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OFFICE OF NATIONAL DRUG CONTROL POLICY
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Hearing on the Reauthorization of the Office of National Drug Control Policy

Committee on Oversight and Government Reform
United States House of Representatives

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Written Statement of:
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Chairman Gowdy, Ranking Member Cummings, and Members of the Committee, I am pleased to appear before you today to discuss the activities of the Office of National Drug Control Policy (ONDCP). As a long-term civil servant with over 20 years' experience at ONDCP addressing our Nation's drug abuse problem, most recently as Director of the International Division, it is a tremendous honor for me to serve as Acting Director of the agency where I have worked for decades. The strong support of the President, Vice President, and Cabinet Members for our vital work addressing the opioid crisis is deeply appreciated by the dedicated expert staff at ONDCP. This testimony describes the wide range of drug policy activities in which ONDCP is involved.

As you know, Congress established ONDCP 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. As a component of the Executive Office of the President, ONDCP establishes policies, priorities, and objectives for the Nation's drug control programs and, through its budget oversight authorities, ensures that adequate resources are dedicated to implement them. In addition, we are charged with producing the *National Drug Control Strategy (Strategy)*, the Administration's primary blueprint for drug policy. We also develop, evaluate, coordinate, and oversee the international and domestic anti-drug efforts of Executive Branch agencies and, to the extent practicable, ensure that such efforts complement state and local drug policy activities. ONDCP was most recently reauthorized by the Office of National Drug Control Policy Reauthorization Act of 2006, during the Administration of President George W. Bush.

ONDCP's Strategic Development Efforts

The *National Drug Control Strategy* provides the Nation with a comprehensive and science-based approach to reducing the use of illicit drugs and the consequences of their use. ONDCP is required, as part of its authorization, to issue an annual *Strategy*. Production of the *Strategy* is an iterative process that is guided by input from Members of Congress; other Federal drug control agencies; state, local, and tribal officials; private citizens and organizations; and appropriate representatives of foreign governments. Prior to publication, the *Strategy* undergoes a thorough interagency review overseen by the Office of Management and Budget and a review by the White House Staff Secretary.

Each Administration formulates and implements its own strategic approach to reducing the use of illicit drugs (including the misuse of controlled prescription medications) and their consequences, using varied approaches to touch on the essential ingredients of a comprehensive drug control blueprint: source country efforts, interdiction, domestic law enforcement, prevention, treatment, and recovery. Some Administrations have favored a supply-reduction approach that stressed eradication of drug crops in source countries, interdiction of drugs on the high-seas and at U.S. borders and ports of entry, and domestic law enforcement activities aimed at disrupting and dismantling drug trafficking organizations. Others have emphasized a demand-reduction approach that stressed preventing youth drug use and providing treatment to addicted populations.

ONDCP's efforts to prepare the inaugural Trump Administration *Strategy* are underway. The consultation process is completed and a kickoff meeting with the relevant senior political leadership of drug control Departments and Agencies was held in early July. We have developed

a schedule that would result in the issuance of a *Strategy* in February 2018, to accompany the President's FY 2019 budget.

Subordinate to, and consistent with, the *Strategy* are border strategies prepared by ONDCP in cooperation with relevant Federal drug control agencies to provide a strategic framework for coordinated Federal law enforcement and intelligence activities to reduce the flow of drugs, weapons, people, and cash across these borders. These include the *National Southwest Border Counternarcotics Strategy* and the *National Northern Border Counternarcotics Strategy*.

ONDCP's Research Division promotes accurate and timely data gathering and analysis to inform drug control policymakers and is responsible for annually publishing a Data Supplement to the *Strategy*. The research staff tracks and analyzes drug indicator data that captures the relative magnitude of an area's drug problem and the trajectory of the trend to enable the focus of resources and policies. Because drug production, trafficking, and use are clandestine activities, it is necessary to collect information from a variety of sources. Federal surveys provide prevalence of drug use estimates. State sources provide such information as drug overdose deaths and treatment admissions. Workplace drug testing data provide insights into the latest use trends in the workplace. Drug-related administrative data sets, measuring such items as drug price and purity, seizures, and arrests, provide unique insights on drug activity. Using such data sets, the research staff has conducted analyses that highlight the disproportionate impact of drug overdose on rural areas and, separately, the effect of illicit fentanyl on drug overdose deaths involving multiple drugs.

The Nation's Opioid Crisis

We are in the midst of an unprecedented opioid epidemic in the United States, and addressing this crisis is one of the primary focus areas of ONDCP. The Trump Administration wants to hit the ground running and address this crisis as part of a *Strategy* that will be comprehensive, including prevention, treatment, and recovery, leveraging the justice system to promote treatment, ensure strong support of drug enforcement efforts, and collaboration with international partners to reduce drug supply.

The scope of the opioid crisis is vast and traces its roots to use of prescription opioid drugs. National survey data show that in the United States in 2015, 97.5 million people (36.4% of the population) aged 12 and over¹ ever used prescription opioids, 12.5 million (4.7%) misused prescription opioids in the past year, and 3.8 million (1.4%) misused them in the prior month.² Heroin use rates are much lower than prescription opioid misuse rates.³ In 2015, 5.1 million

¹ For the remainder of the document, age 12 and over will be the demographic reported on, except where noted in the text.

² SAMHSA, Center for Behavioral Health Statistics and Quality, 2015 National Survey on Drug Use and Health, Sept 2016. Table 1.68B Any Use of Pain Relievers in Past Year and Misuse of Pain Relievers in Past Year and Past Month among Persons Aged 12 or Older, by Demographic Characteristics: Percentages, 2014 and 2015.

³ The National Survey on Drug Use and Health uses a methodology which likely undercounts heroin users who are in prison or jail or who are homeless and thus not contacted by the survey.

people (1.9% of the population) reported lifetime heroin use; only 828,000 (0.3%) reported past year heroin use, and only 329,000 (0.1%) reported past month heroin use.^{4,5}

In 2015, 2.0 million people (0.8%) met criteria for prescription opioid addiction, and 822,000 reported this being the reason for their last or current treatment episode in the past year.^{6,7,8} In addition, 591,000 people (0.2%) met criteria for heroin addiction, and 639,000 reported this being the reason for their last or current addiction treatment in the past year.^{9,10,11} No data are available to show how many people are dependent on fentanyl or its analogues.

