest, Puerto Rico, Southwest Border (SWB)-Arizona, SWB-San Diego/Imperial Valley, and Washington/Baltimore) specifically target marijuana, among other substances, in their prevention efforts. For example, the Southwest Border HIDTA–San Diego/Imperial County works closely with more than a dozen other organizations on prevention initiatives, including youth service organizations and a U.S. Border Patrol program that educates children about drug use. One of this HIDTA's primary coalition partners is California for Drug Free Youth, Inc., a DFC grantee that shares an office location with the HIDTA. The Oregon HIDTA and Oregon Partnership, another DFC grantee, work together to provide resources to law enforcement officers to educate youth on the dangers of using drugs, as well as the risks associated with use that can lead to youth violence and criminal street gangs.

In addition, ONDCP coordinates the Public Lands Drug Control Committee (PLDCC), a Federal interagency group that focuses on eliminating marijuana production on our public lands. The PLDCC aligns policies and coordinates programs to support field-level marijuana eradication operations, investigations, and intelligence and information sharing. The PLDCC also focuses on minimizing the environmental impact caused by marijuana production on public lands. Outdoor marijuana cultivation creates a host of negative environmental effects. These grow sites affect wildlife, vegetation, water, soil, and other natural resources through the use of chemicals, fertilizers, terracing, and poaching. Marijuana cultivation results in the chemical contamination and alteration of watersheds; diversion of natural water sources; elimination of

[39] Colorado General Assembly. House Bill 13-1325. [2013]. Available: http://www.leg.state.co.us/clics/clics2013a/csl.nsf/fsbillcont3/746F2A0BF687A54987257B5E0076F3CD?open&file=1325_enr.pdf

[40] Washington Liquor Control Board. I-502 Full Text. State of Washington. [2012]. Available: http://www.liq.wa.gov/publications/Marijuana/I-502/i502.pdf

native vegetation; wildfire hazards; poaching of wildlife; and disposal of garbage, non-biodegradable materials, and human waste. The PLDCC is helping coordinate research into the scope and scale of this environmental impact, and is working with Federal, state, local, and tribal agencies and stakeholder organizations to minimize the effects on our public lands.

Conclusion

We continue to work with youth, parents, educators, and our Federal, state, local, tribal, and international partners to reduce marijuana use in America. Marijuana use strains our health care system, and jeopardizes the health and safety of the users themselves, their families, and our communities. Due to the considerable variation in state laws and constantly changing attitudes toward the drug, there is no silver bullet to reduce its use across the country. There are ways to prevent and reduce marijuana use in America, particularly among young people. Our ongoing work must combine prevention, early intervention, rational enforcement measures, and ongoing study of the drug and its consequences.

Thank you for the opportunity to testify here today and for your ongoing commitment to this issue.