The average amount of opioid prescribed in 2015 remains three times higher than in 1999.¹² There is great variability in morphine equivalent rate per county, suggesting that many people are using and often misusing prescription opioids, and these individuals are vulnerable to initiate illicit opioid use. This also suggests in many places that prescribers have not adopted the concept that long duration and high potency prescriptions can be dangerous.¹³ Data provided by the Centers for Disease Control and Prevention (CDC) analysis of prescriptions from IMS Health show that the amount of opioids prescribed varied widely across the country. From 2010-2015, although half of U.S. counties saw decreases in the amount of opioids prescribed per capita, nearly a quarter saw increases (see Figure 1).¹⁴

⁴ SAMHSA, Center for Behavioral Health Statistics and Quality, 2015 National Survey on Drug Use and Health,, Sept 2016. Table 1.1A Types of Illicit Drug Use in Lifetime, Past Year and Past Month Among Persons Aged 12 or Older: Numbers in Thousands, 2014 and 2015.

⁵ SAMHSA, Center for Behavioral Health Statistics and Quality, 2015 National Survey on Drug Use and Health,, Sept 2016. Table 1.1.B. Types of Illicit Drug Use in Lifetime, Past Year and Past Month Among Persons Aged 12 or Older: Numbers in Percentages, 2014 and 2015

⁶ SAMHSA, Center for Behavioral Health Statistics and Quality, 2015 National Survey on Drug Use and Health,, Sept 2016. Table 7.40A Substance Use Disorder for Specific Substances in Past Year among Persons Aged 12 or Older: Numbers in Thousands, 2002-2015

⁷ SAMHSA, Center for Behavioral Health Statistics and Quality, 2015 National Survey on Drug Use and Health,, Sept 2016. Table 7.40B Substance Use Disorder for Specific Substances in Past Year among Persons Aged 12 or Older: Percentages, 2002-2015

⁸ SAMHSA, Center for Behavioral Health Statistics and Quality, 2015 National Survey on Drug Use and Health,, Table 5.22A Substances for Which Last or Current Treatment Was Received among Persons Who Received Substance Use Treatment in Past Year, by Age Group: Numbers in Thousands, 2014 and 2015

⁹ SAMHSA, Center for Behavioral Health Statistics and Quality, 2015 National Survey on Drug Use and Health,, Sept 2016. Table 7.40A Substance Use Disorder for Specific Substances in Past Year among Persons Aged 12 or Older: Numbers in Thousands, 2002-2015

¹⁰ SAMHSA, Center for Behavioral Health Statistics and Quality, 2015 National Survey on Drug Use and Health,, Sept 2016. Table 7.40B Substance Use Disorder for Specific Substances in Past Year among Persons Aged 12 or Older: Percentages, 2002-2015

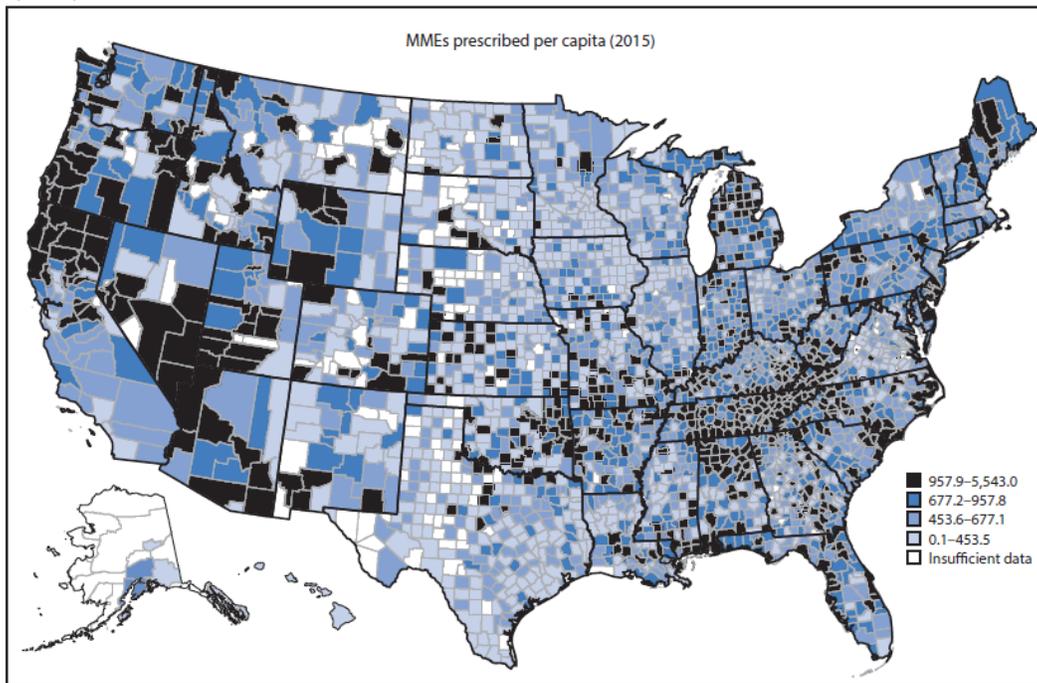
¹¹ SAMHSA, Center for Behavioral Health Statistics and Quality, 2015 National Survey on Drug Use and Health,, Table 5.22A Substances for Which Last or Current Treatment Was Received among Persons Who Received Substance Use Treatment in Past Year, by Age Group: Numbers in Thousands, 2014 and 2015

¹² Guy GP Jr, Zhang K, Bohm MK, Losby J, Lewis B, Young R, Murphy LB, Dowell D Vital Signs: Changes in Opioid Prescribing in the United States, 2006-2015. MMWR Morb Mortal Wkly Rep. 2017 Jul 7;66(26):697-704. doi: 10.15585/mmwr.mm6626a4. <https://www.cdc.gov/mmwr/volumes/66/wr/pdfs/mm6626a4.pdf>.

¹³ Ibid

¹⁴ Ibid

Figure 1. Morphine milligram equivalents (MMEs) of opioid prescribed per capita in 2015¹⁵



Data for the years 2011-2014 show that an estimated 2.2 million people aged 12 or older nationwide had opioid dependence or abuse in the past year, and that the estimated “treatment gap” – people with opioid addiction who need treatment but did not receive it – was 1.7 million (82%).¹⁶ The treatment gap is highly influenced by a lack of adequately trained and credentialed health care providers. Recent workforce projections indicate that significant shortages of treatment professionals are expected by 2025. Rural areas are especially affected by provider shortages.

There have been significant increases in treatment for opioid addiction through the expansion of medication-assisted treatment (MAT) – using FDA-approved medications for opioid addiction (methadone, naltrexone (Vivitrol), and buprenorphine (Suboxone)) – in conjunction with behavioral therapies. Regulatory changes in 2016 expanded the numbers of patients that one physician could treat with buprenorphine, and the *Comprehensive Addiction and Recovery Act* permits MAT by nurse practitioners and physician assistants, which may help in rural areas that often lack a sufficient number of providers certified to prescribe buprenorphine.

With the growing numbers of women with opioid addiction, more babies are being born with neonatal abstinence syndrome (NAS). MAT is effective in these cases and is the treatment of choice for pregnant women. NAS is prevalent in some American Indian and Alaska Native (AI/AN) communities, and the drug overdose rate among AI/AN people is almost twice that of the general population.

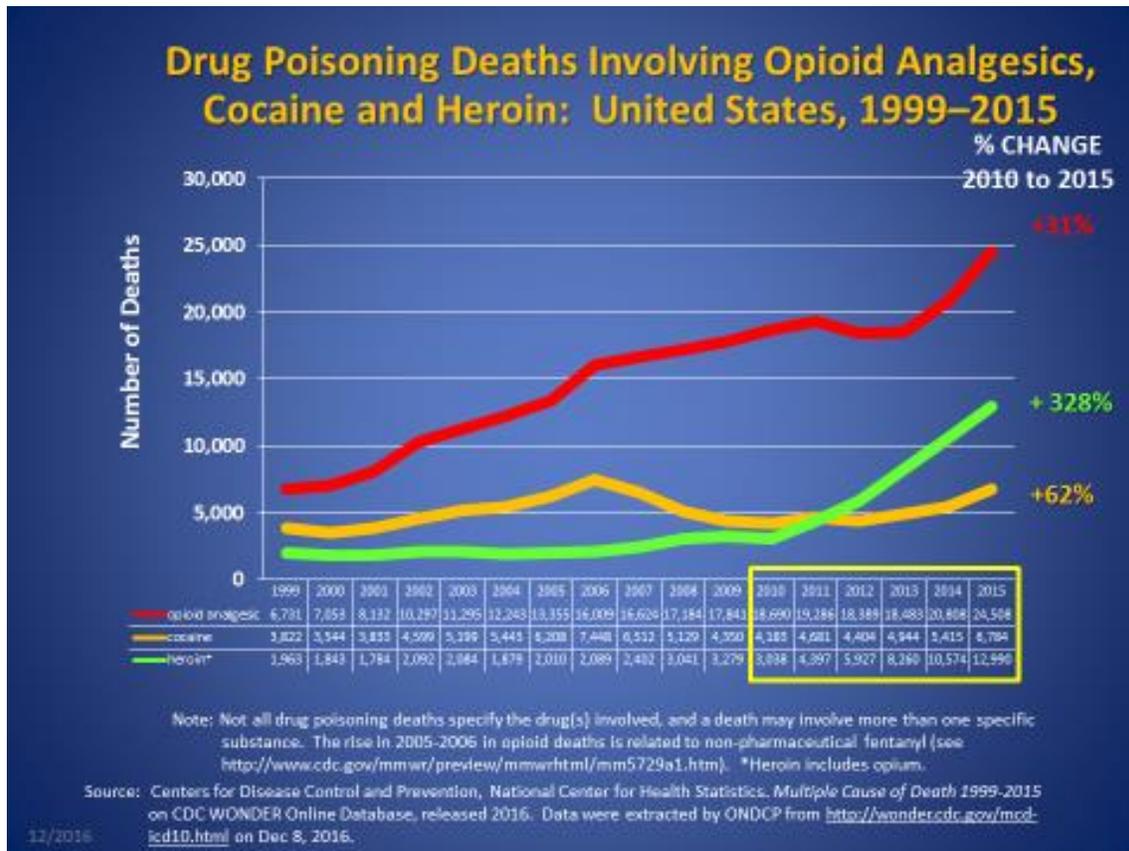
¹⁵ Ibid

¹⁶ SAMHSA, Center for Behavioral Health Statistics and Quality. National Survey on Drug Use and Health, 2011-2014. Unpublished special tabulations (2016).

Overdose Mortality

According to the CDC, in 2015, the most recent year for which data are available, deaths from drug overdoses numbered 52,404, an 11 percent increase from 2014.¹⁷ Deaths from drug overdose outnumbered all other injury death categories, including those involving firearms and deaths from suicide, homicide, and motor vehicle crashes.¹⁸

Figure 2.



Opioids made up the largest category of drugs contributing to overdose deaths in America. Drugs categorized as opioids were involved in 33,091 deaths, a 16 percent increase from 2014.¹⁹ Since 1999, nearly 310,000 people died from an overdose involving an opioid.²⁰ Most of these deaths involved prescription opioid analgesics, as shown in Figure 2. Opioid analgesics are pain medications including drugs such as oxycodone, methadone, and fentanyl.

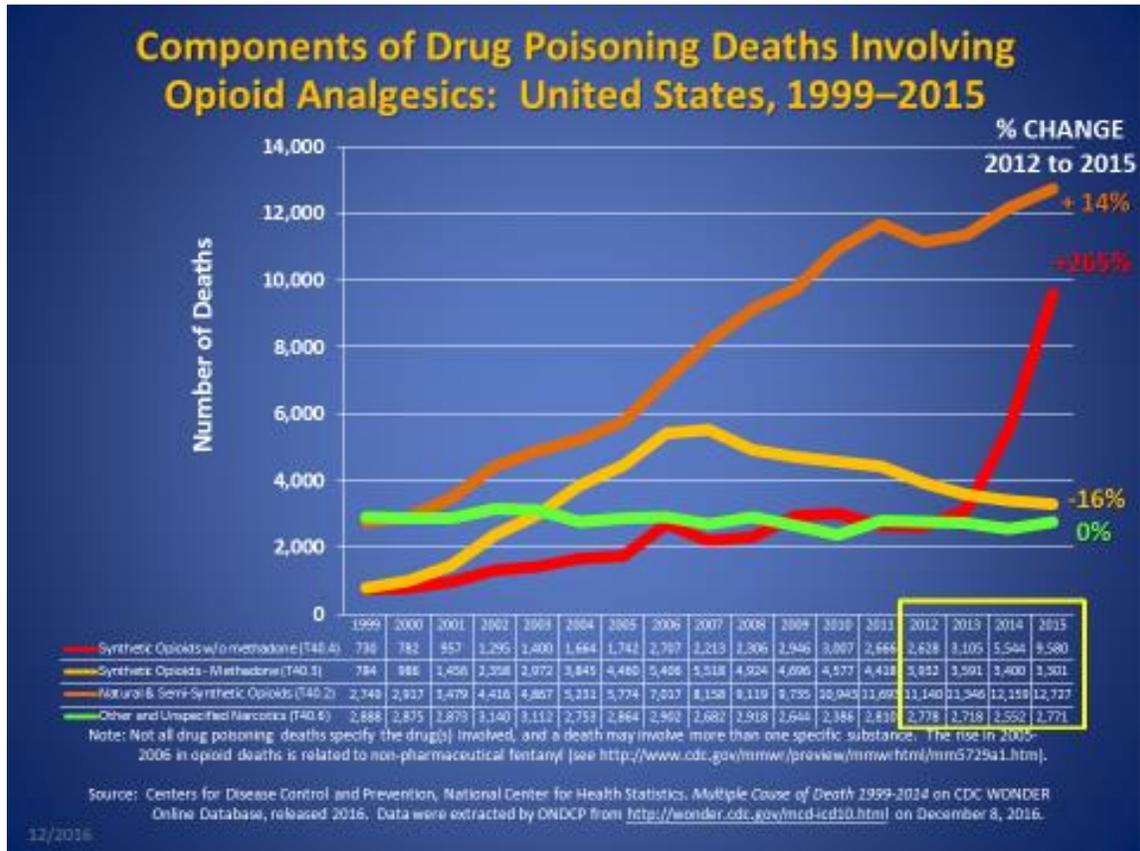
¹⁷ Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999–2015 on CDC WONDER Online Database, released 2016. Data were extracted by ONDCP from <http://wonder.cdc.gov/mcd-icd10.html> on Dec 8, 2016.

¹⁸ Ibid

¹⁹ Ibid

²⁰ Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999–2014 on CDC WONDER Online Database, released 2016. Data were extracted by ONDCP from <http://wonder.cdc.gov/mcd-icd10.html> on December 8, 2016.

Figure 3.



Further analysis of the various components of drug overdose deaths involving pain medications shows the effect of the recent increases in fentanyl into the U.S. market (see Figure 3). The red line in Figure 3 measures the number of overdose deaths involving synthetic opioids other than methadone, a category primarily including illicit fentanyl. From 2013-2015, drug overdose deaths in this category increased over 200 percent.²¹ In 2015, overdose deaths involving natural and semi-synthetic opioids, which include oxycodone and hydrocodone (12,727) reflected only a five percent increase over 2014 and a three percent change in the population age-adjusted death rate.²²

Actions Taken

ONDCP, along with our executive agency partners, has been committed to addressing the evolving crisis favoring a comprehensive approach to address many aspects of prescription opioid misuse and illegal opioid use. Many prescription opioid misuse deaths have occurred in people with apparently legitimate prescriptions. Therefore, addressing the opioid mortality rate is not only a matter of engaging people with opioid addiction in treatment, but also providing better pain management oversight for patients who providers treat with opioids.

²¹ Ibid

²² Ibid

The Federal Government's strategies for addressing prescription opioid misuse have included efforts to: educate prescribers and the public concerning risks and their management; decrease the excess supply and availability by, for example, decreasing quotas in 2016 and approving partial fill of opioid prescriptions for schedule II drugs; prevent unused opioids from being diverted for misuse by creating additional opportunities for disposal of prescribed opioids; improve the monitoring of patient opioid use and prescriber practices through electronic prescription drug monitoring (PDMP) databases, pharmacy benefits management programs, and offering regulation for electronic prescription of controlled substances; enhance laws and heightening enforcement; support novel pain and addiction medication development and pain treatments; and raise awareness and create opportunities for overdose prevention with naloxone and follow-up engagement in care.

The current epidemic of drug overdose deaths continues to be a tremendous strain on state and community resources as public health and public safety officials struggle to respond. It is a particular challenge for rural communities that have fewer resources and often are hard-pressed to address health problems, much less the challenge of a growing and evolving opioid epidemic. In addition, far too few Americans needing treatment for drug addiction access treatment services. This includes individuals who have opioid addiction and who have experienced potentially fatal overdoses. Engagement mechanisms beyond standard screening approaches need to be explored, to include the many pathways to treatment that can potentially be provided at the scene of an overdose, at the emergency room, or even prior to an arrest for a non-violent drug offense.

Across the Nation, emergency physicians, hospitals, and others are developing innovative approaches to more effectively respond to opioid overdose and opioid addiction, such as buprenorphine induction in the emergency department followed by direct linkage to primary care and other services. Additionally, we have seen an increase in 24-hour crisis lines to dispatch recovery coaches/peer specialists to emergency departments or to the site of overdose reversals in the community and teams of recovery coaches/peer recovery support specialists who are on-call to engage overdose survivors in the emergency department and provide direct linkage to treatment and ongoing recovery support.

ONDCP has been actively engaged with a number of innovative approaches, often spearheaded by or incorporating local law enforcement, fire departments, and the treatment community, and that are developed through grassroots efforts in communities hard hit by the opioid epidemic. These efforts offer examples of communities responding to the crisis in their backyard, and we are working with these organizations to learn from their successes, and to help accelerate these programs by providing models and best practices that can be replicated across the country.

It must be noted that actions to encourage providers to prescribe fewer opioids need to be balanced with the need to address pain. Providers often lack education on smoothly transitioning patients from opioids, on recognizing misuse and addiction, or on recommending alternatives to opioids to treat pain.

The President’s Commission on Combating Drug Addiction and the Opioid Crisis

In March 2017, President Trump established the Commission on Combating Drug Addiction and the Opioid Crisis (Commission) to study the scope and effectiveness of the Federal response to drug addiction and the opioid crisis and to make recommendations to the President for improving that response. I serve as the Executive Director of the Commission, and ONDCP provides administrative support as the Commission develops its interim and final reports. Once the Commission submits its final report to the President, we expect to have a major role on the President’s behalf in the consideration and implementation of the recommendations contained therein.

ONDCP’s Policy Work

The majority of ONDCP’s policy work is conducted by experts in the Office of Policy, Research, and Budget, the latter two of which have been covered in the *Strategy* section of this testimony. Activities to address prevention, treatment, and recovery are at the heart of ONDCP’s efforts to reduce the demand for drugs, while efforts to reduce the supply of illicit drugs into our country are pursued by policy experts in our International Division and Coordination Groups, as well as the U.S. Interdiction Coordinator. ONDCP also has an Office of Intelligence that provides analytic support of intelligence-related issues and coordinates drug-related Intelligence Community and law enforcement intelligence efforts.

Prevention

To address the many challenges of substance abuse, ONDCP encourages investing in evidence-based prevention programs as the key to reducing drug use among youth. Evidence-based prevention programs are interventions that have been evaluated rigorously and found to have a favorable impact on a relevant youth outcome. Each dollar invested in an effective school-based drug prevention program can reduce costs related to substance abuse by an average of \$18.²³ Prevention programs that are evidence-based can prevent young people from initiating substance abuse, including use of alcohol, misuse of prescription drugs, and use of illicit drugs.

The most effective prevention messaging is not drug-specific, but rather a general message that links drug use prevention with better health and well-being overall. Prevention is most successful when programs identify enhancing risk protective factors and reversing risk factors as one of seven key principles for preventing drug use. Drug education programs that focus on the harms of specific drugs are not identified as “evidence-based”.²⁴ Due to the nature of prescribed opioids and the population susceptible for abuse, misuse, and accidental overdose, prevention initiatives for these drugs will differ from other illicit drugs.

²³ Miller, T. and Hendrie, D. Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis, DHHS Pub. No. (SMA) 07-4298. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2008.

²⁴ National Institute on Drug Abuse./ Preventing Drug Use among Children and Adolescents (In Brief); A research based-Guide for Parents, Educators, and Community Leaders. 2nd Edition. Available https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/preventingdruguse_2_1.pdf.

ONDCP coordinates with prevention, public health, and youth development stakeholders as well as other Federal agencies to educate youth about the health implications of drug use, increase the use of evidence-based prevention practices, and implement environmental policies to make communities safer. ONDCP also oversees the prevention inter-agency workgroup (IWG), which brings together 15 Federal agencies to increase the use of evidence-based programs, policy, and practices across multiple settings using a multi-disciplinary approach.

ONDCP is working with the Interagency as part of the development of the *National Drug Control Strategy* to look at ways to expand prevention messaging efforts, as part of an integrated Federal, state, and local prevention effort that also includes school-based programs. I have met with Cabinet officials to discuss this prevention effort, and these discussions have been very encouraging.

Treatment

ONDCP operates at a unique level to heighten awareness and unite the Nation in addressing drug abuse and its consequences. ONDCP is actively involved in raising awareness of the need for treatment, promoting research on the efficacy of treatment, and coordinating services and practices across multiple systems to ensure access to evidence-based treatment. ONDCP has been a leading partner in designing, collecting, and reporting rigorous data to shape the Federal Government's understanding of elements of successful treatment, and the challenges and opportunities to influence efficacy of treatment.

ONDCP also has a critical role to play, along with the National Institutes of Health and other scientific research agencies and researchers in the field, in setting the national research agenda around treatment and promoting the science of addiction and evidence-based treatment. Research on the neuroscience of addiction as a brain disease with psychological and behavioral components has helped to shape important shifts in policy that integrate a public health approach to drug policy.

A substantial part of ONDCP's efforts have focused on bringing drug treatment into mainstream healthcare, including greater awareness of addiction to licit and illicit substances by medical providers, increased avenues to provide intervention and referral to treatment when necessary, compliance with parity laws, and the advancement of Addiction Medicine as a medical specialty. For example, ONDCP has worked to support early intervention with substance abuse through Screening, Brief Intervention and Referral to Treatment (SBIRT), a comprehensive, research-based framework that provides healthcare providers with skills to discuss health behavior changes with their patients.

Recovery

Expanding access to treatment alone, however, is not sufficient. We must also work to eliminate the stigma and misunderstanding that deter so many Americans from seeking treatment; we must eliminate barriers to fully rejoining and contributing to the community following treatment; and, we must put in place the services and supports that will help people sustain recovery and that will reduce the need for multiple treatment episodes and repeated encounters with the criminal justice system.

The 2015 National Survey on Drug Use and Health found that the largest proportion of people who needed treatment but who did not receive it and felt the need for it, reported believing that they were not ready to stop using drugs.²⁵ This is a belief many in recovery report having held until their problem had become so severe and had done so much damage that they could no longer maintain this belief – or until they found themselves confronted with a choice of incarceration or other severe consequences and treatment.

ONDCP has worked extensively to educate and inform and to shift attitudes and perceptions about addiction and recovery among the public, health professionals, and policymakers. Among our greatest allies in this effort are those who have experienced addiction and have found recovery and their families. ONDCP seeks to identify new ways to share the message about addiction and recovery, including through social media campaigns, speeches, newsletters, and other publications.

Criminal Justice Efforts

In many cases, untreated drug addiction motivates criminal activity under the influence of or in the pursuit of illicit drugs. The result of this that is too many people end up incarcerated instead of receiving the treatment they need. Nearly one-third (30%) of referrals to treatment come from the criminal justice system.²⁶ For many persons, engagement with the criminal justice system is the first opportunity to access treatment services for drug addiction.

ONDCP has focused on supporting ways for the criminal justice system to better address its populations who engage in substance abuse, integrating public health and public safety through growth in diversion and alternatives to incarceration, such as drug treatment courts, family drug courts, juvenile drug courts, and swift and certain sanction programs. Such changes have also guided efforts to provide drug treatment during incarceration much like other health services provided to offenders. ONDCP has placed particular emphasis on ensuring the use of MAT as the evidence-based approach to services for justice-involved populations with opioid use addiction because of the high risk for relapse and fatal overdose following release from incarceration.

ONDCP has convened leaders in the corrections field at the Federal, state, and local levels (e.g., National Sheriffs Association, Association of State Correctional Administrators, National Drug Court Institute, and the Large Jail Network of the American Corrections Association), to encourage the adoption of best practices to provide treatment, while ensuring safety within facilities. ONDCP has been an active supporter of collaboration between the National Institute of Corrections and the Bureau of Justice Assistance on an initiative using Centers of Innovation to provide training and technical assistance from peer correctional institutions, and expand wider adoption of MAT.

²⁵ SAMHSA, Center for Behavioral Health Statistics and Quality. 2015 National Survey on Drug Use and Health: Detailed Tables (table 5.61B).

²⁶ SAMHSA, *2015 Treatment Episode Data Set, table 2.6b* (February 2017).

International Efforts

Many of the drugs threatening the health and well-being of our communities are produced abroad, and ONDCP's International Division works with international partners and Federal drug control agencies to reduce the supply of drugs entering the United States, while also helping partner nations to develop stronger institutions to resist the corrupting influence of drugs and build communities through expansion of prevention, treatment, and recovery initiatives.

In concert with the NHCG and NCCG, the International Division works directly with source and transit countries as well as with countries who are also threatened or affected by the global drug trade. The International Division also synchronizes and focuses the bilateral, regional, and multilateral work of U.S. drug control agencies to ensure Federal operational and programmatic activities are targeted, coordinated, and support the Administration's drug control policies.

Through a variety of working groups, Memorandums of Intent, and other mechanisms, ONDCP works with source countries such as China and Mexico to increase their domestic controls on illicit substances and transparency in global movement of precursor chemicals. International efforts also include strong U.S. collaboration with countries that share similar drug problems, such as Canada, the United Kingdom, and Australia. This includes exchanging information in real time about emerging and evolving drug threats; implementing innovative domestic responses; and aligning approaches and support for source and transit countries.

The International Division also leads or provides policy guidance for a number of regional mechanisms to help dismantle the drug trafficking networks in the Western Hemisphere. These include the North American Drug Dialogue with Canada and Mexico and Organization of American States Inter-American Drug Abuse Control Commission (known as CICAD).

Similarly, the International Division supports interagency preparations for multilateral engagements, including the annual United Nations Commission on Narcotic Drugs (CND), providing policy guidance on key issues and policy priorities for the U.S. delegation's activities. Since 2007, the CND has passed eight resolutions, with leadership from the United States, to reduce the manufacture, distribution, and availability of synthetic drugs and precursor chemicals. These resolutions have also strengthened the International Narcotic Control Board's (INCB) authority to follow up through communications with individual countries about problematic shipments and to launch regional cooperative time-limited operations to identify primary chemical trafficking routes. In recent years, in response to the domestic opioid crisis, ONDCP alerted interagency partners to the illicit fentanyl threat and, with the Department of State and the Department of Justice (DOJ), successfully supported a request from the U.S. Secretary of State to the United Nations Secretary General to consider a review of two fentanyl precursors (4-anilino-N-phenethylpiperidine (ANPP) and N-phenethyl-4-piperidone (NPP)) for international control. In March 2017, 51 CND Member States voted to control the precursors. The INCB also recently added ANPP and NPP to its special surveillance list of non-scheduled substances.

More recently, the United States initiated the process to review carfentanil for international scheduling. ONDCP, working with DOJ and the Department of Health and Human Services (HHS), provided much of the input necessary to show cause for the request and continues to

work closely with the Department of State and HHS ensure the review of substances for scheduling.

The National Heroin Coordination Group

In addition to its other activities with the Interagency to address the opioid epidemic, in November 2015, ONDCP established the National Heroin Coordination Group (NHCG), in coordination with the National Security Council, as the hub of a network of interagency partners to leverage agency authorities and resources and synchronize their activities against the heroin and illicit fentanyl supply chains to the United States. ONDCP formulated the NHCG to be uniquely positioned to identify gaps and redundancies in U.S. efforts, connecting actions taken on the front end of the supply chain with effects on the domestic market and user population.

Among its initial actions, the NHCG developed a Heroin Availability Reduction Plan (HARP), in close coordination with its interagency partners to synchronize the strategies and partnerships at the Federal, state, local, and tribal levels to reduce the availability of heroin and illicit fentanyl. Such coordination of multi-agency, multi-jurisdictional actions, including investigations and prosecutions, against the organizations that are manufacturing and distributing heroin and illicit fentanyl directly contribute to the overall goal of reducing the availability of these drugs in the United States.

Early on, ONDCP made the decision that the HARP would deliberately conflate heroin and illicit fentanyl into a single problem-set. Traffickers sometimes add fentanyl as an adulterant to boost the effect of their heroin, or mix it with diluents to create and sell as synthetic heroin, and they likely utilize the same supply chains and distribution mechanisms for both drugs. Moreover, both heroin and fentanyl belong to the same class of opioids that create a similar effect in the user, often making their user populations one and the same. And finally, addressing both heroin and illicit fentanyl in a singular fashion minimizes the chance of accelerating the growth of exclusive illicit fentanyl use by addressing it as part of the larger heroin problem.

Law enforcement efforts to disrupt the supply of heroin and illicit fentanyl – from manufacture, through transport, and to sale – are having some impact on availability in the U.S. market. However, in focusing our attention on the connection between actions on the front end of the supply chain with the effects on the domestic market and user population, we can assess the strength of that impact on use, overdose, and mortality rates and its long-term sustainability. The desired HARP outcome is a significant reduction in the number of heroin-involved deaths in the United States due to a disruption in supply chains through the complementary effects of international engagement, law enforcement, and public health efforts.

The NHCG hosts eight coordination meetings per month to facilitate and drive discussion and data sharing throughout all levels of government, which allows for Federal law enforcement engagement and open dialogue with the public health community across the United States. Notably, on public health community calls, Federal and state public health professionals share near-real-time overdose data with each other and with law enforcement, which provides a critical early warning window for other stakeholders and helps inform our understanding of the problem. In a recent session, four out of five states reported that fentanyl caused more overdose deaths than heroin. While this information points to an alarming shift, our early access to this

information will be used to alert and help prepare Federal and state public health and law enforcement professionals in other states for this change in the trafficking and use environment. Absent these coordination meetings, we would have to rely on annual mortality data sets and lose valuable time as we work to simultaneously reduce the number of people who use these substances and disrupt the heroin and illicit fentanyl supply chain.

As a result of HARP implementation, information-sharing, and coordination, the NHCG is better informed and more prepared to work to reduce overall heroin and illicit fentanyl availability, which allows the following:

- We can discover, identify, and disseminate information about the rapid changes to various fentanyl-family drugs. For example, when carfentanil, a powerful fentanyl-family drug used as a large animal tranquilizer, entered the illicit market and caused several multiple death overdose outbreaks, we were able to recognize and respond to its emergence.
- We have been able to focus efforts to identify the source of production of fentanyl and fentanyl analogues. Compared to heroin, which is derived from a plant that can be tested to determine geographical origin, fentanyl is synthesized from chemicals in a laboratory, making identification of its manufacturing origin extraordinarily difficult.
- Agencies are sharing important information to help law enforcement detect fentanyl in the field, including technology that is available or under development, as well as improving the efficacy of training techniques to assist in fentanyl detection.
- Agencies are successfully coordinating efforts to detect packages at international mail facilities, looking for illicit fentanyl shipments originating abroad.
- Federal health agencies are more directly engaging in collaborative efforts with Federal law enforcement agencies to share information, collaborate on a comprehensive response, and discuss strategies to effectively address the evolving opioid epidemic.
- The NHCG worked with HHS and CDC's National Institute for Occupational Safety and Health to produce science-based handling instructions for fentanyl and disseminated those instructions to Federal agents and local police to better protect law enforcement and first responders from potential fentanyl exposure.

The NHCG is also engaged with Mexico, China, and Canada on these drugs. With the Department of State, ONDCP has engaged in high-level bilateral discussions with Mexico to emphasize the importance of increased poppy eradication efforts by the Government of Mexico, as well as drug interdiction, clandestine laboratory destruction, and disruption of precursor chemical trafficking. We have also had successes in our work with the People's Republic of China. After the United States raised the need for better regulation of Chinese chemical and pharmaceutical industries at a number of high-level engagements, including the Strategic and Economic Dialogue and the Law Enforcement Joint Liaison Group, China responded by domestically controlling 116 of such substances in 2015, and another four critical fentanyl

analogues, including carfentanil, on March 1, 2017.

The National Cocaine Coordination Group

Of course, in addition to addressing issues surrounding the opioid crisis, ONDCP must also keep a watchful eye for issues concerning emerging or re-emerging drug availability and use. For instance, coca cultivation and cocaine production in the Andean Region of South America have dramatically increased in recent years.²⁷ This rapid increase in cocaine availability threatens U.S. national security interests and has the strong potential to undercut U.S. foreign policy goals by further undermining the rule of law and exacerbating violence, corruption, and drug use in the Western Hemisphere. A surge of cocaine in the United States may create an additional public health crisis and strain over-burdened medical, law enforcement, and emergency services entities. This rapid increase in cocaine availability threatens to reverse the gains we have made to reduce cocaine consumption. The number of current cocaine users rose by nearly 40 percent to 1.9 million in 2015, from the low in 2011.²⁸ Cocaine-involved drug overdose rose 45 percent, to 6,784, over the same period.²⁹

Given these circumstances, ONDCP established a National Cocaine Coordination Group (NCCG) in 2016 to develop a proactive response to counter the impact of the increased cocaine supply on the United States. The strategic goal of the NCCG is to significantly prevent and reduce cocaine use. Since the anticipated domestic impacts of rising cocaine supplies are only beginning to be felt in the United States, an opportunity exists to strengthen the response *now*, before our Nation experiences a resurgent cocaine crisis. In order to do this, appropriate Federal agencies must closely coordinate with state, local, and tribal agencies, as well as international partner nations and non-government organizations, to address three principal areas:

1. Focus the domestic public health and safety response on at-risk people and communities.

Federal departments and agencies have an opportunity to act definitively before the early indications of increased cocaine use in the United States adversely impact public health and safety. Strengthening the continuum of care – including prevention and early intervention with at-risk people, as well as treatment and recovery services for people diagnosed with a cocaine addiction – will be key to mitigating the impacts of increased cocaine availability.

Unfortunately, as we have seen with the heroin and illicit fentanyl issue, most current datasets have significant delays that limit their predictive value for identifying at-risk people and communities. Consequently, the first step in the implementation of the domestic response should focus on identifying preliminary indicators and sharing those among law enforcement, judiciary, criminal justice, prevention, treatment, and recovery communities of interest.

Efforts should encourage continued research on expanding SBIRT; and support for research to develop and test new treatment options for cocaine addiction. In addition,

²⁷ CNC Annual Coca Production Estimates

²⁸ SAMHSA, 2015 National Survey on Drug Use and Health (September 2016).

²⁹ Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2015 on CDC WONDER Online Database, released Dec. 2016.

efforts to promote information-sharing among Federal, state, and local officials are essential to understanding the effects of use.

2. Disrupt and dismantle major cocaine trafficking organizations through enhanced intelligence sharing, de-confliction, and coordinated interdiction and law enforcement efforts.

Federal agencies conduct robust efforts to identify, disrupt, and dismantle major transnational criminal organizations through a range of U.S. and partner nation actions, including investigations, prosecutions, interdiction, and financial sanctions. This work is coordinated and de-conflicted through interagency entities, including the Drug Enforcement Administration's Special Operations Division (SOD) and the Organized Crime Drug Enforcement Task Forces (OCDETF), by focusing on the Consolidated Priority Organization Target (CPOT) list, a multi-agency list of the command and control elements of the most prolific international drug trafficking and money laundering organizations.

Financial gain both sustains and incentivizes cocaine trafficking, especially to U.S. markets. Therefore, we are working to deepen our understanding of these illicit financial flows to ensure that they are an integral aspect of investigative efforts to disrupt and dismantle transnational criminal organizations.

3. Reverse the spike in coca cultivation and cocaine production.

More than 90 percent of the cocaine entering the United States originates in Colombia.³⁰ Recently released U.S. Government coca cultivation estimates for Colombia indicate that there were 188,000 hectares under production in 2016, an 18 percent increase from 2015 and the highest number ever recorded. This equates to a record potential production of 710 metric tons of pure cocaine from Colombia alone during 2016.³¹ Peru and Bolivia are similarly experiencing resurgent levels of coca cultivation, although most of the cocaine produced in these nations is primarily destined for consumer markets in South America, Africa, Europe, and Asia.

The drivers behind the rapidly expanding coca cultivation in Colombia are complex. For example, the Colombian Government terminated aerial eradication in 2015 and significantly reduced manual eradication efforts. Coincident with the reduction of supply reduction efforts, the Revolutionary Armed Forces of Colombia (FARC) leadership reportedly encouraged increased coca cultivation in areas it controls. The U.S. Government strongly supports the Colombian peace process, but we need to ensure that as the Government of Colombia implements this historic accomplishment, significant efforts are maintained to constrain coca cultivation and cocaine production. We have discussed our concerns with the Government of Colombia, which has committed at the highest levels to redouble its efforts against coca cultivation, as well as the production and transportation of cocaine.

³⁰ DEA Cocaine Signature Program

³¹ U.S. Government Estimate

The U.S. Interdiction Coordinator

As set out in ONDCP's authorization statute, the ONDCP Director appoints the U.S. Interdiction Coordinator and The Interdiction Committee Chairman. Both advise the Director on Federal interagency illicit narcotics supply reduction and interdiction efforts. The U.S. Interdiction Coordinator's responsibilities include the coordination of the interdiction activities of the National Drug Control Program agencies. This is primarily accomplished through the development and issuing of the National Interdiction Command and Control Plan (NICCP).

The NICCP establishes the Government's strategy for drug interdiction, states the specific roles and responsibilities of the relevant national Drug Control Program agencies for implementing that strategy, and identifies the resources required to enable the agencies to implement that strategy. James Olson, RADM USCG (ret) is currently the U.S. Interdiction Coordinator.

The Interdiction Committee (TIC) is an interagency body of Federal senior executives who regularly meet to discuss and resolve key issues related to the coordination, oversight and integration of international, border, and domestic drug interdiction efforts in support of the *National Drug Control Strategy*. TIC also reviews the NICCP and provides advice to the Director and the U.S. Interdiction Coordinator concerning that plan. TIC Chairman currently is Admiral Paul Zukunft, the Commandant of the U.S. Coast Guard.

ONDCP's Grant Programs: HIDTA and DFC

In addition to the activities discussed above focused on drug policy across the Federal Government, ONDCP administers two significant grant programs, the High Intensity Drug Trafficking Areas Program and the Drug-Free Communities Support Programs.

High Intensity Drug Trafficking Areas (HIDTA) Program

The High Intensity Drug Trafficking Areas Program, which was created as part of ONDCP's original authorization, provides essential assistance to Federal, state, local, and tribal law enforcement agencies operating in 28 regions of the United States determined to be critical drug trafficking areas. The HIDTA Program invests in law enforcement partnerships in order to combat drug trafficking in our cities, at our borders, and along our highways. The program demonstrates a return on investment in both drug and cash seizures. The HIDTA Program also serves as an incubator, where innovative strategies move from conception to implementation. Above all, because of the role played by state and local law enforcement in leading the regional HIDTA Programs and shaping their approaches, the HIDTA Program addresses the specific needs of each community.

Currently, the 28 regional HIDTAs include designated areas in 49 states, Puerto Rico, the U.S. Virgin Islands, and Washington, D.C. These regional HIDTAs facilitate cooperation among Federal, state, local, and tribal law enforcement to share intelligence and implement joint enforcement activities. The HIDTA Program supports law enforcement strategies that leverage and supplement existing resources to target the most dangerous drug traffickers and to reduce the supply of illegal drugs in the United States. The 28 regional HIDTAs bring together more than 800 initiatives and more than 6,000 Federal agents and analysts and 15,000 state, local, and tribal

officers and analysts. In total, more than 500 Federal, state, local, and tribal agencies participate, coordinate and collaborate directly with HIDTA task forces.

The HIDTA Program accomplishes its mission to disrupt and dismantle drug trafficking and money laundering organizations by: 1) facilitating cooperation among Federal, state, local, and tribal law enforcement to share intelligence and implement law enforcement activities; and 2) supporting coordinated law enforcement strategies that leverage available resources to reduce the supply of illegal drugs in the United States. In 2016, the regional HIDTA Programs collectively disrupted or dismantled 2,600 drug trafficking or money laundering organizations, removed illicit drugs valued at more than \$17 billion wholesale from the Nation's communities, made 80,000 drug-related arrests, and apprehended 47,000 fugitives. In addition, every regional HIDTA Program works to ensure the safety of all law enforcement officers operating in their regions – whether they formally participate in HIDTA or not – by offering essential training and de-confliction services which are critical tools in preventing conflicts in the field between officers of differing jurisdictions.

Each regional HIDTA is controlled by an equal number of state/local and Federal agency law enforcement executives. The combined Federal, state, and local perspectives of the drug threats in those communities develop a more comprehensive approach to this Nation's drug problem, but also allow early identification of emerging or evolving threats.

Participating HIDTA partners provide direct insight into drug activity everywhere in the United States, at the land and maritime borders, on the highways and streets, and in schools and homes. State and local partners also provide a distinct vision that equips the regional HIDTA Programs to try new approaches, and the network of programs enables the sharing of ideas with communities facing similar threats that may not be in close geographical proximity.

The HIDTA Heroin Response Strategy (HRS) is an example of HIDTA's ability to swiftly identify and respond to drug threats. In 2015, the HRS was launched with an initial investment of \$2.5 million in HIDTA funds to address the heroin and opioid epidemic by coordinating the efforts of regional HIDTA Programs across 17 states. In 2016, the initiative received \$3.9 million in HIDTA funds and was expanded to three additional states. At present, the HRS brings together eight regional HIDTAs. The HRS has an ambitious goal – to leverage its strategic partnerships to target the organizations and individuals trafficking deadly drugs like heroin and fentanyl so that overdoses are reduced and lives are saved. The HRS is achieving this goal by creating a human network spanning the law enforcement and public health communities to share actionable information. For example, drug intelligence officers (DIOs) track and relay drug-related felony arrests of out-of-state residents and then report this information to the individual's home law enforcement agency. Since January 2016, DIOs have shared more than 6,000 of these felony arrest notifications. In multiple instances, the sharing of drug intelligence across the HRS network resulted in the identification and arrest of heroin/fentanyl distributors linked to outbreaks of fatal and non-fatal overdoses.

Drug-Free Communities (DFC) Support Program

The Drug-Free Communities Support Program, created by the Drug-Free Communities Act of 1997, serves as the Nation's leading prevention effort to mobilize communities to prevent and

reduce youth substance abuse. The DFC Program has two main goals: 1) establish and strengthen collaboration among communities; and 2) reduce substance abuse among youth. The DFC Program funds community coalitions to prevent and reduce youth substance abuse by emphasizing finding local solutions for local problems. DFC-funded coalitions are made up of representatives from twelve sectors of the community that organize to meet the local prevention needs of the youth and families in their community. Since 1998, the DFC Program has consistently been successful in meeting the DFC Program's goals as demonstrated in its National Cross site Evaluation reports.

The DFC Program is funded and directed by ONDCP, and HHS's Substance Abuse and Mental Health Services Administration (SAMHSA) provides day-to-day grant monitoring support. Training and technical assistance intended to strengthen capacity of the DFC coalitions, including the required National Coalition Academy, is provided by the Community Anti-Drug Coalitions of America's (CADCA) National Coalition Institute.

Currently, the DFC Program funds 698 community coalitions across the country in all 50 states, Puerto Rico, Guam, American Samoa, and the Yap Islands and Micronesia. The DFC Program awards community coalitions with up to \$125,000 per year for up to five years, with a maximum of 10 years of DFC funding. Coalitions receiving DFC funding must comply with a minimum one-to-one match requirement, effectively doubling the Federal investment in substance abuse prevention.

In the most recent evaluation of the program, in 2016, DFC coalitions were found to have mobilized over 19,000 community members, with school and law enforcement as the sectors most involved in coalition activities. For youth in DFC-funded community coalitions, there was a reported decrease in the past 30-day use of alcohol, tobacco, marijuana, and illicit prescription drugs. Because the DFC Program is predicated on developing local solutions to local problems, many of the coalitions have engaged in a range of activities around preventing the misuse and abuse of prescription drugs. Efforts have included: working with the medical community to encourage responsible prescribing and monitoring practices, especially when prescribing to youth; sponsoring prescription drug takeback days (94% of DFC coalitions reported such an event and 67% were a result of their DFC grant aware); and educating student athletes about the risks of opioid use following injury or surgery.

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 drug abuse. ONDCP supports a comprehensive approach in an effort to reduce drug use and its consequences, as well as the availability of illicit drugs. We appreciate the Committee's ongoing interest in working with ONDCP on drug policy matters, and we look forward to working with the Committee on a reauthorization measure that aligns with the Trump Administration's priorities.